HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The work of NHS England, HC 563

Wednesday 29 January 2025

Ordered by the House of Commons to be published on 29 January 2025.

Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Deirdre Costigan; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 1-94

Witnesses

I: Amanda Pritchard, Chief Executive Officer, NHS England ; Julian Kelly, Deputy Chief Executive and Chief Financial Officer, NHS England; and Duncan Burton, Chief Nursing Officer for England, NHS England.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Amanda Pritchard, Julian Kelly and Duncan Burton.

Q1 **Chair:** Welcome to today's session of the Health and Social Care Committee on the work of NHS England. Welcome to our witnesses. May I start by asking them to briefly introduce themselves, starting with Duncan Burton?

Duncan Burton: Morning. I am Duncan Burton. I am the chief nursing officer for England.

Amanda Pritchard: I am Amanda Pritchard. I am the chief executive of NHS England.

Julian Kelly: I am Julian Kelly. I am the chief finance officer for NHS England.

Q2 **Chair:** Thank you very much, and thank you for joining us in the first of, hopefully, many appearances in front of the Committee to talk about your work.

Amanda, you will have seen today that the Public Accounts Committee has published a report that questions whether senior officials in the Department and the NHS have the ideas or drive to deliver the Government's three shifts and to realise the transformational change they feel is necessary. May I invite you to respond to that report?

Amanda Pritchard: Thank you very much. There are a few points raised in the PAC report that it is really helpful to address; you may want to talk more about it during this Committee hearing. I should say, of course, that we will be formally responding to the PAC on the factual inaccuracies in their report.

But, first, I would like to say that NHS England is absolutely not complacent about productivity, and it is completely wrong to suggest otherwise. While NHS productivity is now improving at double the rate it was pre-covid, there is still a gap from where we are now to where we were pre-covid. Far from being complacent about that, we have been repeatedly open about the challenges and our plans to address them, whether that is in Committee appearances, in the media or in every public board meeting that we have. We will be publishing further improvement measures in planning guidance tomorrow—or hopefully tomorrow.

On earlier budget allocations, of course everyone in the NHS would like to see earlier budgets, and the earlier that we can give NHS colleagues their allocations and operational priorities for the financial year ahead, the better. However, if I can just quote Julian and what he actually said during the PAC appearance, "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."

It is worth saying that NHS England's planning guidance for the NHS, alongside ICB financial allocations, is subject to cross-Government clearance, and that is an important principle. It is important because the NHS budget is billions of pounds and therefore—understandably—has to be subject to proper engagement with Ministers. That is not just in the Department of Health; that has to be across Government, because these are really difficult decisions for Government. But as soon as we have had cross-Government clearance, we have released planning guidance that same day—certainly in the last two years—and we plan to do so again, hopefully tomorrow.

There is a suggestion in the PAC's report that the shift to community has stalled. Obviously, that shift to community was hugely disrupted by the covid pandemic. But that is why, far from stalling, NHS investment in primary medical care and community services increased faster than overall ICB spend in '23-24. This year, we and Government have put in additional funding for primary care to enable up to 1,000 extra GPs to be recruited at PCN level.

Finally, to your initial point, there is no shortage of fresh thinking in the NHS. At the moment, we are working really closely with Government to drive that innovation forward as part of the development of the 10-year plan, which will be a really ambitious plan to build an NHS fit for the future. But really importantly, I will just add that nobody is waiting for that in order to get on with the job of delivering reform. As the Secretary of State has said, these shifts are "not radical new ideas", but actually delivering them, of course, would be.

So, in advance of the 10-year plan, we have, for example, set out plans to go further, both in building on existing initiatives and in radical new ways. For example, the recently published elective reform plan sets out how we will provide more convenient care closer to home in the community diagnostic centres that we have been establishing over the past few years, and how we will transform patients' experience of care through the use of the NHS app.

Q3 **Chair:** I used to sit on the Public Accounts Committee. Saying that the report is full of factual inaccuracies is a bold claim. May I invite you to also write to that Committee about what those are? I also take umbrage at the quote that was put out by the Department suggesting that Parliament as a whole—not that Committee and not that report—does not understand how the NHS is funded. Putting that out the morning before you appear at the Health and Social Care Committee is, again, rather bold. I wonder if you might want to retract that particular wide statement. You have every right to respond to the Public Accounts Committee and how they might have interpreted the evidence given before them. But can we start this session on a footing that perhaps suggests that we have a level of knowledge, and that it might not be the entirety of Parliament that does not understand how the NHS works.

Amanda Pritchard: Are you referring to a quote from the Department of Health and Social Care or a specific quote from NHS England? Apologies, I have not got it in front of me.

Q4 **Chair:** It was a quote that we saw in the HSJ—forgive me, I do not have the specific quote.

Amanda Pritchard: On a personal level, let me be clear that all of the comments that have been made by NHS England refer not to the NAO report, but to the report from the PAC. We will be writing to the PAC as soon as we can, but in an appropriate way, to go through the factual issues. There is no query at all with the NAO's report, but I think there have been, clearly, some examples where the evidence of the NAO report and the evidence from the session have not been reflected in the PAC report, and those are the things that we will be writing to the PAC about. In terms of understanding how financial flows work, my experience over the last few years is that people are hugely knowledgeable within Parliament about that, and I am sure we will get into more of that detail today.

Q5 **Chair:** Yes, we are very keen to. And please would you commit to writing to us as well when you respond on those financial inaccuracies?

Amanda Pritchard: Yes, of course.

Q6 **Chair:** Thank you for responding to that report. We will be getting into the detail of much of what it said, but also more. You started by talking about the 10-year plan and the three shifts. You pointed out that it had stalled and that covid-19 was part of it. But we do need to do things differently now, don't we? What have you done, as chief exec, to prepare the NHS for when this plan is published, or will we have to wait even longer once it is published, so that you can prepare for how to actually get it done?

Amanda Pritchard: As I say, we are not waiting for the 10-year plan in order to get on with the job. It is worth saying that some of the things that we are discussing are about how we build on the work of the last few years and how we then do the new and radical initiatives, some of which we have already covered.

To take the three shifts in turn, if we are talking about what we are doing that the shift to community is building on, then a lot of the work of the last couple of years has been about putting some of the basic infrastructure in place. That is particularly things like urgent community response, virtual wards, single points of access for services, and the investment that has gone into primary care, and particularly technology—99% of GP practices now have cloud-based telephony. We have invested in triage systems, and we have invested in workforce, in particular—I have just talked about the additional GPs this year. There are a number of other things, which we are going to write about tomorrow in planning guidance, that we need to do clearly to continue to strengthen that foundational work. Then, the things that we would expect to describe in the 10-year plan will be about what the really bold and ambitious additional steps are that will turn those

pieces of the jigsaw into a much more comprehensive neighbourhood health offer. It is the both/and.

Digital is probably the area with the most visible of the changes that we have been making over recent years. I think our spending on digital has gone up by about 30% over recent years. That has gone into frontline digitisation, which is about ensuring that places have electronic health records—they are moving off paper and on to digital systems. It has also gone into the data infrastructure to join up the data that sits in different systems. The federated data platform has been the big thing on that, although not the only thing. It also includes things like making it easier for GP systems to talk to pharmacies, and vice versa. So there is a range of things in that space.

The third element of the digital investment—again, this probably comes into the slightly more transformational piece—has really been about where we have done things where there are some big bets that we have made. One of those has been in developing the app. As an example, at last count, 90% of GP practices have now made patient records available on the app—a huge shift from where we were a couple of years ago. Again, all of those are foundational steps that will allow the 10-year plan not just to turbocharge things, but to allow some really radical shifts, whether that is into AI-enabled ways of working or things like ambient technology, which have the potential to really make a difference to productivity, in particular.

On prevention, the question is always how much we are talking about primary prevention versus secondary prevention. We would absolutely acknowledge that the NHS has a huge role to play in prevention, but in lots of ways we have to be a partner to others who are much better placed to lead prevention work in the round. The development of ICBs and ICSs was a big commitment a couple of years ago—in July ’22—to saying that the NHS needed to have the right structures in place to build stronger relationships locally. They were leaning on some of the expertise and insight that colleagues in local government, in particular, have about their own local populations and the needs of those populations, and then designing solutions that would work locally, rather than us trying to do things just at a national level.

Q7 **Chair:** But that does mean you are going to have to relinquish control from the centre. Is that accepted in NHS England?

Amanda Pritchard: Completely. I do not know if you want to go on to talk a bit about planning guidance—

Chair: We do. In fact, that leads on to my question.

Amanda Pritchard: I was going to say that it leads on to that.

Chair: I am very keen to understand what levers you have that you can pull while, at the same time, genuinely allowing that devolution of power. It will mean letting go. What is the appetite in NHS England to do that in a way that is meaningful?

Amanda Pritchard: Our view on this—I hope this is consistent with what you would expect me to say—is that nobody is better placed to respond to the needs of local populations than local leaders. They know their populations; they build local relationships. It has to be done in partnership, and that is between the NHS and local government, but also between the NHS and patients, between the NHS and the public, and between the NHS and voluntary sector partners.

What we want to do is give maximum flexibility to local leaders to get on with that, but the other bit of this is accountability, because we have to have both. With planning guidance, which, as I say, is hopefully coming out tomorrow, you will see—the Secretary of State has been very clear about his view on this as well—a streamlined set of national asks. The clear intention is that that gives the space for local leaders to make the best use of their resources locally and to agree with local partners, as I have just said, how they best spend those resources to get the best possible benefit for local patients.

Q8 **Chair:** Financial leads in the NHS will also say that that perhaps gives a more realistic view of what they can actually deliver with the money they have. However we will have further questions on finances later.

I want to come back to the 10-year plan. What, from your perspective, given that you are in charge of, not an organisation but an organism—

Amanda Pritchard: Yes, very much so.

Chair: It is enormous. What do you want to see come out of that 10-year plan to help drive that transformational shift that will be different from what we have seen before? We have seen many such plans over the last few decades. What do you need out of this plan to make it really meaningful and to deliver that change, rather than you saying you will deliver the change, but then it does not happen?

Amanda Pritchard: I would say there are three things, and then some key enablers. One is a plan that sets a very clear vision that has been co-designed and built bottom-up, and that is the way it is being done at the moment, with huge, real engagement. There is not a secret plan just waiting to be revealed; this really is being developed as part of a true engagement exercise, but then setting out a very clear vision for patients, for the public and for staff. Secondly, it is the road map that sits behind that that then allows us to be very clear what the steps are that will turn that vision into reality, particularly over the next few years.

The big thing that I would like out of this is stability and certainty, so that we can all see, "That is where we are going. We know we have a plan." Aligned with that, we have a spending review settlement that means people know the resource allocation they will be planning with, and we have a clear period of stability for local and national leaders to get on with the job.

