

Public Accounts Committee

Oral evidence: DHSC Annual Report and Accounts 2023-24, HC 639

Thursday 13 March 2025

Ordered by the House of Commons to be published on 13 March 2025.

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Members present: Sir Geoffrey Clifton-Brown (Chair); Mr Clive Betts; Nesil Caliskan; Anna Dixon.

Health and Social Care Committee member present: Layla Moran (Chair).

Abdool Kara, Executive Director, NAO, Peter Morland, Director, NAO, Rachel Nugent, Director Financial Audit for UKHSA and NHS England, NAO, and David Fairbrother, Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1 - 74

Witnesses

[I](#): Professor Sir Chris Whitty, Interim Permanent Secretary and Chief Medical Officer, DHSC; Andy Brittain, Director General, Finance, DHSC; Professor Dame Jenny Harries, Chief Executive, UKHSA; Julian Kelly, Chief Financial Officer and Deputy Chief Executive, NHS England.

Examination of witnesses

Witnesses: Professor Sir Chris Whitty, Andy Brittain, Professor Dame Jenny Harries and Julian Kelly.

Q1 Chair: Welcome to the Public Accounts Committee on Thursday 13 March 2025. In May of last year, our predecessor Committee found that the Department of Health and Social Care and the UK Health Security Agency had been failing in their financial management and accountability for taxpayers' money for two years running. DHSC is one of the most complex tasks in Government, with an annual budget of approximately £191 billion and an average of 1.7 million patient interactions a day, ranging from GPs to community interactions, hospitals, NHS 111 and ambulance services. While progress has been made, the C&AG has qualified his opinion on the DHSC accounts for 2023-24 and highlighted issues within financial management and oversight of the departmental group, as well as financial and compliance issues in some of the bodies across the group.

At today's hearing, we will constructively examine, through the Department's annual report and accounts, what went right and what went wrong last year, as well as other key issues relating to the Department's accountability to Parliament. I extend a special welcome today to Layla Moran, who is not only Chair of the Health and Social Care Committee, but also a former member of this Committee, so she knows how it works probably better than most of us.

Today, to help us with all those momentous problems, we warmly welcome Professor Sir Chris Whitty, acting permanent secretary and chief medical officer. Sir Chris is the current interim permanent secretary at DHSC, pending the appointment of a new permanent secretary. We have also Andy Brittain, the DHSC director general of finance. Andy has been at the Department since 2020.

We have Professor Dame Jenny Harries, who has been chief executive of UKHSA since 2021. I understand that she will be stepping down from this role in early summer, so I would like to thank you, Dame Jenny, very much for the excellent work you have done in this position. It has not been easy. It was set up in a hurry, there were a lot of problems right from the start and you have taken a lot of brickbats, so thank you for all that you have done.

From NHS England, we have Julian Kelly, chief financial officer and deputy chief executive. Julian joined NHS England as chief financial officer in April 2019 and this week it was also announced that you too would be stepping down. Julian, thank you very much for your six years of dedicated service with NHS England, particularly helping navigate health and social services through the pandemic and out the other side. I wish you the very best of luck in the future. You have always been very helpful to this Committee and answered our questions with patience and candour, so thank you very much for what you have done for this Committee.



HOUSE OF COMMONS

At this point I would also like to pay tribute to Amanda Pritchard. It has also been recently announced that she will be stepping down as chief executive of NHS England this spring. In fact, I think that she has already stepped down, has she not? No, not yet. She oversaw the NHS at a time when it was under so much pressure following the pandemic, and I wish her all the best for her future endeavours. Julian, would you like to say a few words?

Julian Kelly: Thank you for your kind words on both my and Amanda's behalf. Certainly when I took this job I do not think I really knew what I was getting myself into. Our medical director said at the time of the pandemic that this would be a five-year journey of recovery. We are beginning to see, I honestly believe, the green shoots of recovery. We will see an improved financial performance this year, with a significant reduction in the deficits in providers and systems compared to last. We will see a falling waiting list and improving elective waiting times. Our monthly polling is showing—admittedly from a low base—improving patient access to GP services. We are seeing recovering productivity. There is a lot that remains to be done and huge challenges still to be addressed. I know that Amanda and I will wish the new team the best of luck.

Q2 **Chair:** Before we get into the main session, we want to, if we can, find out from any of the witnesses here exactly what is happening to NHS England. Healthcare leaders have told us that NHSE and DHSC are to be cut by 50%. We want to try to get into what that really means in terms of headcounts, functions and everything else. Julian or Sir Chris, are you able to help us with that, please?

Professor Sir Chris Whitty: Shall I have a first go? Julian may well want to add to that. This needs to be situated, in a sense, in two areas. One is what the Government wish to do about the centre of Government and civil service as a whole. The Prime Minister is making a major speech this morning, which is going to lay out more details on that. Within that, they have made it clear that they want two things. They want the centre to overall become smaller. Their view is that there were increases that occurred at various points along the lead-up to preparations for Brexit and then during covid, and they feel that there should be a clear reduction in that. They have been very clear about that.

The second is a shift in the way that Government do their business as a result of changes in society, which mean that you need changes for those reasons, and opportunities that come from things such as artificial intelligence and other roles. Those are general things that have been flagged for the Government as a whole.

For health specifically, the Secretary of State for Health and Social Care has said he feels that the centre should be smaller and leaner, and whatever resources can be freed up should be moved to the frontline. That is the first area. Additionally, he wants to make sure that there is closer working between NHS England and the Department, which was set



HOUSE OF COMMONS

up in a way to be very independent. He has laid that direction of travel out. He is giving a statement to Parliament later on, which will give further details on this. That is the overall background.

As a result of that, a headcount reduction with a percentage target has been announced within NHS England by the incoming chief executive of NHS England and Amanda Pritchard, the current chief executive. DHSC has some functions that overlap with NHS England but, to be clear, does many things that are unrelated, for example public health, science and work across Government in other areas. There will definitely be a reduction there. That has been announced to staff. I announced earlier on this week that there will be a voluntary exit scheme in the Department, on top of some recruitment controls already in place, with the aim of essentially achieving these two broad goals.

Q3 Chair: Sir Chris, are you able to put any numbers on both NHSE and your own Department?

Professor Sir Chris Whitty: The NHSE has chosen to put some numbers. The view of our Secretary of State—and this very much follows what the Chancellor of the Duchy of Lancaster said about the civil service as a whole—is that they want to review. In my view, it should be reviewed with the incoming permanent secretary. Either way, they want to review which bits of the service need to change, either as an overall result of the changes I have talked about in the civil service or as a result of the specific ones that fall out of the changes with NHSE and the way that interaction between the Department and NHSE occurs.

Q4 Chair: Others may want to come in in a minute. I understand maybe the sensitivity there. You do not want to put numbers on it at the moment. Is that correct? There is no point in me keeping asking you questions you do not want to answer.

Professor Sir Chris Whitty: It is not a question I do not want to answer. If the Secretary of State was here and you were to ask him, "What is the number?", he would say that we have not yet got an exact number but the direction of travel is clear. I am being entirely open with you. This is what I have said to my colleagues and that is what we are saying privately. That is the situation at the moment.

Q5 Chair: In that case, the really important question, to be fair to the staff in your Department and NHSE, is when the detail of this will become clear.