On key enablers—if we are talking about why some of these shifts have not happened in the past, apart from the obviousness of a global

pandemic—I would highlight four. One is the estate, particularly if we think about the state of the community estate, which is one of the reasons why £100 million in additional funding is going in to support the primary care estate this year. The state of the estate will be a key enabler.

Technology is another, and the continued development of not just the tech in individual parts of the system, but the join-up and particularly the data sharing.

The third key enabler will be workforce. We have a long-term workforce plan, which was produced under the previous Government, and that is due to be refreshed this summer in line with the 10-year plan. That will be really important.

The final one is financial flows and making sure we have a system that is designed to support the ambition and the road map, such that if we are shifting activity into the community, as everybody is completely committed to doing, the money follows the patients. We can make sure that that is then embedded in the way that we work.

Q9 **Chair:** That will be music to the ears of this Committee, I am sure. On that note, I want to clarify what I said earlier: it was NHSE that gave that quote, and it was not about Parliament; it was specifically on the PAC report. I do apologise for that.

Finally, I know you cannot comment specifically on the streamlined guidelines, because they have not been released yet, but do you feel—having seen them, presumably—that that balance is achieved with half the number of targets? It has been trailed that it is something like half the number of targets. My understanding is that planning guidance is not what is measured—that is separate—so, presumably, you would be expecting more localised targets from the ICBs and the ICPs. We have a plethora of targets, and any local leader will say that there are too many for them to ever be accountable for. Given the things that they have to measure on top of those, they are spending so much time doing that and not doing their actual jobs. Planning guidance aside, on the approach to targets at an even more localised level, how can you provide leadership to make sure that leaders are leading, not counting?

Amanda Pritchard: We would agree with the distinction you have just drawn between targets and transparency. The NHS produces huge amounts of data, and sometimes that is difficult to penetrate, because it is quite complex. There is more work that we should do—which we have undertaken to do—on how we make that data easier for the public to understand, turning the theory of transparency into easy-to-access, transparent data about what is happening.

It is essential that we continue to publish data on what is going on, so that local scrutiny can take place, particularly around the things that matter locally, but we are trying to distinguish between that—we will continue to do all of that work—and the things where we have said that there is now a smaller set of streamlined national asks.

Q10 **Chair:** That is a budget-setting exercise really. The national guidelines will set the core budgets for the ICBs, which get to have more flexibility on what they deliver around that, but that will not take away from transparency, which is a different endeavour, and one that I would say we support.

Amanda Pritchard: On the budget-setting, the other thing we are doing—you might want to talk a bit more to Julian about this in a moment—is reducing the number of things where there is ringfenced funding.

Q11 **Chair:** Reducing?

Amanda Pritchard: So there is more flexibility for local leaders to spend their budgets—on the range of things that they are being asked to do, to make those decisions locally. There is a bit of tension here, and it is worth being transparent about that. Understandably, there is a desire to see particular things that people care about written into national guidance, and often to see ringfenced funding around that. As you say, if you are a local leader, the risk is that, if you have lots of different targets and pots of money, that makes it very difficult to make some of those local decisions about how you do things and how you prioritise what is more difficult. It reduces the flexibility to address things in a way that makes most sense to your local population and your patients. We are trying to get the right balance between setting out some things that are national must-dos and reducing the amount of ringfences, so that local leaders have more flexibility to work out how they respond to both that national set of targets and the things that matter most locally.

It is worth saying that, just because something is not written in planning guidance, it does not mean that it is not important, and it does not mean that the work will not happen. I will pick up the example of women's health, because it has been in the media in the last couple of days. The Committee will not be surprised to hear that it is something I care about quite a lot personally. Women's health is a priority for the Government and for the NHS. We have 39 of 42 ICBs that have women's health hubs now. It is a priority that we have set out explicitly in the elective reform plan. We have regional leads for women's health, which we did not used to have, so each region has its own lead. We are working on things like a new specification for endometriosis services. We have done work on some of the policies and information available on women's health. For example, there is a national baby loss policy and a national menopause policy, and we have rolled those out within the NHS as an employer. We are not going to stop caring about all these things or stop working on them, whether or not there is something explicit written in planning guidance.

Q12 **Jen Craft:** Just to follow up on the niche subject of ringfencing and what appears in planning guidance, what is your approach to planning, and how does it ensure that historically overlooked populations in healthcare do not continue to be?

Amanda Pritchard: I really recognise that people have different views on the ringfence issue. There have been times when we have had lots of

ringfenced funding to try to drive progress in certain things. In line with the shift of your direction, Chair, at the moment we are really clear that we want to actively shift to a more local, devolved leadership arrangement within the NHS and stronger partnership locally. The only way we are going to do that is by giving people more freedom and flexibility on how they spend their money and what they do.

Having said that, this transparency point for us is then a bit of a safeguard. For example, we now publish data on inequalities as a core part of the data that we look at nationally and what we expect people to look at locally. Just to take one example, if we are looking at elective reform, we publish the data on waiting lists nationally not just on total numbers but cut by inequalities, so that you can see whether there is disproportionate access for people from particular backgrounds or deprived populations. We are choosing, where we have the opportunity, to prioritise our initiatives around inequality. One such example is the Further Faster 20 work, which is the Getting It Right First Time team working with those trusts to tackle those with the longest waiting lists, where we have the biggest inequalities challenges. Trying to mainstream the data, and therefore the focus, on inequalities within all our policies has been the approach that we have been trying to take, rather than ringfencing funding around specific inequalities initiatives. Was that what you meant? Sorry, I might have slightly misunderstood the question.

Q13 **Jen Craft:** Almost. I am interested in whether your approach going forward is to remove ringfencing in general in planning guidance.

Amanda Pritchard: Sorry, I have gone right into the detail of something completely different—my apologies. Yes, in principle that is the approach we are now trying to take but there are some exceptions to that. Importantly, for this year, we are retaining the mental health investment standard.

Q14 **Chair:** For this year? That is interesting.

Amanda Pritchard: For this year and for next year—and I am not pre-empting planning guidance because I know the Secretary of State has said that to the Committee before.

Chair: That is right.

Amanda Pritchard: For next year, that ringfence will remain and there are a few others but, as a direction of travel, we are trying to reduce the number of things for which there are specific ringfences.

Q15 **Jen Craft:** Can you provide a list of existing ringfenced spend, and what it will look like going forward?

Julian Kelly: When we publish the planning guidance, we can work that out and, in writing, we can set out for you what has been ringfenced this year—

Chair: Yes please, and what has been removed.

Julian Kelly: And what has been removed, and what is ringfenced for next year. You will then be able to see the difference.

Chair: We would be keen to follow that through because the consequences may be interesting over time.

Julian Kelly: As a point of principle, I would not say that all ringfenced funding is bad; it is a question of choosing when and where it is appropriate. Take the example of targeted lung health checks, where we provided ringfenced funding to drive a programme of work that we know improves early cancer diagnosis and saves lives, and which we focused on areas where we know there have been high health inequalities. As a result, we have seen a change in the early cancer diagnosis rate—the first since we started measuring it—and a narrowing of health inequalities. It is a question of being very careful and choosing when it is appropriate, but we will reduce the total number of ringfences.

Q16 **Jen Craft:** Do you not feel that there is an appropriate case for ringfencing women's health, if we look at the specifics? The Women and Equalities Committee identified pervasive misogyny in the healthcare system. Is there not a case to be made that ringfencing would go some way to addressing that? I understand what you said about measuring inequalities, and having that as a measurement standard across localised healthcare, but is there not a risk that we are aware of the problem of pervasive misogyny and that the solution to it is ringfenced spend?

Amanda Pritchard: I shall start on that, but I am sure Duncan will want to come in because Duncan leads for women's health in NHS England.

I agree about misogyny. We are clear that there is a big cultural challenge within the NHS, and the work of the Women and Equalities Committee has been really helpful in shining a light on that. We are supporting lots of specific initiatives that speak to some of the particular needs of women and the things that they have told us are priorities, such as endometriosis diagnosis and care, where people can have multiple different appointments in multiple different places before they get a proper multidisciplinary assessment treatment plan. The commissioning specification is an important part of responding to that and saying, "We know we can do this better and we have to." But that is not going to address the bigger cultural challenge in an NHS that was initially, largely speaking, built by men and does not always have the needs of women at its heart.

The other big parts of what we need to do are things such as the regional women's health leads, and the women's health network of senior clinicians and leaders working together to look at how you make every part of the service more responsive to women's needs. It is about working out which are the best levers to do that—though I will let Duncan speak for himself.

I agree with Julian that ringfencing can be a very powerful lever, but it tends to work best when there is something quite specific that we are trying to fund and do differently. Our sense is that the misogyny is a much

bigger challenge, and we will need to use different approaches to make real change happen.

Duncan Burton: I want to say how important this is to me. I am at the head of a profession that is 90% female. It is really important that we get this right for women and girls. Our ambition is to have a women's health hub in every ICB and, as Amanda said, so far 39 ICBs out of 42 have one, but we actually have more women's health hubs than that—over 80—because other ICBs have, locally, taken the example given by those 39 ICBs and expanded their services. It is important that we share the successes of these initiatives to make sure that there are local decisions to invest in them and take them forward. But we also have lots more to do on this, and it is really important to recognise that we have a long way to go. As Amanda said, we are doing work on how we provide good national leadership on this. We now have our first national clinical director for women's health championing it, and supporting the champions that we have across regions and ICBs to lift the profile of the work. There is also work on how we make sure we have better information for women on things like the NHS website, where we have over 100 more pieces of information on a whole range of areas around women's health, from contraception and heart health to periods, as well as tools to help make decisions around that.

Q17 **Jen Craft:** There is one other thing I want to pick out. You said there is a health hub in pretty much every ICB. There is an ambition to have one in every ICB area. Is there potentially a risk that, if you remove this ringfence, ICBs that are not doing that work and do not have a hub may opt to put their funding somewhere else? You speak about a cultural issue, and I think we all know that that cultural issue is there—this underlying misogyny. If you look at it on a micro and local level, funding decisions that are inherently male are still being made. Is this not one way to ensure that 51% of the population do not continue to be overlooked?

Duncan Burton: There are two things. One is recognising that all our services are caring for women and girls. One of the things that we have been doing nationally is making sure that we bring together not just the women's health programme, but all the elements across NHS England, such as cardiac or cancer care, to ensure that we focus on the needs of women, and obviously other groups as well. That is one way: bringing that leadership together.

On women's health hubs, I can also give you the example of Tower Hamlets hub, which has reduced the number of women requiring secondary care from 85% to 26%. That is a good example: why would you not do this? Why would other ICBs not start adopting that? The fact that we have had some ringfenced money this year to demonstrate the impact enables us to spread the information and the success, so that others can adopt it.

Q18 **Gregory Stafford:** I declare an interest as previously having worked for NHS England. Let us go back to the 2% productivity that you say we are going to achieve by 2028-29. Can you outline how you are going to

achieve that? How is that reflected in your financial and business planning?