Professor Sir Chris Whitty: Having had the experience of going through several contractions and expansions within the civil service and in other organisations, my experience has been that setting headcount targets before you have even worked out what exactly the shape is that you are going for is a recipe for disaster, if I am honest. I am really clear that, within this particular context, there are a variety of things we need to change. There is a very different context to NHSE and the logic of what the incoming chief executive has said makes a lot of sense in terms of



HOUSE OF COMMONS

that organisation and the way he wants to go forward with it, in consultation with the current chief executive and the Secretary of State.

In terms of what we are trying to do at the moment, we have these two moving parts. We have what the Prime Minister and the Government want to do for the civil service as a whole, which affects all of DHSC, and then the bit that faces NHSE directly, which has to interact with NHSE. That is the reason for our view that we do not want to do a number until we are clear what we are trying to build in from the base.

Q6 Chair: Thank you for that. That is very clear. Uncertainty in any organisation is not good for patients, in this case, and the poor staff who have to cope with these changes. How long is this all going to take before it is clear what the strategy is, what the functions are for each of the two organisations and what the consequences for staff are?

Professor Sir Chris Whitty: I fully agree with the premise of what you are saying. The aim at the moment is to, in a sense, do two things simultaneously. One is to make sure we can provide the service to the public and the parts of the NHS, local government and social care that we serve, so that that can continue all the way through any changes. That is really critical. That, in a sense, has to be the first priority because, if we see a significant diminution of that service, that is not in the public interest at all. Of course, we want to finish this as soon as we can within those constraints.

Those are the two things we are trying to achieve. I agree with you that certainty is ideal. False certainty is worse than no certainty. Putting a number that is not a number we have really worked through does not seem to me, at this point, given these moving parts, an appropriate thing to do.

Q7 Chair: I agree with your thought process entirely, but I am still going to press you slightly on the timetable. Are we looking at weeks or months? Those in the organisation—there are huge numbers in the organisation—and the patients themselves need some form of guidance as to what the answer to that question is.

Professor Sir Chris Whitty: I will first make the point that the civil service, like every organisation, is continually in change. On the idea that there is a point of absolute stasis, I have never seen one, nor have I seen it in any organisation I have ever worked in. There is not a point where you come to a complete end. There are two bits of the component to do with DHSC, which is the one that I am involved in, for which there is a relatively clear timeline. Then there will be bits further to that, which are the consequences of the interactions with us bringing together our work with NHSE.

Q8 Chair: Would you like to just set out what is happening in your Department?



HOUSE OF COMMONS

Professor Sir Chris Whitty: That is what I am trying to do. I am trying to give you a proper answer rather than a passed over answer.

Chair: We appreciate what you are saying.

Professor Sir Chris Whitty: There are two components that we have announced so far. One of them is immediate and will continue for probably some time, which is a cap on new appointments, particularly new external appointments. Because there is a turnover of staff, which on average tends to run at between 5% and 10% a year, but let us say 7% for the sake of argument, that means that you can manage down without anyone having to leave and have a package or anything like that. Just by the natural turnover, you can manage staff down. I had already put that in place a while ago. We have slightly tightened the rules around that. That is from now. That is happening at this point in time.

In terms of the next stage, I have then announced that there will be a voluntary exit scheme. This is with Cabinet Office and Treasury, but I do not anticipate them saying that this is inappropriate. I would anticipate that opening and I have said this to staff. It is very important that I do not say anything to you that I have not said to staff. That would be very wrong. I have said to staff that I anticipate that opening, I hope, before Easter. If we do it before Easter, that will, at least in initial phase, run through until probably about November of this year.

That does not take into account the consequences that need to be thought through carefully of the changes that are happening in our relationship with NHSE. We need to do that properly from the base up and actually ask the question, and then the Secretary of State needs to make the final decision, of what the shape and size of the organisation we want is, as a result of the changes. The first two things I have announced already are irrespective. They are really there to deal with the overall view that the overall system should be smaller. That is a view, as I said, that is across Government, as has been trailed heavily by the Chancellor of the Duchy of Lancaster. It is in editorials today by the Prime Minister and he is giving a speech later on today, which will flesh that out.

I am not saying that everything will be over by November, because the process that the Secretary of State has set in train, in terms of closer working together of DHSC and NHSE, has a lot of consequences that need to be thought through. Julian may well want to add to this; he may not. It is important that we understand that those two have to interact. This therefore, in my view, is not a point where I can say to you, "This is the exact point where this is going to end". There will be a further stage beyond that. I have been clear with my colleagues, who are outstanding. I have been clear with them that that is where I think we are.

Q9

Chair: We will come to Julian in a minute, but there is another important component to all of this. *HSJ* also says that ICBs are ordered to cut costs by 50%. That is getting much closer to the patient and that seems to me



HOUSE OF COMMONS

quite an ambitious sort of thing to achieve. I do not know whether you or Julian want to say something about that.

Professor Sir Chris Whitty: I will have a first go, but this is very much more in Julian's area than mine. The overall aim, which was announced by the incoming and outgoing chief executives of NHSE, is to make sure that resources and decisions are, where appropriate, taken as close to the patient as is possible. That does not mean that all of them can be or should be, in terms of the most efficient delivery of services.

There are some services that are more efficiently delivered at a national, regional or more local stage, but not absolutely at the far end. For example, science is usually best done at a national level. Some areas of data aggregation are best done at a national level or, in some cases, a regional level. It is not more efficient to push them further out; it actually is less efficient, but there are other areas where the reverse is true. That is, philosophically, what the aim of it is.

There are also very important budgetary reasons for this. That drives a lot of the thinking that NHSE, I know, has gone through in these very difficult decisions. I do not know whether Julian wants to add to that.

Julian Kelly: Sir James Mackey, the incoming chief executive, has set the target to reduce the size of NHS England by 50% and asked ICBs to look at how they can reduce their size by 50%. As you have just said, it will require a redundancy scheme to achieve that scale of change. That will be part of the conversations that Sir Chris has just referred to with the Cabinet Office and HM Treasury. Some of this is certainly looking at where there is duplication of functions, as Sir Chris has said, between the Department and NHS England, and indeed we will have to look at ICBs.

I would expect the detail to come through as the 10-year plan is finalised, because that will set out the structures that are envisaged. To see through the delivery of the 10-year plan, clearly that will not just be about duplication when you are talking about that scale. It will have to be a hard look at specifically what functions are being done where and, as Sir Chris has said, how more of those functions, and indeed greater freedom, will have to be given to providers to get on and do the job of delivering for patients.

Q10 **Chair:** Golly. The scale of change in NHSE is of course far bigger than the Department, so there will be far more uncertainty in the staff. They will know the outline of this by now. Sir Chris has been very candid with us about the voluntary redundancy scheme and the freeze in recruitment. When are we going to get the similar announcements for NHSE?

Julian Kelly: Sir James has already told staff about the size of cuts coming. We have already said that, as a result, we are implementing a vacancy freeze. There will have to be some limited exceptions. He will announce, I would suspect in the coming days, his transition team—i.e. the team that he is going to put in place and, for example, whoever is



HOUSE OF COMMONS

going to replace me. He has not yet set out the detail of what he thinks will be the change in functions. That will be some work over the coming weeks, because it will also involve what the interaction is between NHS England and, as I said earlier, integrated care boards, and then how the oversight regime works with providers.

- Q11 Chair:** I can see that colleagues are anxious to come in, but I just want to get the bones on this and then let my colleagues pick at that. Bearing in mind our previous conversation in this Committee about ICBs' budgets and the lateness of being given those budgets, when are they likely to see those budgets and guidelines?

Julian Kelly: ICBs already have the totality of the budgets for next year, so they already have those. This is clearly—I was going to say “a detail”; it is clearly a significant detail. That is, in £180 billion-worth of spend I am saying that it is a material impact, but they have the totality of the spend. This will shape, effectively, not the quantum we have shown them but how it is deployed. That is the aim: how do we make sure as much money as possible is going to the frontline services this year—i.e. hospitals, GPs, dentists and so on?

- Q12 Chair:** There are lots of clouds still on my horizon here. I am Gloucestershire ICB. I have been given a budget. Thank you for that, because that is a lot earlier than it has been. I have been told that I have to halve my administration costs, but I have got a budget. Does that mean that budget stays the same but you are expecting more to the frontline?

Julian Kelly: That is exactly it, yes.

Chair: That is really helpful.

- Q13 Anna Dixon:** Thank you, Sir Chris and Julian, for your honest responses to the Chair's questions. Given this is a hearing about the accounts, I want to try to probe the financial implications of what you have both spoken about. Perhaps, Julian, you could help with this. In figure 1 on page 5 of the accounts, there are four blue boxes on the left with some £41.9 billion flowing into them, of which one is NHS England administration. I wondered what is currently spent on NHS England administration. We have talked about headcount and quite a lot of staffing, but more in monetary terms what sort of estimated long-term savings might be being talked about here?

Julian Kelly: In really simple numbers, we had originally set a budget—I am going to use round numbers, if you do not mind—for around 15,000 people in NHS England. If you took 50% of that number out, you would be saving, on a fully annualised basis when completely delivered, around £400 million. In ICBs, they currently employ around 25,000 people. If you reduced their staff by around 50%, you would be achieving around £700 million to £750 million of savings on an annualised basis once fully delivered. Those would be the rough orders of magnitude.



HOUSE OF COMMONS

- Q14 Anna Dixon:** That is helpful. As you are explaining, the idea is that there is more flowing down in those arrows towards NHS providers. I was going to ask about ICBs. Again in round numbers, it appears from this set of accounts that there was some £30 billion that seemed to go from the money coming into ICBs, which was taken in some sort of overhead administration cost of running the ICBs, to the amount that then flowed further down to providers. I was trying to get a grip on, if the ICBs were a smaller administrative cost, how much more would flow down directly, as intended, to the frontline. Thank you for giving us those estimates.

That is steady state into the future. We know that redundancy and reorganisation costs money. I wondered whether there were any estimates at this stage of what sort of region of money you might be in with the redundancy programmes for halving NHS England and halving ICBs, given experience of these types of programmes in the past.

Julian Kelly: I do not have a firm estimate. This has all been reasonably quickly announced this week, but our turnover rate is not dissimilar to the one that Chris described. If you are going to reduce it by 50% and want to do it mostly in this year, you are going to have to work out how about 40% of those staff are made redundant. You are best assuming that you are going to pay on average the annual salary if a redundancy package is required. As I said, not everyone would be required to be made redundant. You often see through a process such as this that turnover can increase, but those are the sorts of rough numbers.

- Q15 Chair:** I do not want to cause alarm, so I want to clarify something you have just said. You have said that the ICBs employ 25,000 staff, but that is 25,000 staff in total—frontline as well.

Julian Kelly: No, that is the total staff, roughly, employed by integrated care boards who are not providing frontline services. They are running contracts, doing the commissioning and doing some of the performance management.

Chair: The 50% applies to those.

Julian Kelly: It applies to the integrated care boards. It does not apply to the staff who are being employed in hospitals and GP surgeries.

- Q16 Chair:** Let us be very clear. Is that 25,000 figure administrators or someone on the frontline? Is the 50% cut coming to the 25,000? If not, how many is it coming to?

Julian Kelly: It is 50%. There are 25,000 people employed by integrated care boards. I think that I am correct in saying that they are not providing frontline services. You could say that they are administrators and commissioners. The 50% applies to that 25,000.

Chair: I did not want to cause any alarm at all, as long as we are absolutely clear. I will pass over to Layla Moran.

- Q17 Layla Moran:** Thank you very much, Chair, and thank you for having



HOUSE OF COMMONS

me. To follow up on that point, Julian Kelly, if I may, is the 50% cut for each ICB? Are they being asked to each find 50%? My concern is that there are some ICBs that are delivering services pretty efficiently. Partly how they are doing that is, for example, having large numbers of place-based teams and fewer numbers of other people.

Also, we hear that there is a lack of commissioning expertise overall in ICBs. I would be really concerned if we ended up with a consolidation towards the centre of ICBs at the expense of place-based teams, which are often the ones that are the most efficient at delivering services. I will give you an example. Buckinghamshire, Oxfordshire and Berkshire West has already got rid of its place-based teams completely, which is the opposite of the left shift that we are hoping to achieve in the 10-year plan. Could you clarify whether it is 50% for each ICB or a 50% system-wide change?

Julian Kelly: I cannot give you a lot of detail now. I was told yesterday the decision, so I am communicating it to you. The detail is still to be worked through. As I said, somebody is going to have to be working out exactly now what the relationship is between not just the Department and NHS England, but NHS England and integrated care boards, and what the expectations are on providers, as well as integrated care boards. That detail will become clear as the Secretary of State, the Department and the NHS team finalise the 10-year plan.

Layla Moran: Is this what the change board—or whatever it calls itself—is going to be working out?

Julian Kelly: Yes, I would imagine so.

Q18 **Layla Moran:** Can I ask Professor Chris Whitty about this? I have a concern that form should determine the function. We have the 10-year plan coming but not yet published and yet we have already decided that 50% is the number for ICBs and the wider teams. Are you concerned that we have an arbitrary number and there is not a form that we are fitting that to just yet?

Professor Sir Chris Whitty: I am probably not the right person to ask about the structures within NHSE, because they are run separately and this was very clearly an NHSE process. I want to keep separate the two processes. I can answer pretty accurately, I hope, questions on the DHSC process, which I have worked through with my colleagues and communicated to our excellent staff in DHSC. I am not really in a strong position to do it for numbers and things in NHSE, because of the separateness of the current structures.

Q19 **Layla Moran:** Will the 10-year plan clarify who within DHSC versus who within NHSE is responsible for which bit? I suppose I am trying to get to, if it is a number of 50% but we do not yet have the plan, how we know what the balance should be. Maybe it should be a 70/30 split.

Professor Sir Chris Whitty: The point you make is exactly right and that is, in a sense, the reason why I am wanting to take each stage as we



HOUSE OF COMMONS

know the facts and work from that basis. There are two separate things, in a way, which intersect very strongly, but are separate. There is the process for the coming together over time of NHSE and DHSC functions to ensure there is no duplication, among other things. There is a process that is separate but linked of the 10-year plan, which includes structural things such as this, but also very much looks to the health of the nation and all the various components you would need to see to improve different elements of the health of the nation on cancers, cardiovascular disease and so on.

Clearly, once that plan is finalised and announced, and the correct interaction between DHSC and NHSE is laid out, we would then, in my view, want to say, "Okay, the Department is going to need to be a different shape to respond to that". Then we should build the structure of the Department around the shape that has emerged from the combination of those two factors. We are quite a long way down that path but we are not at the end of the path. My view is that that is a very strong position to say, "Here is the logic as to why these bits here we want to preserve as they are, some bits we want to grow and these bits we want to shrink, or indeed are no longer relevant in the new environment". There will be quite a lot, I think, in the second area, but any organisation is dynamic. This is just probably a rather hyperdynamic period.