Julian Kelly: It is worth rehearsing a bit of the productivity story. Clearly, there was a big drop as we went through covid. The ONS data published for '21-22 shows quite a sharp recovery, but not back to pre-pandemic levels. I will admit that we have particularly been tracking acute sector productivity, where we have the best and most comprehensive data. I will come back to that. We are now measuring—it is early days, so the data will need improving—both community service productivity and mental health service productivity. We are looking at this in the round.

We are working with the Office for National Statistics and the University of York to look at how we can continue to improve the measurement of productivity across the NHS. In particular, we are looking at how we take proper account of prevention work, where often you are investing in something, but the output is not like that of a healthcare treatment—it avoids a healthcare treatment, which is clearly a harder thing to measure.

Q19 **Gregory Stafford:** Sorry, can I just interrupt? What you are saying is that to get to 2%, you are going to change the way you record stuff.

Julian Kelly: No, that is not what I am saying. I am saying that that is the work we are continuously doing to improve our understanding and measurements, and to properly take account of prevention work, which is otherwise hard to capture in productivity data. I am saying that we are working constantly to refine it and make sure that we are not, for example, disincentivising prevention work.

On the 2%, since '22-23, '23-24 and now '24-25, we have been seeing acute sector productivity recovering by around 2% a year. That is what we are currently achieving. Year to date, at the end of month seven, October, we see that, compared with last year, acute sector productivity is about 2.4% higher, so we are currently achieving the 2% a year goal in the acute sector. We can see that there is still a gap to recovering to pre-pandemic levels, so this is not complacent—there is still a challenge for us to go at. As we look at the next few years, our way of tackling that is first to focus on continuous improvement.

We can see from the data that we can continue to improve length of stay. When you benchmark mental health trusts, community trusts and acute trusts, you can see those who are high-performing or not performing so well. We provide all that data to trusts and commissioners. We are investing this year in a national modernisation improvement programme focused on improvement in length of stay. We think length of stay is one of the big drivers of the productivity hit that we have seen. We are still almost a global leader in that area when you look at international data, but we think we can go further.

There is further to go in out-patient productivity in avoiding unnecessary referrals. We have made big advances in that through advice and guidance, and we think there is further to go across the country. We can see the variation is out-patients per clinician across the country, so we are

focusing on that with clinical support. We will continue to look at—when it comes to the radical transformation—how we continue to promote patient-initiated follow-up, where you avoid unnecessary follow-ups. We have not made as much progress as we wanted, but we are beginning to see the data turn there. Those are areas focused on continuous improvement.

We are improving the use of our workforce through improved retention, which, by the way, is at the moment around 7%—much lower than we have had historically. We have invested in a national retention programme.

Amanda Pritchard: Retention is higher.

Julian Kelly: Sorry, retention is higher; turnover is lower. Because we have improved the growth in the substantive workforce, we are now driving down the use of temporary staffing. We have seen a big reduction in agency spend—about almost 40% over the last two years. We can see that using substantive staffing rather than temporary staffing improves productivity. That is an area focused on continual improvement.

We have streams of work focused on improving prevention, such as increased use of the diabetes prevention programme—growth in the numbers there—and improved management of hypertension and cardiovascular disease. We think that will improve productivity over the next few years by about 0.2% or 0.3% a year.

The thing that will transform it over time, which we will really see come through in '26-27, '27-28 and '28-29 is the investment in technology-enabled change. At the moment, we think we can do 2% a year—a lot of that through the things I have just described, but as you get into the back end of this Parliament, it will be through the programmes of work that Amanda has already referred to: the investment in electronic patient systems, the basic IT in providers and the federated data platform joining up the data across the NHS.

Q20 **Chair:** We are going to come to digital transformation in a moment. Can I pick up on the point you made about length of stay as one of the key drivers? Are you referring to social care? Where does that fit in all of this?

Julian Kelly: There are clearly two issues in broad terms. One is the internal NHS processes, such as when someone is ready, making sure—within hospitals—that discharge notes are done, and pharmacy prescriptions are provided. There is still a job of work within NHS organisations, and we can see where the variation is to improve NHS processes.

Q21 **Chair:** Absolutely, we accept it is not the whole of it, but where does it play its part? I am trying to speed you up a bit here.

Julian Kelly: I am just saying that there is some that is the NHS, and then we can see that access to domiciliary care does impact on the ability to get people out of hospital. The previous Government put about £1 billion in through a discharge fund. We are trying to simplify the

arrangements around the better care fund, being much clearer jointly with MHCLG on what the goals are for the better care fund, particularly around faster discharge and fewer admissions from care homes. There is work going on, but clearly domiciliary care capacity has been an issue.

Q22 **Chair:** I am trying to make a specific point. You are putting a big bet on the digital stuff, and we will come to that in further questions. What I am trying to get to is this. What is social care worth to NHSE in terms of productivity, and do you have a number for that? If you do not have one with you, could you write to us?

Julian Kelly: We could write to you with at least a number on that.

Chair: We would be very keen to see it. As you might be aware, we have got an inquiry on this, and it would be very helpful to the work of the Committee. Thank you.

Q23 **Gregory Stafford:** Carrying on from the Chair's point, putting aside digital transformation, which we will talk about in a minute, what else are you going to do that is a radical transformation programme? A lot of what you have said is very steady as she goes—we are going to do a little bit better at this and a little bit better at that. To get to real productivity increases, surely there has to be a massive transformation of the way the NHS runs itself, and I have not really heard much about that. Does it help that you still only have an interim director of transformation at NHS England? Why have you not got a substantive director of transformation?

Julian Kelly: We can come on to the particular role—Amanda can pick that up—but technology is the thing that will allow some absolutely radical change in the way the NHS works. Through the development of the app, we will be able to put more of the information and power in the hands of patients themselves. We will be able to give them better guidance. It will in future be possible for them to link up their own health data in real time, even through the classic wearables. It will be possible, over time, for people to track what is going on with patients outside of hospital conditions.

Amanda mentioned things like ambient voice documentation and the use of large language models. We have just run a large-scale trial with NHS England, in conjunction with Great Ormond Street, looking at its use in primary care, ambulance services and acute trusts. We can see that that could make a massive difference in clinical productivity and the reduction of time clinicians spend on admin tasks—

Q24 **Chair:** All of this is really interesting to the Committee. We would love to see numbers, so please write to us later. All these workstreams are fascinating to us, and you are giving us great examples, but we want to see the numbers behind the examples.

Julian Kelly: It is worth saying that we think that by the time you get to the back end of the Parliament, with the appropriate investment the 2% should account for around half the change, year on year.

Q25 **Gregory Stafford:** Just to be clear, why do we not have a substantive

director of transformation? I think Vin Diwakar is a great guy, but why is he not the substantive director, or someone in his place? Does that not give a message to the sector that transformation is not as important as you suggest it is?

Amanda Pritchard: Shall I take this one? Thank you for saying what you have; I think we are incredibly lucky to have Dr Vin Diwakar as our interim lead for transformation. For those of you who do not know him, he is a paediatrician and also a real expert in this area, so he brings that clinical focus along with a deep understanding of what it takes to deliver change, as well as a really ambitious programme around all the things that Julian has just said there—getting on with the job, putting the basics in place and the innovation. All the things we have just talked about—those innovations—have happened under Dr Vin Diwakar's watch, but also thanks to his fantastic predecessor, Dr Tim Ferris.

Particularly with a new Government in place, the opportunity now is to make sure that between us and them, we are confident that we have the right leadership arrangements in place across NHS England and the Department, so that we are aligning with the vision from the 10-year plan and, as the Secretary of State said to you before, really working as one team at the centre of the NHS and making sure we have the right complementary skills across the piece. But for me, that strength of clinical leadership is absolutely one of the things that makes NHS England best placed to do its job, which is to really support the NHS to deliver. It is great to have Duncan alongside me today, but having Vin as one of the senior colleagues is another huge asset.

Q26 **Gregory Stafford:** Were you hinting there that there is going to be another reorganisation of NHS England?

Amanda Pritchard: As you probably know, we have just completed a very substantial reorganisation, bringing five organisations into one. We have reduced the headcount of NHS England by 35% as a consequence. It was a very difficult and long process. I have been on the record thanking my colleagues at NHS England for their patience and professionalism through that—I would like to say that again, if I may. But we are very clear that what we now need to do is not another big top-down set of changes, but we do need to continue to do the work where we look at making sure of two things: first, that we are really aligning around the priorities of this Government—both the today things, as per planning guidance, and the 10-year plan—and, secondly, that we are also continuing to make our organisation work as effectively as possible to support the NHS, so the operating model. That includes looking at where we can work even more closely with the Department, as well as where we can devolve more out to ICBs and others.

So, no big top-down reorganisation, but definitely a process of continually looking at how we, frankly, continue to bear down on the centre so that we are releasing funds out to the NHS and working as effectively as we can.

Chair: Thank you. We need to move on.

Q27 **Joe Robertson:** Good morning. The NHS has received a funding increase of £10.6 billion additional money, but there are clearly additional costs in there that will have to be met, through inflation and pension contributions and national insurance contributions, to the extent they are not rebated. What assessment have you made of how much that £10.6 billion will go towards simply meeting increased costs?

Julian Kelly: Much will hinge on the pay settlement, but if the pay settlement were in line with our evidence to the pay review body, where we have said we can afford a 2.8% pay settlement, that would cost about £3.8 billion. The ENICs pressure is worth about £1.6 billion. We know that the kind of non-pay inflation that we see, based on Treasury forecasts, is worth about £1.9 billion. Then you have what we know will come through in the cost of new treatments and medicines, in particular those approved by NICE already agreed or that we can see in the pipeline. That adds about half a billion pounds-worth of pressure a year. Then, clearly, we are already in negotiation with the GPs on a new funding deal. That adds about £0.8 billion. That does consume most of the £10.6 billion that you just discussed.

Q28 **Chair:** If we were adding it up correctly, that is £8.6 billion. Is that about right?

Julian Kelly: Let me quickly do the maths. It is £3.8 billion plus £1.7 billion—which is the ENICs pressure this year. That gets you to just about £5.5 billion. The £1.9 billion gets you to about £7.5 billion. Then it is another £1.3 billion on top, so that is about £8.8 billion.

As I said, it then depends what actually happens on the pay deal. Normally, basic demand growth in the NHS is worth about £3.5 billion a year—it is worth about 3%—so, clearly, it does not cover that. That is where this year the real focus has been on us working out what we reprioritise within NHS England, what we can do in terms of reducing our own costs, plus, clearly there is not a lot of new investment that will be going into new transformation programmes, because we cannot afford it, and then it is a real focus on productivity within the NHS and the recovery that we were just talking about with Mr Stafford.