Q20 Layla Moran: "Hyperdynamic" is one word for it. I have one more question. Julian Kelly, it has been reported that you were going to stand down anyway but you have expedited it following the announcement from Amanda Pritchard. It is worth saying, Chair, that we have Sir Stephen Powis, who served for seven years as national medical director, to whom we should also give our thanks. There is also chief operating officer Dame Emily Lawson and chief delivery officer Steve Russell who are leaving their jobs, so thanks to them. I hope that I can extend that on behalf of everyone here for the work that they have done. That is the entire top team.

Julian Kelly, I do not know whether you can comment on this. When the whole of the top team goes, that is a lot of institutional memory that is going too. Are you aware of any processes in place to keep some of that going? When is your last day?

Julian Kelly: My last day is 31 March, so in about two and a half weeks. It is definitely a new phase for NHS England. Jim will want to bring in his team to see through this phase of work, the closer working with the Department, the finalisation and then the next year of the delivery of the 10-year plan. There are excellent people in NHS England. I think of the teams who work for me directly, who have a huge amount of experience and knowledge. I am confident, certainly when I look at my own areas or even at some of Emily's areas, that we have some really good, experienced people who will have that continuity of knowledge.

Layla Moran: Is their last day also 31 March?



HOUSE OF COMMONS

Julian Kelly: I think that Emily's last day is 31 March. Steve does not step down until the early summer and Steve Russell's, I will admit, I cannot remember.

Q21 **Layla Moran:** Were you asked to leave by Sir James Mackey?

Julian Kelly: No. I had made the decision. I have done this job for six years. It has been quite a gruelling six years. We were definitely entering a new phase and I thought it was the right time for me to step away. With the finalisation of the 10-year plan, it was right for someone new to come in, pick up the baton and do the next phase of the race. That coincided with Amanda's announcement, and with Jim coming and saying, "I want a transition team"—so us agreeing timing for when I would move on.

Chair: Thanks very much to the chair of the Select Committee. We are very pleased to have you with us. I too would like to pay my tribute, on behalf of this Committee, to Professor Sir Stephen Powis and Steve Russell. Certainly Professor Powis has appeared before this Committee many times. He has always been very straightforward, down to earth, and very knowledgeable, so I thank both of them. They have done a great service to the health service in this country. There is Emily Lawson too. Yes, she is most important. Thanks to them.

Q22 **Mr Betts:** I am going to try to pursue the issue of the ICBs. Maybe you cannot answer the questions, but we ought to at least express some concerns. We had a little discussion prior to the hearing about our view of our ICBs in our area and how they work. They work very differently in different areas. The satisfaction of Members of Parliament with what happens in their areas is very different as well.

Following up the issue, with the new structure of ICBs, how much engagement is there going to be with the people in the locality? I am thinking about Members of Parliament, local councils, directors of public health and local GPs, so the people who have an interest in seeing probably improvements and change happening in a positive way. Is the centre of the ICB going to say, "Right, okay, that is it. We are going to hold on to what we have here and everything else can go by the board"? Are they going to be allowed to do that?

Julian Kelly: I do not think that the vision that the Secretary of State has for what I am going to call the pattern and provision of healthcare is to allow the relationships with local communities, local authorities, directors of public health, local politicians, MPs or councillors to go by the board. One key question that the 10-year plan will answer is what the right approach is for delivering a neighbourhood health service centred on high-quality effective primary care, with integrated multidisciplinary teams wrapping around local GP services, to in fact strengthen their relationship with patients and their communities.

One question that the 10-year plan will resolve is how you play the role of ICBs as strategic commissioners and what responsibilities you see



HOUSE OF COMMONS

providers—it could be GPs or other organisations—taking on for commissioning local care and strengthening the direct link between providers, local communities and local authorities. I cannot give you all the detail here, but that is one of the things that will emerge out of the 10-year plan.

Q23 Mr Betts: I understand that. I am just trying to put a marker down for things that I am worried could be lost. It follows what Layla Moran said about the place element in ICBs. We look after our own areas and understand them. When ICBs were set up in Sheffield, we, as local MPs, fought very hard indeed, along with the local council, to keep a Sheffield place element to the ICBs, because the working relationship between the NHS at that level and the council director of public health is brilliant in Sheffield. It works. It worked through covid. Everyone feels confident and positive about it.

Therefore, to take that level away and suddenly think that you can do everything at a higher, more central level in the ICB would actually destroy the push that is going on. It is at that place level that there is a move towards community care, equalities, looking after the poorest areas and prevention. The drive is at that level and I do not want to lose it.

Julian Kelly: Rather than me respond to the point, I will take the input into the thinking that is going on. That is completely understood. I do not think that the intention is to weaken the links between healthcare provision, commissioning and the local people you have just talked about.

Professor Sir Chris Whitty: I recognise all the points that you are making. Not every ICB works. Not only do they work differently, but some work more effectively than others. Let us be honest. I get herograms and the reverse from local residents, senior leaders and indeed MPs from areas, who know their patch. That is true, of course, of the NHS and health services as a whole. If everything could be as good as the best, it would be a different situation. A lot of what you are trying to do is make sure that everything does move as close to the best as you can get.

Some ICBs were set up in an easier way to succeed. That worked in particular where the geographical limits of the local authorities and of the NHS, so in a sense the political and administrative boundaries, were similar, and when they were a size that was sufficient to produce additional scale, but not so big that they were unwieldy. I do not want to go through a list of which ones are which. That would be inappropriate. On the other hand, I do not think that there is any intention from certainly the Secretary of State's philosophy to take things from the periphery to the centre. In fact, if anything, his tendency would be the opposite direction overall.

Q24 Mr Betts: Julian Kelly, you cannot make the commitments now because you will not be there to see them through. Perhaps the message could be passed through that there has to be a requirement to engage with the



stakeholders at local level, including MPs, but also councils, directors of public health, local GPs and others, about how they think things are working and how they want to ensure the best of what is working now carries on in the future.

Julian Kelly: Yes, of course.

- Q25 **Chair:** I cannot emphasise too strongly what Clive Betts has said. These local connections are so important. If I was sitting this morning as chairman or chief executive of the Gloucestershire integrated care board, I would be really scratching my head, asking, "What is going to come down the line?" The sooner you can give answers to those questions, the better. I cannot emphasise that too strongly. These people have local connections. They are locally embedded in our communities and they will be interacting and worried about what is going to happen.

Julian Kelly: I completely understand. I will absolutely take the feedback and the strength of it.

Professor Sir Chris Whitty: I would go further actually. We understand and agree.

Chair: Great. That is really helpful.

- Q26 **Nesil Caliskan:** Can I thank the panel members too for their contributions so far? I want to build a little bit more on Mr Betts' points around place-based. As an ex-council leader of six years, I absolutely concur with what other panel members have said around the importance of footprints aligning—that is more of a technical point—but also how ICBs have examples across the country where they are working excellently. I agree with you, Professor Whitty, that there are some that are quite dysfunctional, to be honest.

As part of the restructuring of NHS England or the Department through an effort, it seems, to redirect moneys to the frontline, we must not lose the very good practice, but make sure it is also an opportunity to improve those areas that are being let down. They are quite often areas that are already badly served in terms of health outcomes. That will be news to nobody on the panel, I know, but I thought it was important to say.

Specifically on footprints, localisation and that place-based approach, there are two things I wanted to mention. One is prevention work. I am looking for some reassurance that, as we embark on what is a major agenda for structural change, commitments around prevention are not lost. Ultimately, in the long run, that is what has the biggest impact on health outcomes. Work of local authorities is part of that.

The second thing is around the work the Government are leading on devolution and footprints that will emerge from that work. I am looking for some reassurance that, somewhere in the system, people are speaking to each other and we do not end up with a mismatch of a hundred different footprints that mean very little to populations or, for instance, council leaders. Then I want to talk about staffing numbers, if I



may.

Professor Sir Chris Whitty: I will do those two first, because I think they mainly come to me, but Mr Kelly and Dame Jenny may want to comment, because Jenny worked in local authorities for much of her career and fully would agree with that. I am the chief medical officer. That is my main job. You will be unsurprised to learn that I 100% agree with you on the prevention. Indeed, I would like to go further on prevention. My view is that it is strengthening the prevention that we need to do, rather than weakening it, in the next phases.

If we wish to make the NHS sustainable in the long run, as well as improve the lives of our fellow citizens, shortening the period of ill health is the only way we will do that, and the only way you can do that is through prevention. I completely agree, and ICBs and local authorities both have a very major role. I wanted to reassure you that that was completely my view, and I do not think that the Secretary of State would in any way disagree with the points I have just made, but I will put them with as much topspin as I can give.

On your second point, some ICBs are set up in a difficult way. The ideal situation is where there is a proper balance between the political structures around local authorities—which hold many of the levers, particularly on the prevention side, but not only—and secondary care, as there are some secondary care providers, and primary care, community care and wider systems, very importantly including charity, third sector and other providers that provide a lot of the stuff on the ground.

In my view, there are two situations where, predictably, ICBs are not functioning as well as they should do. One is if the leadership is poor. That is true in any organisation. The other is when those get out of balance. If an ICB becomes, for example, almost entirely dominated by one secondary care provider, one hospital, that is going to lead to trouble. That means that the other bits of the system, which all have to interact, do not work as well. The same can go in the opposite direction. It is making sure that the different elements are combined in an effective way.

There are good examples of this, as the Committee has said, and some less good examples scattered around the country. There is not a complete predictability about this. It is not just that all the good ones are in areas of affluence and all the poor ones are in areas of deprivation. That is absolutely not the situation at all. If anything, the correlation might go the other way. It is much more to do with these kinds of factors. All of us want this to work and I do not think that anybody, certainly on this panel, would in any way backtrack from any of the points you have made. Can I check with Dame Jenny and Mr Kelly whether they want to add anything?

Professor Dame Jenny Harries: As Sir Chris has said, I have spent more of my time as a director of public health and in fact I came in as



HOUSE OF COMMONS

deputy chief medical officer on the health improvement and prevention front, so I absolutely support the comments that have been made. I am now working in health protection. If we think about these changes, I see great opportunities. Let us take vaccination—say, we do not get the system interoperable and vaccination rates drop, for example. We have a role in oversight of all the national immunisation programmes. NHSE has a key role in the delivery, but people will not come forward unless they have long-term trusted relationships with local services, often voluntary services, religious leaders, or whoever that might be. The opportunity to shift the focus to prevention and local is a strong one that I would support.

From my own organisation perspective, we have nine regional teams. We have specified consultants in communicable disease control. They work with the directors of public health. I was in Leeds the day before yesterday with colleagues from the council and the director of public health. We will be looking to maintain and strengthen those arrangements.

Julian Kelly: I have nothing to add and would completely concur.

Q27 **Nesil Caliskan:** May I ask some questions around staffing numbers? It is true, is it not, that, in recent years, the Department of Health and Social Care, and indeed NHS England, has seen a significant growth in terms of staffing? If you take, for instance, the Department, there are tens of new recruits every month. The very fact that it has been agreed that there will be a freeze, as Professor Whitty has already said, in and of itself will create an immediate saving and is also the right thing to do in the context of what might be redundancies in the coming months. Any sensible organisation would do that.

In the context of frontline services being at utter breaking point and chief executives of hospitals, for example, frequently talking about staffing issues, budgetary issues and appointments not being able to be met because of resourcing challenges, the public, you will understand, will be surprised, to say the least, to hear that there has been such an increase of numbers in the Department of Health and Social Care and NHS England, not in terms of frontline healthcare provision but what they would describe as backroom staff. That is not to diminish the important role that these civil servants or NHS England staff do. I should say that a long time ago I worked for NHS England in the health inequality team. From a patient perspective, the fact that they cannot get an appointment is difficult for them to accept. You may or may not want to comment on that.

I wanted to ask about the freeze. Is there an immediate understanding of what savings the freeze will create? Have any decisions been made about what that immediate saving will be used for? Will it be used to just close what is an existing gap in the finances, or have any decisions been made about redirecting that as it stands to any frontline services?



HOUSE OF COMMONS

Professor Sir Chris Whitty: I will answer the first bit of that, if I may, Chair, and pass over to Mr Brittain for the second bit on the numbers. On the first one, I would like to, in a sense, agree with the first bit of your first section and challenge—not to you—the perception on the second, because I think that there is a misunderstanding on these things.

On the first, it is true that the Department grew, and it grew in two waves. There was a wave that was associated with the Brexit point, in a particular way. There was a concern about a hard Brexit, what that was going to do to drug supplies and a variety of other issues. The anticipation was that that would then retreat as we went through that period of change, but then covid hit almost immediately afterwards. Unsurprisingly, the Department grew very substantially during covid, and I do not think that anyone would expect anything else.

It then shrank again, quite a long way actually, but there was a creep up before the election. Then quite a lot of people came in after the election in response to the priorities of new Ministers, and that happens in most situations. Nevertheless, new Ministers were, rightly, not at all in favour of increasing numbers and wanted the numbers to go back down. They were clear about that and that is the reason why we started the initial headcount stop that we are talking about. That is a mathematical fact, but I do not want people to get this out of proportion. I want people to understand the reasons for that, but I think we are all agreed that the correct direction of travel is down.

On the other hand, however, there is often a very misleading impression of what frontline actually means and the scale of the numbers we are talking about. The Department that I have the privilege of being part of when I am in this part of my job is around about 3,600 people for the whole of the UK. Sorry, that is the whole of England, to be clear—before my other CMO colleagues point out how wrong I am. I also work as a doctor in UCLH, which is well over twice as big as one hospital, in terms of the number of people. Some of the bigger trusts, such as Guy's and St Thomas', are many times bigger than that. Actually, the Department for the whole country is a lot smaller than a single trust. There is the idea that this is a kind of behemoth. The NHS is a huge organisation and these organisations are really relatively small. That does not in any way invalidate the point that they should go down, but I do not want people to get these things out of kilter.

The other thing is that, within that, there are people, for example, who are helping to do public health across the wider system and make sure we have research for the future. These are the things that are going to mean that health improves in the long term. The largest research organisation in Europe is run out of the Department of Health and Social Care. Are those people frontline? I would argue that you could say they are, but they are counted in this sense as back office. If you want new drugs, vaccines or hip replacements, those are central people. There is a real misunderstanding and I want both of those to be held to be true.



HOUSE OF COMMONS

What the Department is doing really affects the frontline, and I would extend this to NHSE as well, but also we agree that the numbers should go down. I just wanted to make sure that those were in balance.

Andy Brittain: Do you want me to come back on the numbers?