Q29 **Joe Robertson:** Thank you. The Secretary of State has also said that raiding the capital budget to fund day-to-day spending in the NHS will not be permitted under new rules. Are you confident that operational costs will be met this year without raiding the capital budget?

Julian Kelly: In ’24-25?

Joe Robertson: Yes.

Julian Kelly: The Treasury will not agree to do any capital to revenue transfers, so there is no plan to switch further capital to revenue to meet cost pressures this year.

Q30 **Joe Robertson:** Given that there has been raiding of the capital budget

long term—I am not seeking to make criticism of that in this question—how confident are you that you can meet the Secretary of State's requirement that it stop in the future?

Julian Kelly: With all the pressures and recognising all the extra funding that has come in to meet things like pay deals, we will live within the NHS budget this year. Our responsibility is to set a plan for next year that lives within the money voted by Parliament. That is what we are doing. The straightforward thing to say is that it is incumbent on us to do it. Next year, as we have just discussed, £10.6 billion is coming in, but a lot of that goes on meeting basic cost pressures; it does not go to fund lots of new activity to meet basic demand, so there is a real focus on driving productivity. That is not easy. We have a plan to do it. Clearly, it limits to some degree the amount of new investment you can put into things you really do want to go further faster on, like technology or some of the things around prevention. But that is the set of decisions that, with the Secretary of State, we have made, and when we give planning guidance, it is with a view to us therefore having a plan and a budget that match up, so that we can live within the total funding.

Q31 **Danny Beales:** My section is on digital transformation, which has been highlighted as quite a major plank in delivering the sorts of changes that are needed in the health service. One of the three major shifts is from analogue to digital, and arguably the other two shifts also hang quite importantly on digital transformation, as you have discussed. We should say it has been discussed for quite a while—electronic patient records, digitising the NHS, getting rid of the fax machine. Apart from spending a bit more money on this, what will NHS England be doing differently in practice to actually deliver transformation as opposed to just talk, as we have had previously in the health service?

Amanda Pritchard: I will start and then I will let Julian come in. We would point to, at the moment, that additional investment unlocking genuine productivity benefit as being one important piece of evidence about why this is not just talk. The whole conversation we have had about productivity brings to life the fact that this is about us doing more of what we are already doing, because we are already delivering that 2% this year and last year, and really saying that continuous improvement approach will keep getting us quite a lot, particularly over the next year or so. But if you look to the longer-term future, it absolutely will be critical that we have got the benefits from technology starting to come through even more strongly than they are already.

I should add that one of the other reasons why we really welcome the focus on maintaining capital funding as capital is that that is another critical enabler of productivity in the longer term. It is also a disabler of it if you do not keep backlog maintenance up to date. I am sorry; I know this is a bit of an aside, but we think it is at the moment a drag factor on productivity, of potentially even up to about 0.5%. So the ability to have that as ringfenced funding is hugely welcome.

To go back to your point about transformation, we know that places with a mature EPR tend to have, on the evidence collected so far, productivity that is about 13% higher than other trusts, so putting the money in to enable everyone to have a decent EPR is a hugely important building block of everything else. We have got about 90% now in place. There are a few more that still need the work done over the next year. Then the second big thing—again, any colleagues who work in the NHS will recognise this—is the joining up of different systems. There is at the moment a lot of wasted time in re-entering data between different systems, logging on to different systems, manual transfer of data, which also brings risk with it—

Q32 **Danny Beales:** You are clearly outlining the problems with the system, which I completely agree with. I suppose my question is what, structurally, culturally or organisationally, will be done differently by NHS England. You have now subsumed NHS Digital. From the centre, in your leadership role, what will you practically be doing? What I have heard so far is that it is kind of a bit more of everything—just doing a bit more, moving the dial a bit—

Amanda Pritchard: Do you mind if I keep going? Sorry, I am conscious of time, but I am just trying to build up the layers of this. It is really important, because I absolutely understand—and we will get to it—that some of this is about radical transformation and what we can do differently, but just to make the really obvious point, we cannot do the really exciting change stuff if we do not have the basics in place, because you cannot put paper through the app.

Q33 **Danny Beales:** Just to challenge that, in Hartlepool at the moment, they are rolling out robotics surgery and they are using AI in MRI scans. You said it is not possible, but why is it fair that in a system like that, people in Hartlepool have access to quite radical transformation and digital innovation, but those in Hillingdon do not? Again, what is the centre's role in driving that? Surely it is not just about EPRs, because a lot of systems do have EPRs now, as you have said.

Amanda Pritchard: Ninety per cent, yes, but we do have to finish the job, and there is still a job of work to do to make sure community trusts and mental health trusts also have that basic EPR coverage. I agree with you completely. From an equity perspective as well as a productivity perspective, we actually do have to finish the job and make sure everybody has the basics in place, so that everyone can then benefit from the next bit.

Q34 **Danny Beales:** So you are saying that delivering the 10-year plan, switching the health service from analogue to digital, involves getting the last 10% of trusts on to EPRs. It does not sound like the transformational vision that is in the 10-year plan, potentially.

Amanda Pritchard: Sorry, I am just saying that that is the foundational layer. If you do not do that, you cannot do the rest. We can have cherries on the cake, but if we do not have a cake, we are only eating cherries. The building block is finishing the job on frontline digitisation. That is not just acute trusts; it has to cover mental health and community, and there is a

big job in primary care. Primary care is well covered, but it then becomes about my second point, which is the connectivity between those systems.

If you really want to drive productivity and change, we need to stop people having to re-enter data lots of different times in lots of different systems, so the second big thing we are doing—and the FDP was a new thing. It is one of the biggest procurements we have done in the public sector, certainly in the NHS, and that was last year. That is already paying back in some of the ways that we can see trusts are able to do things, like better manage waiting lists—much more efficient waiting list management—and patient flow, which is one of the things that Julian was just talking about. But that cannot be a thing on its own; we also need to do things like continue the work we have done to connect pharmacies to GP surgeries and GP surgeries to secondary care, so that secondary care can prescribe straight to community pharmacies, for example. That connectivity layer is the next key building block.

The third bit is where we get on to the more transformational and—I agree with you—much more exciting stuff. We have brilliant examples across the NHS now, where those things are in place, of people showing what you can do with real innovation, so the third big bit of this is spreading that across the NHS so that everyone can benefit, and going further.

Q35 **Danny Beales:** I guess my question, which I asked five minutes ago, is how and what you will be doing to do that.

Amanda Pritchard: It is specifically the app—I am on my third layer. It is continuing developments on the app. The priorities at the moment are continuing the roll-out of, and investment in, the ability of patients to manage their own appointments and have much greater connectivity. It is not just being informed about what is happening but changing appointments, being informed about appointments and having genuine two-way communication. It is also things like proxy access, so that you can manage care for children and older people through the app, and so on. There are loads more things that we can do with the app.

Secondly, it is things like the use of AI. Going back to some of the stuff Julian was saying, we have got pilots in place, such as AI supporting the writing of discharge summaries. For junior doctors at the moment in Chelsea and Westminster, there is a pilot going on that is allowing AI to write the discharge summaries. If that works, it is something that we will then nationally support being rolled out much more widely across the NHS, but we have got to test that it is safe first and work out how to do it. That is a good example of something that is going on. Julian has just talked about ambient voice technology. We have just done a big pilot of that, and we would really like to do that in primary care at scale now. We could go on, and there are loads of other specifics, but those are the kinds of things that we now—

Danny Beales: That is helpful. I am just conscious of time.

Amanda Pritchard: Our role is to support and sponsor those things to happen, so that we can do the learning and work out how to do them at scale. You are absolutely right: our job is to support the NHS to learn from—I think that was the Secretary of State's phrase—the best of the NHS to the rest of the NHS.

Q36 **Danny Beales:** It might be worth reflecting on what that role is, because I have not really heard compellingly what it is to drive pace and transformation.

When will the NHS be paperless? When will pagers, fax machines and mountains of letters going between primary and secondary care be a thing of the past? Is there a date by which that will be achieved?

Amanda Pritchard: Many previous Secretaries of State have made commitments about being paperless. Almost all of them have ended up regretting making a specific commitment on that, not least because it has turned out to be true that it is much more complicated than just doing the secondary care side; it goes back to the connectivity point.

At the moment, we do not have a specific timeline of investments and developments that would allow me to say to you, "We have definitely got it cracked by this particular date."

Q37 **Danny Beales:** Are there specific dates for this kind of issue?

Amanda Pritchard: What we will be able to do, which will hopefully be part of the road map that sits behind the 10-year plan, is set out much more clearly what the next few years will look like in relation to the technology development and roll-out. We would then be able to give you a much clearer sense of what that will look like.

Q38 **Danny Beales:** Apologies for rushing you; so there isn't a date in mind. I appreciate the context, but I have two more points before I finish in two minutes.

Neighbourhood working is obviously crucial to the future of the NHS. You have talked about the lack of interoperability between different parts of the health sector in digital infrastructure. We heard that ourselves when we recently heard about Health Checks and the lack of data flows between local authority commissioners and providers and real issues in service provision.

In terms of data sharing and electronic patient records, will that expand to primary care and to community care settings? Are any plans in place for that? I think the Hewitt review also called for a minimum data-sharing framework for the health and care service. Are you committed to that?

Amanda Pritchard: Do you want to pick this one up, Julian?

Julian Kelly: GP practices are already well covered by electronic patient record systems. We will complete the implementation of EPRs into our major trusts, and I include in that community trusts—

Q39 **Danny Beales:** Apologies again—I am sorry to rush you. I am not asking

about trusts or GPs: I am asking about broader primary care and other community healthcare settings. Are there any plans there?

Julian Kelly: But our community trusts do lots of our community services. We have clearly done and will continue to do a lot of work on, for example, joining up community pharmacies with our acute trusts and GP practices. There is a lot more that remains to be done. We will be joining up the app, so we are joining up patients with the trusts and their GP practices all through one mechanism. My answer is: yes, that is the programme of work that is going on. As Amanda said, the data platform is absolutely about how we join the data up.

We continue to work with local authorities. We have data-sharing agreements with 152 of them. We have a specific team that meets with local authorities and public health providers—

Q40 **Danny Beales:** Is there a commitment for a minimum data-sharing framework with all ICS areas? I think the Hewitt review recommended that. Do you think that has happened? Is that still to happen?

Julian Kelly: We are putting things in place. There is a common framework and common legislation—it is complicated, but there is common legislation. The point of trying to join up the EPRs is to set a consistent set of data standards that makes it easier technologically to do it. That work is under way.

Q41 **Chair:** It sounds like you are describing the framework.

Julian Kelly: Yes.

Chair: Thank you; that is good.

Q42 **Josh Fenton-Glynn:** I am going to focus mainly on the shift from hospital to community, which is one of the other major shifts. First, Darzi outlined that since we said that we wanted to shift from hospital to community in about 2006—this is a multi-Government failure—we have gone from 47% of the NHS budget being spent in hospitals to 58% of it being spent in hospitals. What will that go down to?