Nesil Caliskan: Yes, in terms of the savings needed.

Andy Brittain: Very briefly, if we assume there are 3,500 people in the Department—I am using round numbers again—and 7% natural attrition from the headcount, the recruitment restrictions that have been put in place will equate on an annualised basis to about £15 million a year. That money will flow through to the frontline.

Professor Sir Chris Whitty: To add two points to that, for the first year it is half that, unsurprisingly, because it happens over a whole year. The second point is that, if you are doing voluntary exit schemes and other forms of redundancy, if they were used in other periods, you do not get any savings in the first year. In fact, you usually spend more money in the first year. You would expect to get savings somewhere between six and 18 months afterwards, depending on the particular scheme that was used.

Professor Dame Jenny Harries: I support the position. As a new agency, we did not have a history and we have downsized from 18,000 staff to 5,500, completely downwards. We have frontline laboratory staff: 2,000 of our 5,500 are literally working next to NHS colleagues. This understanding of what is sitting behind the numbers, as we started with, is a really important feature.

Professor Sir Chris Whitty: To avoid us having to dance around something that we have been slightly dancing around, the Prime Minister has just announced that he is intending for NHS England and the Department to merge over time, so not just a bringing together but an actual full merger. I thought it was important that you were aware of that.

Q28 **Chair:** I think that the subtext to this is that most of us were expecting that. That adds another complexion to it. Can I say one thing very briefly to you? We have not got on to the accounts yet, but Nesil led us into that with prevention. The only bit that I can find about prevention in the accounts is a very short paragraph on page 79. I do not want a huge, long answer to this, but, given the interest, certainly in this Committee, the Health and Social Care Committee and Parliament, about prevention, could we in next year's accounts have a little bit more importance paid to prevention?

Andy Brittain: Of course, yes.

Q29 **Chair:** That is very helpful. I have two points for either Chris or Julian. Both of you have acknowledged place-based, local context and all of that in the ICBs. Chris, I totally agree with you. There is a lot of difference



HOUSE OF COMMONS

between the best-performing ICBs and the worst. You have put a blanket number on this 25% cut in staff for ICBs. If I was chairman or chief executive of the Gloucester ICB this morning, I would be asking myself, "Am I up at the top there or at the bottom? What effect is that going to have on me?" How will this be negotiated with the individual ICBs as to what their cuts should be? How are they to be encouraged to perform better from the bottom to the top?

Professor Sir Chris Whitty: First, I did not put a number into this at all. I have deliberately avoided doing so. Secondly, I apologise, Chair, since I realise that, in a sense, I am abusing the Committee by saying this, but many of our colleagues will be watching this.

Chair: Yes, of course.

Professor Sir Chris Whitty: I want to be clear that, as of tomorrow, everybody who is working in NHSE and DHSC is doing the same job as they are doing today. At this point, the line of sight is absolutely between ICBs and NHS England, and that will be as true tomorrow as it is today.

In the long run, of course, that will move more closely. Therefore, Mr Kelly may wish to comment more, but we all agree with your point, which is that we would all want to take a look at each ICB in the round in terms of the decisions that are taken next, but those are not going to be taken by any of the people sitting in this line-up here, so it is probably sensible for us to stop at that stage.

Q30 **Chair:** That is really helpful, Sir Chris. I have one more question and then I am going to take a break, because I hope that we have got us as far as we have on this reorganisation point this morning, and we want to get into other bits in the annual report and accounts. In a sense, this may be for you, Julian Kelly, but it may be for others. To what extent are you liaising with MHCLG in relation to local government reorganisation? Reorganisation in health, as Clive has made clear, has a huge impact on local government. Local government delivers local public health and many other functions.

Julian Kelly: We are liaising with and through MHCLG precisely to make sure that the devolution agenda that is being pursued through MHCLG aligns with the direction of travel and, indeed, as I said, whatever conclusions are reached as the 10-year plan is finalised.

Chair: It has been a fairly momentous morning, so I am now going to take a bit of a break in order to give us all a bit of a breather to clear our minds as to what we have all heard this morning.

Sitting suspended.

On resuming—

Q31 **Chair:** Thank you for that really interesting earlier session. It raises a lot of questions, but we have at least got the gist of it all now. We now want to get into what we originally were going to do, which was to examine



HOUSE OF COMMONS

bits of the annual report and accounts. It is probably the easier bit of the session, in a way, because there is some certainty in that.

I am going to come straight to you, Professor Dame Jenny Harries, if I may, and talk to you about the UKHSA accounts. What steps did you take in 2023-24 to improve your accounts and remove the C&AG's disclaimed audit opinion?

Professor Dame Jenny Harries: The interventions that I will describe have clearly been beneficial, because we have had that disclaimer removed, and we are on an upward and steady trajectory, although still with lots more work to do.

We have been working very closely with DHSC colleagues, and particularly with NAO and GIAA. We have been putting in a timed approach, so that we have very realistic timescales and can escalate very quickly, and we are looking forward to doing that.

We have looked very deeply at the accounts and some of our processes, and have been using some third-party assurances, both to help the process of the audit going through, so that it is an easier audit for NAO to deliver in a timeframe, and to give us assurance that we are doing the right things.

Of course, we have particularly addressed, in quite a lot of detail, the issue around the CVU model. While it has caused a number of problems over the accounts, there has never been a problem with the model itself. It was a good model and it predicted well, but it was the governance around it that was the problem.

To answer that part of your question, we have made our governance processes more robust. We instituted a financial control programme. We have just revised that, because we have been making progress, and we are refocusing it in phase 2. We have ensured that our governance processes are strengthened. I have personally been overseeing the financial control and improvement board, but there is, of course, now a very strong and challenging ARC to which our programme goes.

On top of that, which we might come to, and which partly relates to the previous conversation, I have restructured the organisation completely at the top level. We have taken out a number of staff and are much leaner. We now have a very tight top level, made up of myself and four DGs, with four groups. I have a new deputy COO joining us very shortly, who has been announced.

Q32 **Chair:** Do you want to say a bit more about that restructuring in terms of the number of staff and who does what?

Professor Dame Jenny Harries: Just to go back to what I said before, you alluded earlier to the fact that we have had quite a complex birth, and it kept changing mid-year, which is one of the lessons that I have learned in this process. We started with 18,000 staff. We made the



HOUSE OF COMMONS

biggest not just people but financial reduction in a single year in the civil service, going from £15 billion down to £3.2 billion. Our staff numbers went from 18,000 down to 6,000, and subsequently to about 5,500, so we have reduced the total number of our staff.

The important thing, though, which goes back to form following function, is that we have the right quality and quantity of the right sort of staff. In terms of what I have done with the restructure, we deliver frontline staff. We have emergency responders. For example, in terms of the collision that you may have seen in the North sea, while perhaps not something where you would think about our agency, our staff are advising on the public health impacts of that.

We have staff in a number of specialist areas and have been trying to boost the number of staff in some specialty areas where there have been historic shortages, but then make very lean the pure administrative functions and get those into a very tight governance shape. We are just about there. We did the formal consultation last autumn. We have implemented it very quickly from 1 January this year, and there are a few people still rolling off towards the end of this financial year.

Q33 Chair: Sir Chris, what we are trying to do this morning is to put certainty on to an uncertain situation. Given that scale of reorganisation, is UKHSA now in a state where it would be fit for the future and not need to go through any of the more radical restructuring that your Department, ICBs and Julian's NHSE are going to go through?

Professor Sir Chris Whitty: I am going to hedge, Chair, for two reasons. First, there is a new chief executive coming in, following Dame Jenny, who has done an absolutely stellar job, I have to say, in an incredibly difficult time. What you have seen is an organisation that has shrunk in size, has balanced the books, and has defended the UK from covid and multiple other threats, as she says, just in the last few weeks. It has been a great organisation.

The two reasons I am hedging are partly that, and partly because it is the bit of the system that is most amenable to have to either scale up or scale down, depending on the threats that hit the UK. The number of people who will have heart attacks or hips is pretty predictable year on year. The need in terms of health protection is much more variable, so I would not see it necessarily as something that is static, even just in terms of the need for the population.

Certainly, I and Dame Jenny would want to give her successor the opportunity to sit down and think about what they want to do before we have prejudged exactly where they get to, under the overall leadership of the Secretary of State.

Q34 Chair: That is really helpful. I echo Sir Chris' remarks about your achievements. I did echo that at the beginning, so we do recognise that. On top of all this restructuring, you had to get your accounts in order.



HOUSE OF COMMONS

You relied quite a lot on external consultants to help you with that. By the way, congratulations on getting from a disclaimed account to a qualified account. What we now want to see is for you get from a qualified to an unqualified account. We are coming on to questions on that in a second. On this external help, are you able to tell us how much that cost?

Professor Dame Jenny Harries: Yes, I can. We have had a mix inherited from the start of the pandemic, when we came into being, where we had very significant costs on external support, which were somewhere around £230 million. Last year, it was £1.04 million. There are reasons why we do that. There are a number of areas in the organisation, partly because of what we do and what we have been required to do in a short time, and partly because getting the accounts past a disclaimed state was really important to me to make sure that the organisation was in a solid, stable position going forward.

We have used that additional resource, not simply as extra finance people, but so that we had assurance on areas. I mentioned the CVU model, which caused some degree of consternation in our accounts. We have used external staff appropriately to assure the model. These were expert modellers looking at that model, providing assurance to me, to exco and to our own ARC, and then, in turn, to NAO. We are using them selectively and appropriately to move the organisation forward. At the same time, we are strengthening our financial team, and I have seen that come through during the year.

The other important thing is that it is not simply about the finance team, but very much about how the organisation understands what its responsibility is. When you look at our accounts and some of the hard work that has been involved—and I would really like to recognise the work of our finance teams and the support that we have had from Department of Health colleagues—we have used them to assure that the processes are as efficient as they are.

Often, what we are not doing yet, partly because of our history, is making sure that we get things right first time and that there is absolute consistency that we are doing things upstream. It is a bit like the prevention agenda. We have moved our accounts forward six weeks in laying them. We are on time to do that again, in October, for this year. I hope that, for the 2025-26 accounts, with a plan there, they should be in a non-qualified state and laid pre recess.

Q35 **Chair:** So you are not confident that this year's accounts, for 2025-26, are going to be regularised and without qualification.

Professor Dame Jenny Harries: Andy may want to come in, but we are technically unable to do that, because of the closing account and the issue of the CVU previously. What you saw in the first year was that we put a lot of work into getting the right basics. You saw that move in the second year, and then we had the CVU issue. Because of our closing



HOUSE OF COMMONS

accounts and the impact that that has on the different account streams, we are unable to do that for next year.

When I was here probably two years ago, I did say that it was going to be a three-year forward look on this. I understand that, with disclaimed accounts, that is not an unusual trajectory to get to that point, but we are certainly aiming to be there for 2025-26, which is the earliest date that we can do.

Q36 Chair: Thank you very much. That is really helpful. What assurance can you give us that you are addressing the Government Internal Audit Agency's concerns about the lack of effective decision making by the executive committee?

Professor Dame Jenny Harries: I can probably partly answer that question for you. In fact, at the time that GIAA did that review, we were already planning. It was running side-by-side and in parallel with the proposed changes.

One of its concerns was particularly around a programme that we ran, called Building for Ambition, which was slightly misunderstood, because what we were trying to do, in quite a novel way, was test out what the structure and the systems looked like by the people in the middle using them. It was not a formal programme and was intentionally designed loose, if you like, to try to get a picture of how we could practically change our decision making and make it slicker and faster.

We have then gone on to formal consultation and reorganisation, as I have just described. As well as making a much lighter top team across the organisation, one of the main purposes was to get the decision making faster and with the appropriate governance.

We now have fewer boards. We did a complete review of all of our boards. The expectation—and there is a leadership element to this—is that our directors and deputy directors get the opportunity, which they were saying they did not have before, of being decision makers, driving and building a new organisation, and really feeling part of it in quite an exciting way, but also the responsibility of doing that.

In terms of the way that exco is functioning now, we have changed our meeting dates. We meet twice weekly. We have a workshop in the morning to focus on strategic issues. Our papers are now completely altered to make sure that they are strategic in intent and that we are, effectively, providing the governance and the guiderails for people a bit further down the organisation to make the day-to-day corporate decisions and take them forward. We are acting as the check and guide to that, which is much more appropriate, but also signals the maturity of the organisation.

Q37 Chair: What changes have you made to your governance board to make sure that your organisation continues on the upward trajectory that you



are projecting?

Professor Dame Jenny Harries: We have restructured where the governance team report into. They report into my chief of staff. It is coming into me. We have refashioned various other areas of importance. Our strategic risk register has been completely reviewed. Our performance indicators have matured. It can be quite difficult to get good indicators on some areas, such as vaccination, where you are part of a system. Nevertheless, we are challenging ourselves to give quite hard KPIs on that, so that we can see where we are on track or not.

We have implemented some very deep-searching but quite broad controls for each of the directors general. I meet with each of them and look at their financial trajectory, but we also include our HR components of that and have our business partners. There is a whole new system of catching things and challenging early, and then a formal governance system going above.

Chair: That is very helpful.

Q38 **Anna Dixon:** You mentioned earlier the abbreviation CVU, or covid vaccine unit, which has been responsible for the procurement and distribution of our supply of covid-19 vaccinations. Can you just tell the Committee what the future of that unit is and whether it is remaining within the UKHSA?

Professor Dame Jenny Harries: Originally, the CVU was part of the vaccine taskforce, which people will probably remember from the pandemic. It did some brilliant things at a time of great uncertainty. It had very fast logistics. It was working with different pharmaceutical providers to ensure that we had the right vaccines in the right place. We were continuously monitoring the virus and getting the right vaccine for the population.

However, that was one vaccine for one disease. Of course, the other half of the organisation, if you like, had always routinely been doing all the other immunisation programmes, evaluating them on a routine basis, and working to support JCVI—the Joint Committee on Vaccination and Immunisation.

We have tried to take the best of the vaccine taskforce and revamp what has been quite a historic part of predecessor organisations in what was the VCR—vaccines countermeasures and response—team. We have now moved them into a new team, which is sitting under our commercial director. That allows us to get best value out of contracts, but working very much with the response. We can do what I would call steady-state vaccine programmes and just-in-time vaccine programmes, meaning we are much better prepared to respond to a pandemic, but can also get better routine value.

The short answer to your question, having gone round the houses, is that we now have a single unit. I have my own acronym for this, CVCD, which



HOUSE OF COMMONS

is the commercial vaccines countermeasures and response delivery directorate.

Anna Dixon: That is a bit of a mouthful.

Professor Dame Jenny Harries: It is quite new. It was launched literally last week.