Amanda Pritchard: I think your analysis is spot on. The Darzi review was really clear about this, which is why the long-term plan in 2019 set out clear ambitions to shift. As we know, we had covid, and that is why we have disproportionately put money back in, particularly in the last couple of years. There has been a start. It is not the end, but we have started to do exactly what I think you are asking for, which is to see that change.

There is a big job of work on financial flows to make sure that, as we move work, the money follows. On Julian's point, we must properly recognise the value of prevention activity and ensure the funding follows that. At the same time, we clearly do not want to take funding from acute trusts, which would mean that there is an impossible ask: they would have to resolve the elective backlog, which is still crucial, while dealing with the needs of patients coming through the front door, particularly through urgent and emergency care. There has to be a bit of a balance. At the

moment, we are trying to ensure that every year we keep shifting and shifting—

Q43 **Josh Fenton-Glynn:** That is why we have the 10-year plan.

Amanda Pritchard: The 10-year plan is the big opportunity. You are right to say that neighbourhood health is likely to be one of the big features of that, but we are not waiting for it; we are continuing to do the work to build the foundational layers.

Q44 **Josh Fenton-Glynn:** What is the proportion in hospitals going to go down to?

Amanda Pritchard: As I say, I do not want to set in January an answer to the 10-year plan, which is going to come out in the summer. We are all committed to seeing that change year on year, but at this point I would be speculating if I gave you more detail.

Q45 **Chair:** Could we expect an answer to that question in the 10-year plan?

Amanda Pritchard: Again, I would not want to over-commit to something that hasn't yet been fully completed. As I say, that huge consultation exercise is ongoing at the moment. What the Secretary of State has said—we totally support this—is that there needs to be a road map or a delivery plan that goes alongside the vision of the 10-year plan. I expect that we will all want to see more detail in that.

Q46 **Josh Fenton-Glynn:** Earlier, you resiled against the idea of ringfences. This morning's PAC report says that NHS England "acknowledged that there would have been more investment and progress in enhancing community services in 2023-24 had it not been obliged to redirect funding to prop up the day-to-day spending of local NHS systems." Is the problem with getting rid of ringfences not that we just end up fixing and keeping going the systems that are already not adequate?

Amanda Pritchard: The thing about ringfences, as we have discussed already, is that they are actually a bit complicated. I apologise if I sounded like I am too black and white; I am really not. Julian has made the point that, where there are specific things that we really can see the benefit of, there is a strong case for ringfences. Equally, if we are going to trust local leaders and move to a more devolved model, we have to untie their hands on some of this.

From a national perspective, we have not reprioritised the funding for community and primary care investment. We have been through a number of reprioritisations over the past couple of years, and we have had to look at some of the other funding pots that have been available nationally in order to give more funding to ICBs. As you say, there is a risk within ICB allocations, which are big amounts of money. The day-to-day reality, particularly before and during covid, has been that the pressures of acute spend have meant that it is harder to find funding for some of the things they would have wanted to do—you will speak to them directly about prevention and other things—because they have ended up having to prop up acute funding. That is why we have unapologetically been focusing on

acute productivity over the past couple of years, and will continue to do so, as well as all the things that I have described in this Committee so far. It is about how we support our acute colleagues—I was one, and I ran an acute and community trust until a few years ago—to make sure they have the tools to deliver. That is particularly about technology, estate and so on.

Q47 **Josh Fenton-Glynn:** I am slightly concerned, because I asked about left shift and you have told me about acute services, which is very much not the shift that we need to see. I appreciate that we need to have the ongoing funding for left shift, but that does not indicate to me that there is a shift in resources. If you look at the prevention question, which is one of the other shifts, one of the points that is made in the PAC report is that the public health grant is going down. It says very specifically that there needs to be a shift in NHS culture and resources towards prevention, so what are we doing? Again, I don't want to hear that there is more money needed in acute services, because I appreciate that money is needed in acute services because prevention has not been done. What are we doing to shift NHS culture and resources, as we are going to have to do with the last public health grant, to both community and prevention?

Amanda Pritchard: My apologies. I thought your question was about how we stop acute services taking up more than their share of the budget, so that is why I was giving you the answer about productivity in acutes, and what we were doing to try to make sure that that isn't the case in the future.

I think what you are saying is: what are we doing on the community shift? Some of the things we have done over the past couple of years have really been about making sure, particularly as far as general practice is concerned, that there has been technology investment in things such as cloud-based telephony, and in the ability to put triage systems in place in the workforce. We have got the increase in ARRS roles, and now specifically, the funding has gone in for up to 1,000 additional GPs this year. We have got additional funding going in for premises this year, as well. We have to try to recognise that there is a huge amount of work to do. This is not a magic bullet; it just begins the journey.

On community services, it has about been virtual wards, so we have now got, I think, well over 12,000 virtual wards. That is in people's homes, but provided predominantly by community services. It is urgent community response services and single points of access, which don't sound terribly exciting but are actually crucial because that is about making sure the patient has the services co-ordinated around their needs. There are also frailty services and fall services.

All of those are building blocks that we have been investing in over the past few years. In a sense, the investment bit means people and tech, and being able to now be in a position where we can start to join that up to begin to form something that looks much more like that neighbourhood health model.

Where does technology matter in this? It matters because it means being able to really segment your population, understand their risk and understand their needs. Then it is the proactive work led by GPs. They are the heart of this model and it is what they want to do, and do, every day, but with an increased focus on continuity of care.

One of the things we are trying to do through the new contract, as well, is support that much more proactive assessment of risk to support patients in their own home, with all of those services available if they do hit crisis, as well as free up time—this is where those additional roles become really important—to do some of the secondary prevention work. Again, I think we would all acknowledge that that took a particular hit in covid. Now it is partly incentivised through the contract, but it is one of the things that we are looking at: contract reform to help go further, particularly for CVD and diabetes, which speaks to the secondary prevention point.

Q48 **Josh Fenton-Glynn:** You talked about how we are shifting things to GP, and getting more efficient and better services there. Have you done any evaluation on how GP telephone triage is working?

Amanda Pritchard: We have got PCN pilots that we are working with at the moment, and they are really exploring with us a whole heap of things. That includes how cloud-based telephony is working. They are sharing all their data with us on volume of calls, speed of response, number of drop calls—all of that data. They are also sharing with us their experience of triage, so there are really different systems in place.

Q49 **Josh Fenton-Glynn:** How are you evaluating that data?

Amanda Pritchard: That is ongoing at the moment, but it is a partnership approach between those PCNs and NHS England. It is a real open-book arrangement. I met with some of them, I think it was just last week or the week before.

Q50 **Chair:** Can you give us a timeline on when you will be evaluating that?

Amanda Pritchard: I will have to write back to you on when we will get a final report. We do audit weeks once a month at the moment. It is real open-book sharing, because we are also looking at the financial sustainability of practices. I think we all share the same ambition, which is to have a really thriving, sustainable primary care service at the heart of a neighbourhood health model. This is the detailed work that we are doing with those partners to try to make sure that we really have understood the impact of some of those initiatives. Then we can course-correct if they are not working in the way that we would want them to, or that they would want them to.

Q51 **Andrew George:** On the issue of workforce and workforce planning, there hadn't been a long-term workforce plan until about a year and a half ago. I wonder to what extent the lack of workforce planning up until that point had hampered the ability of the NHS to achieve the productivity and efficiency gains that you are seeking. Now that it is in place, and I think it will be updated in the summer, to what extent is it likely to drive efficiency

gains, or be a means of seeking the efficiency gains, that you seek to achieve?

Amanda Pritchard: I might let Julian come in, because of the link that you have rightly made with productivity.

By way of introduction, I will just say that there has been real cross-party support for a workforce plan, which was completely right. There are three elements to the plan: train, retain, reform. Some of the plan definitely reads across to productivity in relation to retention and, as we talked about before, sickness, and really supporting our staff, which is a huge component of it.

However, on the reform part, to be honest, productivity is important, but it is also just as much about making sure that as the health service evolves and changes, we also have a workforce that has the skills to be able to work in different ways. One of the things that will be critical to some of the neighbourhood health work will be colleagues who have the right skills to work in the community but also more generalist skills to deal with the whole person.

Do you want to pick up from there, Julian?

Julian Kelly: One of the real benefits of having a long-term workforce plan—inevitably, you are making assumptions about the future, some of which will turn out to be wrong and some of which will turn out to be right—is just being able to track and have some sense of where we can see that we have problems with the workforce, and then consider whether our plans to address those issues, for example in mental health nursing or learning disability nursing or radiographers, are on track. If they are not on track, are we taking action now, cognisant of what you need to do in three and four years' time? Clearly, if you do not have the right people in the right place, you will end up with a productivity problem. I would say that that is a real benefit.

Q52 **Andrew George:** It was not intended to be a trick question to draw you down the route of just looking at the plan in two-dimensional terms—purely in terms of productivity.

Looking at workforce needs, your other clear headline requirement for efficiency gain, is there not a tension between some of the policy, such as pursuing changes to the workforce, and pressures on the workforce that might be counterproductive?

For example, there is the failure to respond, as some professionals would argue, to address clinical numbers—for example, the ratio of clinically trained registered nurses to patients within the acute sector is causing difficulties with retention of staff. A lot of those staff are retiring early because of stress and other reasons. It can be counterproductive not to address those issues. As for perhaps bringing in nursing associates, sort of dumbing down standards, is that likely to be counterproductive? On the face of it, you can see that potential superficial efficiencies might be gained from it, but perhaps in the long run it might be counterproductive

in terms of the actual outcome.

Duncan Burton: I will pick that one up. I think the first thing to say is that it is really important that we set standards around safe staffing. We have mechanisms in place nationally to direct that, because we know the impact that not having the right number of staff with the right skills in the right place at the right time has on patients. We have systems and guidance in place for our trusts, our chief nurses and others to be able to set the standards on safe staffing. That is really important. However, that also has to be balanced with efficiencies, reducing agency and actually managing the overall budgets that we have and working within them.

On nurse staffing, it is really important that we have lots of different routes into the nursing workforce. If you think about nursing associates, for example, that route has given people an opportunity to come into nursing that they would not have had if it was not there. Having sat with many groups of nursing associates who have gone through apprenticeship routes into nursing, I think that has opened the door to many healthcare support workers who are working in our organisation.

The other thing to say is that part of the reform work, and all the things we have been talking about this morning, will be delivered only if we think about some of the workforce reforms we need to make—the introduction of an expansion of roles, such as within nursing. If you think about advanced clinical practice and making sure that we have senior clinical decision makers and that we retain nurses who are much more experienced in patient-facing roles, that is a great way of doing that.

But we also have to think about the way in which we support staff to make a cultural shift. My colleague talked a moment ago about how we do the shift from hospital to community and the way in which we train our nurses and think about placements. When I was trained, I spent probably about eight or 12 weeks in the community—it was very hospital-based. In many circumstances, it is still like that. We have to think about how we make sure that there is enough placement capacity across the NHS in community services, but also adult social care, to really drive that visibility and give people exposure to the opportunities for working in a different setting and the community. We have to do a whole load of things in the reform space as well as make sure that we have nurses and midwives in the right numbers in our clinical areas.

Q53 **Andrew George:** No one is arguing to the contrary. In other words, no one is saying that you want the wrong nurse in the wrong place at the wrong time. Pardon my expression, but management babble is worthless unless you have something by which to measure it. I would have thought that the RCN and others were looking for mandated staff-to-patient ratios in certain settings. Can you not see that there is a good case for achieving better patient outcomes and therefore better productivity if you follow that route rather than trying to cut the cloth within those settings?

Duncan Burton: We do not set ratios for nurses nationally. I know that the RCN has a specific view around that. Our guidance is that people

should use validated tools, such as the safer nursing care tool, to determine locally what the staffing ratio should be. That takes into consideration things such as the geography of the ward or department you are working in and the skill mix you need for the patient group that you have. This is a complex area. The key thing here is that we enable people to set the staffing numbers that they need to be able to provide care safely for the patients that they are looking after locally.

Q54 **Andrew George:** The long-term workforce plan has been in place for only 18 months, but now that you have had associates in place and had the opportunity to look at some of the pressures within the system itself, has there been any kind of study to see whether that approach is producing productivity or counterproductivity?

Duncan Burton: I do not think we have specifically looked at the nursing associates through the productivity lens, but I would say that certainly about 50% of our people who have gone on to train to be nursing associates then go on to top up and train to be fully registered nurses. So that is a really good way of increasing the flow of individuals into registered nurse roles. That clearly then has an impact in terms of making sure that we have sufficient staff that we retain in our services.

Q55 **Deirdre Costigan:** Thank you very much for coming in today. I want focus on elective recovery and waiting lists, but I have more of an overview question. As we have heard, the Public Accounts Committee has said that it feels that you are complacent about the finances of the NHS. Its report says that you do not have the ideas or the drive to bring forward the changes that the Government want to see in the NHS. This Committee and my constituents in Ealing Southall need to know who to believe, because it is hard to know—you are saying one thing and the PAC is saying another.

How do we judge whether you have the ideas and the drive or whether you are complacent about the finances? How will we judge you in 12 months' time on the number of people on the waiting lists for operations? How many people are you expecting in 12 months' time to be on that waiting list? How will it come down from 7.6 million? How long will my constituents in Ealing Southall be waiting on the phone of a morning to get a GP's appointment, and how long will they wait in hospital car parks for ambulances? I know you have said that the work has already started, so what are you expecting in a year's time?

Amanda Pritchard: I think you should judge us on the results—that is exactly the right thing to do. I know we have laboured the point on productivity a bit in this conversation, but it is the results of the last two years in particular that we should be looking at in order to judge whether we have taken this seriously. Clearly, this Committee and others will also judge on what is in planning guidance, the elective reform plan, the 10-year plan and all the other plans, and decide whether this is as ambitious as you would want it to be.

As I have said before, I do not think there is any lack of ambition in the health service—everyone I speak to is 100% up for it—but this is not easy

stuff. We are also really conscious, as the Secretary of State has said himself, that having too many different initiatives that pull people's attention in different directions is not helpful. Actually just delivering the things that we said we would deliver is point one, and then backing the things that are going to make the biggest difference is the other big thing that we are trying to get right in planning guidance, the 10-year plan and everything else.

How will we judge core performance? We will be setting out those standards in planning guidance tomorrow. The elective reform plan has already said that we will be at 65% achievement of the 18-week standard—that is the referral to treatment standard—by March next year. That is a target for the next financial year. We are at about 58% nationally now, so that would require every organisation to improve by five percentage points—and then a bit more—to get up to the 65%. That is on the way to delivering 92%, which is the national standard, by the end of the Parliament.

We have set really clear goals around elective recovery. There is then a lot of detail, which no doubt Committee members will have read, that sits behind that and explains how we think we are going to do that. It will be a combination of doing more of what we know already works.

For example, over the past two years, we have targeted the longest-waiting patients. From your constituents' point of view, there was a point just after covid where we had far too many people waiting more than two years for treatment; we now have pretty much none—there are a handful, and those are hugely complex patients with very specific needs. We have then targeted going down to 78 weeks, then 65 weeks. We have now virtually halved the number of people waiting over a year and we are down to about 96% improvement on the number of people who are waiting 78 weeks. That has been the focus before, and again, I would say to judge us on that.

The real target—it is a big pivot for us with the elective reform plan—is now getting back to the referral to treatment standard. That is the thing that we are now really going to be focusing on and measuring for the coming year. We are going to set out expectations for the other areas you have mentioned in planning guidance tomorrow.

Q56 **Deirdre Costigan:** I guess that not many of my constituents in Ealing Southall are going to read that planning guidance in detail. What they really want to know is if they are referred for treatment in a year's time, will they be fast-tracked and will they get that treatment in the time required. The big number that they have heard is that there are 7.6 million people on the waiting list. Are you able to answer those big numbers? How many people do you expect will be on a waiting list in a year's time, and what will the average wait be?

Amanda Pritchard: There is modelling that sits behind what I have just said in relation to the size of the waiting list.

Q57 **Chair:** Is the modelling in the public domain?

Amanda Pritchard: I don't think it is, but I can check on that, and if it is we will happily share it.

Q58 **Chair:** If it isn't, could we see it? It would really help the work of the Committee to be able to understand the numbers you are looking at behind some of this stuff.

Amanda Pritchard: The really important thing on this is that the size of the waiting list is a means to an end. The end is how long do people wait for treatment. That is why this Government—and we completely agree with them—have said that getting back to 18 weeks has got to be the target. If I wait a year, or if I wait three weeks, I do not really care how many other people are on the waiting list—what I care about is how quickly I can get seen.

Q59 **Deirdre Costigan:** They are both related, aren't they? The more people on the waiting list, the longer you are going to wait.

Amanda Pritchard: Exactly—which is why it is an enabler. But it is also why, over the last two years, without seeing much of a shift in the size of the waiting list—although it has gone down now, as you know—we have been able to do those big improvements in length of wait.

Q60 **Chair:** But could we get that commitment from you? If the modelling is not in the public domain, do we get to see it? We understand the context you have given—that is very helpful. It is just a model, but we would love to see it.

Amanda Pritchard: As long as I can confirm with the Department of Health that there is no restriction on sharing, I am very happy to do so.

Chair: Of course. Thank you.

Q61 **Deirdre Costigan:** Is there a number for how many people you think will be on a waiting list in a year's time? As you have said, the number and the length are related. Are you able to tell us what that number is? How many people do you expect?

Amanda Pritchard: No, but I will confirm if that is something we can—

Q62 **Deirdre Costigan:** You don't know what that number is now?

Amanda Pritchard: I do know what the modelling says, but given that it is not in the public domain, I am going to double-check that it is okay for me to share it with the Committee. But then I would be very happy to take colleagues through that.

The other thing that is worth saying on elective reform is that we have recommitted to focusing on the people whose wait is most urgent—for example, for cancer waiting times. We have made a continued commitment on the faster diagnosis standard, which is how quickly you find out that you have cancer. At the moment, I think we are at 77% against a 75% target on that, and we are looking to go up to 80%. At the

same time, we are also targeting earlier diagnosis, which is the big headline. Again, we are at about 58.5% at stages 1 and 2, which is an improvement from where we were and continuing to go up.

In terms of what you can tell your constituents on the elective reform plan, we are making further progress on the 62-day referral to treatment target. That is all part of a package to make sure that we are tackling the longest waits and the clinical priorities, and reducing the length of wait overall.

Q63 **Deirdre Costigan:** Right. Can I ask you about surgical hubs? They are a key part of achieving this target and getting people the hip and knee operations that they need. What percentage of the size of the waiting list and the length of time people are on a waiting list will be addressed by putting in place these surgical hubs? How much of the job will be done with 14 new surgical hubs and three more being expanded? What percentage will be done and what have you got left to do? Will there be a gap that you still need to work on?

Amanda Pritchard: Surgical hubs are really important. They allow you to protect elective care through winter when there is a lot of pressure on urgent and emergency care, but they are a relatively small part of the overall amount of activity. That is partly because a great deal of the elective activity that takes place—in fact, about 80%—is out-patient and diagnostic, and the amount that requires surgical intervention or admission is much smaller than that. A big chunk of that, about 17%, is day case. The number of people who need overnight admission—the much more complex cases—is smaller again at about 3%.

The surgical hubs are hugely important, particularly for the small number of people who require surgical intervention and an overnight stay—they are a critical part of our plan. But that is why so much of the plan, as Julian said earlier, also focuses on out-patient transformation and on expanding what we can do with community diagnostic centres, because that is where the big volumes of patients are.

Q64 **Deirdre Costigan:** I expect that the 3% you mention is related to more complex procedures. What is the plan for that? Will the hubs work for those more complex procedures or are you looking at a different plan?

Amanda Pritchard: Yes, they will. At the moment, surgical hubs and stand-alone surgical centres tend to work really well for surgery that is complex enough that you need to be in a theatre and often admitted overnight. Recently we went to visit an orthopaedic hub in south-west London, which had the wraparound support of a whole hospital infrastructure. That is how the surgical hubs have mostly been developed, which allows you to deal with the more complex patients.

Sometimes it is not the surgery that is complex, but the patient, so the ability to have access, for example, to high-dependency or intensive care facilities enables those hubs to do almost all the work in that planned pathway. Certainly when we went to south-west London, there were very

few patients who needed orthopaedic surgery who could not go through the hub.

Q65 **Deirdre Costigan:** I have a final question related to finances. There are two issues. We talked about ringfencing earlier, and we are looking at ringfencing elective recovery and the surgical hubs. But in doing that, there is the worry, as we covered earlier, that it might have a detrimental impact on urgent and emergency care. At the same time, we are also talking about using the private sector to help us deliver some of this, just like in covid times.

In relation to both of those, what radical changes are you making to your financial management so that you can work with the private sector and ensure that you are making good use of taxpayers' money, while also ensuring that the ringfence sticks and that you are not having an impact on acute services?

Julian Kelly: Clearly, we have used the private sector more than we did pre-pandemic. They are doing about 150% of what they did pre-pandemic; they have been an important part of the recovery. We have well-established mechanisms that we are not about to radically change, because they work well, in terms of clear common prices across the country for paying for elective work provided by the NHS or the independent sector.

Every year we look at whether those prices need adjusting depending on where our biggest needs are. For example, to go back to women's health, we have a problem with gynaecological waits. We are looking at the price that we pay there to make sure we are incentivising the right level of provision.

One of the areas where there has been a radical change, which we need to build on, is the thing I said earlier about pre-referral advice and guidance and avoiding unnecessary out-patient referrals, where we have a plan. That have grown quite rapidly, but we are going to properly reflect the cost to GPs of doing that and we will pay, and we will provide them with a fee for that service.

We need to see that expanded because we think we can reduce demand going into hospitals—witness the conversation about the left shift earlier. We have avoided about 1.5 million appointments this year. That is a radical change, and we will look to build on that.

On emergency services, we are not planning to ringfence elective funding this year. The Government required us to do that previously. With local services, we are setting goals to improve elective waiting times and improve emergency care, but it is for them to work out how to do that.

Q66 **Deirdre Costigan:** Just very briefly, you said there that you do not think that there are any changes that need to be made to the financial systems. Having looked at the PAC report, do you seriously stand by that? I know that the report is talking on a wider level.

Julian Kelly: Specifically on elective care, I said that we are not planning a radical change. I think there are bigger questions we are looking at. For example, should we move to paying for some of our out-of-hospital care in a similar way to how we pay for elective activity? Because if you want to increase capacity, that is one way of doing it.

Also, what can we learn from things we have done previously where we have given providers population-health-level budgets? Things like GP fundholding or the models of what are known as accountable care organisations, where you give a provider—not the commissioner—responsibility for the budget for, let us say, people over 65 with complex conditions. Those are things we are looking at as part of the work on the 10-year plan, but they would be a more radical change from '26-27 onwards.

Q67 **Paulette Hamilton:** Good morning, all. I am going to build up to my question because I think that gives context.

I am talking about winter pressures. I have been following this for a number of months. Back in July, NHS England made it very clear that it had given trusts clarity over their finances for the winter, and it had given them £250 million, and that money was between '23-24. I may have got that wrong, but note it down if I have.

Then, by September, NHSE published a letter to say that it had recognised that winter was going to be a bit of an emergency and there was going to be a significant strain. It had given the money in July, but by September, you guys had said that you that now recognised that there was a significant strain. Nothing else seemed to come out. Then, in October, the national director—I have to declare an interest because I know her extremely well—Sarah-Jane Marsh had a board meeting. She is the urgent and emergency care director and she said that she had concerns about the service and its resilience to deal with winter pressures this year—again, another red flag.

Then in January, the hospitals were declaring critical incidents. As I was watching this happening, as a former nurse and now an MP, I felt like we were on the Titanic, knowing that the iceberg was there, but I could not see what was being done to avoid it. I have also to say that NHS Providers, Sarah-Jane, the Royal College of Surgeons and ICBs—everybody—was shouting alarm bells. My question to you guys, especially to Amanda, is this: do you believe that the steps taken earlier in the year to prepare for winter pressures have been robust enough to deal with the winter crisis, which the Department recognised back in September?

Amanda Pritchard: We have always been absolutely clear that the NHS is under an extraordinary level of pressure. That has absolutely been the case every month this year, not just in winter, but it has been particularly the case over winter. We did take a different approach, in agreement with the previous Government, this year: rather than hold funding back to give out later in the year for winter, we gave all the money out at the beginning of the year and therefore have been clear in planning guidance

and in the refresh of the urgent and emergency care plan that Sarah-Jane put out in the summer—

Q68 **Paulette Hamilton:** Amanda, it was obvious—I am going to stop you there, because people do not understand this. If you are running a service and the outputs of the service go up by 3.5 times compared with the previous year, even though you made an agreement that that was what you would give, surely there must be something in place to allow you to do a revision if that is needed. I am just asking you to keep that in mind as you are answering my question.

Amanda Pritchard: We have to live within the budget that we voted by Parliament. The call from system leaders—as I say, having been one myself—was always: "More certainty is helpful." If you can tell people at the beginning of the year what their allocation is and what they have to live with, that is more helpful than saying, "Here's part of the answer" at the beginning of the year, and then giving sort of additional bits of money out later in the year when they are not expecting it and they cannot necessarily use it as effectively.

There have been a number of moments across the year when we have tried to do two things. The first was to help the NHS to prepare as well as it can within resources for what we have always known was going to be a really difficult winter. A lot of that has been, as you know from the conversations you have clearly had with Sarah-Jane—

Q69 **Paulette Hamilton:** No, no—get it right. I haven't seen her—it is written everywhere—but I do know her.

Amanda Pritchard: Our evidence is that what has worked well in taking some of the strain off the NHS has been codifying where we have seen things really work and then supporting the NHS to do that everywhere. When I say "support", what does it mean? That has been people like Julian Redhead, who is our clinical director for urgent and emergency care, leading a team of clinicians on the ground in trusts under the rapid improvement programme with the support of people like Getting It Right First Time and with the support of other clinical leaders to help with the detail of how things work, including everything from rostering plans to front-door triage to helping people with flow—

Q70 **Paulette Hamilton:** I am going to stop you there, because they give me a limited amount of time. Clearly it was not working, so what was done in its place to say, "Look, what we've always done, and what Julian Redhead is doing, is just not enough. This year, because it was such a bad year, we need to put something extra in."? The one thing I know about Wes is that he wants the NHS to be a little bit more proactive in how it addresses things. Were there any discussions on how we could address some of what then happened in January with the critical incidents?

Amanda Pritchard: To be really clear, it was not that people did not start planning early—they absolutely did. All the things I have just said were a national programme of improvement, which was new for this year. That

has not stopped the pressure over winter, but it has made the difference in some areas such that we can—

Paulette Hamilton: I am afraid that the Chair is going to stop me. When you start going off on a tangent, the Chair stops me.

Amanda Pritchard: I am not; I really want to talk about delivery.

Paulette Hamilton: Okay, go on.

Amanda Pritchard: Actually, we have had massively more activity through urgent emergency care this year. Again, it has been the busiest year. If you look at the data on four-hour performance and ambulance response times, that has broadly held stable, despite that increase in demand. That is because of all the things that the urgent emergency care team have supported local systems to do. The doing is always local and it is people in A&E departments, GP surgeries and community care services who are putting in place and rolling out more virtual wards, more same-day emergency care, more rapid response services in the community and more work to improve flow on the ground. To be really clear, we know that it has not been enough to solve some of the real challenges.

Q71 **Paulette Hamilton:** Can I stop you there? You know how bad it has been this year. I am a great person with numbers. If there were two things you would like Government to hear, which you would like to see happen next year so that we do not end up where we have ended up this year, what would be those two things be?

Amanda Pritchard: Two is a good discipline, isn't it? The big thing we have struggled with this winter is the combination of winter viruses. We have had huge numbers of patients with flu, and not just flu but covid—

Chair: That is not in the Government's control though, to be fair.

Amanda Pritchard: It is not, but it is about a real focus on the vaccination campaign.

Q72 **Chair:** So that is No. 1—the vaccines. What is No. 2?

Amanda Pritchard: Where I was going with that is, particularly with children and young people, there is real evidence that, if you can get to them, that helps to protect older people, especially those who are clinically vulnerable. That is my big No. 1.

No. 2 is going to be about support for social care. While there is loads of stuff that we can do, and we will do—I completely agree that we need to do more because of the very obvious pressures on staff and patients from this winter—support for social care is going to be critical, particularly if we are going to keep the corridor of people flowing from A&E into beds and back out of hospital again. I know we have talked about that already a bit.

Paulette Hamilton: I am going to hand back to the Chair. I did have a second question, but I went on. Thank you, Amanda.

Chair: I call Ben Coleman.

Q73 **Ben Coleman:** That very neatly segues, as I wanted to talk about social care. I want to declare an interest as a former cabinet member for health and adult social care for a number of years before the election. I am delighted to hear you say that it is critical that we support social care. I noted in your evidence to the Public Accounts Committee that you said, "We cannot talk about health without talking about social care at the same time." You also said in your evidence, "If there is a spare pound, put it into social care rather than put it into an acute trust." I would just like to understand what that means to you.

Amanda Pritchard: I am really aware that social care does a huge amount more than what is overlapped with the NHS. This is just for me, and I am not trying to take away from the importance of all that. Where there is an overlap, there are two big things for us. Going back to neighbourhood health, if we really want to enable people to stay well and be well supported at home, social care is absolutely critical to that. Then if people have got into a health crisis and are in hospital, to enable them to get home again, it is hugely important that the relationships are right locally and there is joint working. However, it also about the capacity.

Q74 **Ben Coleman:** Absolutely, we all agree that—it is generally understood. I suppose, in practical terms, I should have been clearer. What does it mean to you in terms of how you are going to change things? In very practical terms, you mentioned the better care fund. Will you put more money into the better care fund, or could the review that you are undertaking lead to less money going in?

Julian Kelly: Just to say: next year, we will publish the details. Tomorrow, more money will be going into the better care fund towards local authorities. We put slightly more than £2 billion of NHS funding directly into local authorities.

Q75 **Ben Coleman:** You mentioned, very kindly, that you were going to write to us about social care's value to the NHS in terms of productivity. Have you done this analysis: "If we put X more into social care, we would expect to save Y from the NHS"? Has that analysis been undertaken?

Julian Kelly: We will write to you with the analysis—

Ben Coleman: Absolutely. Has it been undertaken?

Julian Kelly: The specific analysis we will write on, which we have done from the data that we see, is on how many patients are not being discharged from hospital because we cannot get them a timely place in a care home or the right domiciliary care package. You can translate that into what you think that would mean for flow if we could free up that capacity. That is what we will set out.

Q76 **Ben Coleman:** I appreciate your answer, but to be clearer: it costs around £800 to £1,300 per day to have somebody in a hospital bed, though the figures I am going on may be a bit old. If you can get people out of beds more quickly, or if they never go into beds in the first place

because they keep on living independently at home, you would save a lot of money. The specific question I am asking is this: have you looked at the amount of money you could save the NHS if, for example, you tripled or quadrupled the amount that you give to the better care fund? Have you done a straightforward XY analysis, or not?

Julian Kelly: You would not immediately save money, because our issue right now is that we have too many people waiting a long time in the emergency department because we cannot admit them to a bed. It is not that we would save money right now, because what we would want to do is improve performance, so we would not close—

Q77 **Ben Coleman:** Are you saying that on the basis of a financial analysis that you have undertaken?

Julian Kelly: As I have just said, we have done the analysis—and this is not perfect; it is based on the data we can see—of how many people are stuck, and what it would mean for productivity and flow if we could free up those beds. But we would not immediately save money, because to save money you have to shut the bed.

Chair: Then you would improve services, but you would not necessarily save money?

Julian Kelly: You would improve services but, certainly right now, we would not immediately save money because we do not think we could afford to shut capacity. Going back to the earlier question from Ms Hamilton about how we can improve winter performance, clearly, if we can improve discharge, that avoids the question of whether we have to build more beds in the future. What is the opportunity cost for the future if we cannot solve this?

Q78 **Ben Coleman:** Have you undertaken the analysis of the opportunity cost?

Julian Kelly: We have undertaken the analysis of how many beds we could avoid building in the future, if we can improve length of stay—yes.

Q79 **Chair:** That is a really important figure for us to have in the light of our cost of inaction inquiry.

Julian Kelly: That is what will come through. As we complete the 10-year plan, what is the ambition, both through the NHS and working with local authorities? We know that, if you get the model right, you get people out of hospital beds faster and reduce the demands on social care.

Q80 **Ben Coleman:** Of course, if you never have people going into hospital in the first place, you reduce the demands on hospitals because the social care at home is better. Forgive me, because I appreciate your answer and I appreciate that you will be giving us figures, but there is a concern out there that the NHS has never really looked at the extra costs that are required to go into social care. But if you are doing this analysis, the better care fund work will perhaps prove—

Julian Kelly: It is the Department that actually decides what the split of funding is.

Ben Coleman: On your recommendation, though.

Julian Kelly: We put around £2 billion of NHS funding into local authorities, and that has grown in real terms every year for about the last 10 years. We are putting more NHS funding into local authorities. My key point is that you do not immediately save money. It is not as if I can just say, "Let's put even more NHS funding in," because to do that, you have to shut capacity, and right now we could not afford to shut capacity.

Q81 **Ben Coleman:** Thank you. I have been trying to get to what was meant by "We cannot talk about health without talking about social care", and "Support for social care is going to be critical". I am still not quite clear that "critical" means a lot more money going in, but I appreciate the answers you have given. I do not see how we are going to get better social care without the NHS itself contributing money, rather than leaving it to MHCLG or occasional settlements.

Julian Kelly: As I said, we are contributing over £2 billion a year and growing in real terms.

Q82 **Ben Coleman:** I am not disputing the money you are giving. We are talking about future needs and about meeting what you and Amanda Pritchard say is a critical need.

Can I also ask about local authorities and finance settlements? I very much appreciate what you said, because every year as a cabinet member—and I am only a cabinet member, not the director of adult social care—I found it infuriating and difficult to try to deal with the NHS. The finance settlements for local authorities are at a very different time from those for the NHS. I think you said in the evidence to the Committee, Julian, that you try to give early informal expectations, but you need to know what the budget is to give a budget. Are you saying that the Government are too slow to sign your budget off? The situation at the moment is that you are blaming the different Government Departments for not signing the budget off, which causes local authorities such problems. Are they too slow? If they are, how can they be speeded up?

Julian Kelly: Clearly, they are two different budgets. The local authority budget is done through the Ministry of Housing, Communities and Local Government. If I was just to take 2024-25—

Chair: Amanda, do you want to help with this?

Amanda Pritchard: No.

Chair: I could see you trying to whisper, and I wondered whether it might be helpful.

Amanda Pritchard: I really want to be clear that we are not trying to blame anyone for anything.

Ben Coleman: I am not trying to blame anyone either.

Amanda Pritchard: What we are saying is that it is just really complicated.

Ben Coleman: It is complicated. Do you think you have sorted it out?

Amanda Pritchard: In my view, it is essential that there is a cross-Government recognition about the trade-offs across the NHS and other bits of public spending, and then for us to ensure that we have an agreed budget, which is necessary for us to issue planning guidance. It was just as simple as that.

Q83 **Ben Coleman:** So it is a big problem and it has to be recognised across Government. Have you made a commitment to sorting out this problem of different timings for the budgets of local authorities and the NHS? Have you sat down and said, "We need to do something about this, and we will do something about it?"

Amanda Pritchard: The thing that we have definitely all committed to is trying to make sure that for future years, as much as we are able, we are getting planning guidance and budgets out as early as possible—ideally pre-Christmas—and in an aligned way with other critical budgets.

Q84 **Chair:** Even in a perfect world, that does not solve his problem. At the moment, the guidance is out in time for the financial year for the NHS, but once it is out, will it be in time for local authority budgets to be set?

Julian Kelly: I think the point is that local authority budgets come out before Christmas, and ideally we would at least align the timing with that. Over recent years, we have formally published later than local government, which I think is the point. We are doing everything we can to get everything agreed with Government as early as we can and get it out.

Q85 **Ben Coleman:** That is helpful, but it is very broad. The '24-25 planning guidance has already come out, and it was not released by you until a week before the start of the financial year. What are you going to do differently for the '25-26 guidance to get over this problem? Is it something you sit around and talk about as a real problem that needs to be cracked?

Amanda Pritchard: Yes. The NAO made a recommendation, which the PAC has now formally adopted, that the Treasury, NHS England and the Department of Health should commit to getting planning guidance out earlier. We agree with that recommendation, but the important thing is to recognise that it takes all of us working together to land that. It is not in NHS England's—

Q86 **Ben Coleman:** When you say "us working together", who is the "us"?

Amanda Pritchard: The Department of Health, the Treasury and NHS England, and then clearly there is a broader cross-Government process of the agreement of budgets and right-round approvals for us to communicate that formally out to the NHS. The key players are those three.

Q87 **Ben Coleman:** Great. Have you pulled all those people together and said, "This is a real problem"? Do they accept that it is a real problem? Have you pulled them together to do that, take it forward, and try to find a solution?

Amanda Pritchard: There are extremely regular conversations that take place—although Julian is in them rather than me, most of the time—between colleagues to try to work through the detail of budget allocations.

Q88 **Ben Coleman:** I don't take that as a yes. Am I right in saying that is not a yes?

Amanda Pritchard: You should take as a yes the bit that says, "Absolutely, we have had the conversations completely collectively about the importance of getting planning guidance out earlier, and getting budgets agreed earlier." We have also had honest conversations about how complicated and difficult that is. We do not have the ability to do that in isolation, and nor should we.

Q89 **Dr Cooper:** I will be quick, because I realise we are running out of time. Following on a bit from Ben's highlighting of the different conversations you have across the different departments, I want to finish specifically on culture. As we all know, culture can eat strategy for breakfast. Perhaps over the decades it has eaten a lot of strategy and perhaps several Secretaries of State. I want to ask about your impression or sense of what the culture is in NHS England. If I were to go and ask various members of your staff what the cultural environment was in NHS England, how would they describe it to me? If you could be brief, that would be great.

Amanda Pritchard: I mentioned earlier that we have just completed a massive reorganisation of five organisations into one. Part of the commitment that we made to colleagues within the organisation, as part of that, was to do a proper OD cultural exercise with colleagues. We have begun that very seriously, so we have staff survey results most recently saying that overall—it is not uniformly the case, but in almost all areas—things have improved since the last staff survey. We take some encouragement from that, but it also shows that we have a very long way to go.

The big challenge for us internally is that we have five organisations with five very different cultures, and five very different ways of working, now all in one organisation. I think it is the biggest public sector reorganisation that has happened, certainly last year, and I think our chair was saying that it is one of the biggest that has happened full stop, not just in the public sector. We should not underestimate—and we do not—the amount of work that we have to do within our own organisation now to align not just processes and ways of working, but cultures, and to create a new culture for a new organisation that is aligned with this Government's priorities and the 10-year plan.

Q90 **Dr Cooper:** Lovely. You will forgive me, Amanda, but I have been in the healthcare sector for quite a while now, and I have heard this said every time we come to a change, which happens quite a lot. If I asked you, "Is

NHS England dynamic? Is it flexible? Is it able to change? Does it have a good relationship with the Department of Health and Social Care?", would you recognise any of these things as true?

Amanda Pritchard: There are different answers to different bits of that. I think we increasingly have a very good working relationship with the Department of Health. That feels really positive, and that is something that we are extremely keen to build on. Parts of our organisation are incredibly dynamic.

Q91 **Dr Cooper:** Which parts specifically would you say are dynamic?

Amanda Pritchard: We have talked a lot about what is going on in the Transformation Directorate today with some of the work that it is doing on AI and the pilots of things like ambient technology. We have a great team on things like life sciences that is also doing some really interesting work on innovation. It is a bit invidious to pick out specific examples.

Q92 **Dr Cooper:** I suppose that is invidious. Then you would say that the underlying cultural dynamic of NHS England is positive overall, and that it is progressive and able to respond to the very substantive issues that my colleagues have highlighted in this session?

Amanda Pritchard: What I honestly think is that we have some incredibly committed and able colleagues in NHS England, who have been through a huge change programme. It has been really hard for people, and I would say that some of them are still finding it really hard to adjust to a new organisation and new ways of working. Others are absolutely thriving, particularly with the opportunity to work within the development of a 10-year plan, and they are really excited about the opportunity to see the things that they are passionate about reflected in that plan.

Q93 **Dr Cooper:** Apologies for cutting you short, but I realise we are nearly out of time. If I think about the Messenger review, and we look at the leadership culture, what do you think is going on with leadership culture following that review? Do you think the levers are in place, and if you come back here in 18 months, do you think you will see a substantive improvement?

Amanda Pritchard: Thank you for that. Can I just commit that we are mindful that, if we are trying to do work on leadership, we have to start with ourselves? The improvement work that we are doing across the NHS, we are doing internally. We are applying NHS Impact internally. When I talk about culture and leadership, that is why we have a formal culture and leadership programme that we are doing within NHS England. Again, we have to walk the walk, not just talk the talk. That is why we did the staff survey using exactly the same questions, so we could compare ourselves with the NHS. In most areas, NHS England is actually doing better than the NHS overall, but there is really no complacency and we have a lot further to go. As I have said, I know there are real pockets that feel very different.

On leadership overall, following the implementation of the Messenger review, which was excellent, there are some things that we have already

done. For example, the implementation and refresh of the fit and proper person test has happened, and the board appraisal framework has happened. There are other things that have started but have not yet come to fruition. We have a big package of stuff around management and leadership, including a code of practice, a competency framework and a national curriculum for leadership and management. That is all due to come out this year, but we have been doing that in a way that is very much co-developed with colleagues in the service as well as using expertise from outside the NHS. They are all in train.

At the same time, we have various other practical elements, such as a refresh of some of what is happening with the national leadership academy. I think we have about 23,000 people currently having some sort of contact with the academy in our various different programmes, but there is definitely work to do to make sure that is aligned with the new curriculum that is being developed.

Q94 **Dr Cooper:** Just as a reflection on that, my overwhelming feeling is that, every time this sort of conversation comes up, it is always the start of something. I would very much appreciate in three years' time hearing not, "We are going to start something", "We are going to refresh something", or "We appreciate that we have done terrible things and we are now going to do things differently", but a real embedded culture of, "This is what we have done, and this is what has actually been achieved." I think that is probably a key part for a cultural shift.

Amanda Pritchard: Great. Can I suggest that we do it in a year, not three?

Dr Cooper: A year, three or five—that would be absolutely outstanding. Thank you very much.

Chair: Thank you very much to our witnesses.