Q39 **Anna Dixon:** "CVU" was a little easier to get your mouth around. The unit, and now this new organisation, holds contracts for vaccines that we do not expect to use. I understand that these are non-cancellable contracts. How much money is locked into these contracts that we cannot get out of, and how does that relate to the partnership with Moderna?

Professor Dame Jenny Harries: I will take those two things separately. If I go back, there will be different values for different vaccines. Each year, with childhood flu vaccines, for example, you will see in the accounts that there was some loss on that, because a flu vaccine is usually an annual vaccine, and you will never predict precisely how many children are going to take that vaccine that year. You do not want to have too little, in case people come forward, because we can create a health benefit. Equally, you do not want to have too much left if people do not come forward. Each year, there will be some components of that in the budget.

The big losses in the budget relate to contracts for covid vaccines, which were taken out prior to UKHSA coming on board. This is difficult because it clearly looks like a loss of resource, but I would say two things. First, commentary into the public inquiry has shown very clearly that, if you have an unknown pathogen and a significant harmful impact for a whole population and its economy, these are relatively small amounts of loss. On the covid vaccines, it is around £1 billion, which sounds a lot, but, if you put that into a context of £300 billion spent on the pandemic, it is a relatively small amount to maintain protection in a context where it is almost impossible to predict.

Having said that, the overall loss there is around £1.7 billion on covid in the accounts. What the CVU, or now our new team, is able to do is always try to maximise the benefits. By adjusting contracts or extending shelf life where that has been possible, clearly only with the right safety guards, we have managed to push forward and save £2.4 billion. Some of those vaccines have been used for the autumn campaign.

Anna Dixon: So they are not all out of date and wasted.

Professor Dame Jenny Harries: They will start to come out of date as we go forward into the next year. There are still some that are being used, but we need to make sure that we are using the right vaccine for the right variant and for the right population.

Q40 **Anna Dixon:** How are your new team going to make sure that they get value for money in the way that they are going to be procuring, entering



into contracts, and predicting the volumes, so that you do not end up with the sort of situation that we have here of £1 billion of vaccine underused, let us say, rather than unused?

Professor Dame Jenny Harries: There is what we do routinely, which I will come to, and I have just given an example of where that team have been working to ensure that, where there were contracts in place, which were there from the pandemic, we maximise the benefit of that, where it is safe to do so.

Anna Dixon: And avoiding this situation in the future as well.

Professor Dame Jenny Harries: Yes. The only challenge that I would put back is that, if we had another pandemic, I would rather have an excess of vaccines than none at all. That is what the vaccine taskforce did and has been praised for doing, because it ended up with 10 shots across the system and success more or less all round, in a way that was perhaps not predicted. We expected more to have failed. If we have something as significant as the pandemic that we had, we should expect this sort of variation if we are protecting the population.

What we do routinely, though—and this comes to your point—is that, for something where we can predict a seasonal pattern or a virus that has a settled cohort of the population that we know will be protected, that is all planned out in advance. Every time a vaccine is recommended by JCVI, it sits on a background of epidemiological, clinical and, importantly, cost-effectiveness evidence. They are continuously reviewed and, as contracts come up for renewal, the commercial team will check those as well.

Q41 **Anna Dixon:** This may not be for you, Dame Jenny, but perhaps for Sir Chris. As we are on covid, in terms of PPE, here in the accounts, it lays bare what I would say in this case is a waste of taxpayers' money. You may argue as well that some of that was unpredictable at the time, but there are £10 billion of what are called here impairment and write-down charges. I wondered if you might just speak to the PPE stockpiles, the costs of the poor procurement that was entered into historically, where we are now, and how we prevent such issues arising in the future.

Professor Sir Chris Whitty: I will do the front end, and Mr Brittain may want to come in and do some additional points. I would acknowledge that this is a pretty complex area of procurement, and the current covid inquiry has been going over this over some weeks. In a sense, I am going to give only a very small comment on really quite a large area.

It is worth casting our minds back to where we were in the early part of 2020. There were three things that were clearly true. First, we had a precarious—and, at a local level, worse than precarious—supply of PPE overall. You have heard the very moving testimony from healthcare workers over the last years. That was a situation that the Government, rightly, said that they absolutely never wished to see happen again during the pandemic, so there was a very strong push to do this.



HOUSE OF COMMONS

Simultaneously, we did not have a vaccine at that stage. We did not know how long we were going to have waves that were going to need this protection. This could have gone on for some years. At that point, the professional scientific view was two years, if you are lucky, and maybe no vaccine at all. The last big pandemic that we had on that scale was HIV, for which we still have no vaccine some decades later.

Thirdly, these waves could also hit the big suppliers such as China. If that happened, they would, as most countries would, use up their own supply before they export. That put lots of areas of uncertainty into a market that simply was not designed for the degree of international demand.

The result of that was some degree of over-ordering. There was probably also some belief that, "If we have it, we can then keep it for the next pandemic", which probably had not been thought through as fully as it could have been.

Alongside that, there were some issues where people, using the most generous interpretation, were in a field that they did not really understand and were procuring things that were not of the highest quality and, in some cases, went beyond that. Some of those are now legal cases, and I cannot go into them, but I hope that what I am saying is clear.

I am not saying that it all falls into "understandable under the circumstances", but a lot of it was understandable under that degree of uncertainty and with that level of risk to staff, which none of us wants to see repeated.

In terms of the accounts, it is important to recognise that most of these have been, in a sense, put into the accounts previously. This is not new information that is in these accounts, but Mr Brittain may want to come in.

Andy Brittain: That is exactly right. We have discussed this at previous Committee hearings on the accounts. The change in the numbers is very minimal this year. What I would add is that the disposal programme is now completed, so we have dealt with all the legacy covid excess PPE stock, and now have just the residual core of what we consider we need for future pandemics. We have disposed of the PPE in line with the Government's waste hierarchy, which is recycling first, then recovery through energy from waste, and then landfill. We have not put any to landfill, so we have got rid of it in the most appropriate way possible.

Professor Sir Chris Whitty: Quite a lot of PPE is used in routine circumstances in the NHS. Things such as gloves, aprons and facemasks are standard.

Q42 **Anna Dixon:** As the account reports, some of it was unsuitable for use. You are saying that, effectively, all the dud PPE has now been disposed of as we sit here.



Andy Brittain: Yes.

Q43 **Anna Dixon:** We have spoken about vaccines and how you can predict better. What are the plans for how you are going to estimate future PPE stockpiles to help for resilience against future pandemics?

Professor Sir Chris Whitty: There are certain things for which stockpiles are going to be needed in virtually whatever form of pandemic you get. Gloves and aprons, I would have thought, are a universal thing that you are going to need under all circumstances.

Just taking the example that I gave of HIV, which is sexually transmitted, masks are irrelevant. Visors are useful only for particular procedures. If you have a vector-borne disease, virtually all these things are irrelevant. The route of transmission does, to some extent, define this. People assume that you can just have a PPE stock. You can have the basics of it, but what you actually need will depend on the disease and particularly the route of transmission.

That said, our aim is to have a longer lead time. What we demonstrated was that we just made an assumption that you could buy in from the international market. If you have an epidemic, that is true. If this had been something that affected just northern Europe, there would have been no problem buying in on the market. In a pandemic, everybody wants it simultaneously, so you need to have, in my view, at least four months' worth of maximum-use PPE available in the country, which buys you time then to be able to work out how you want to respond in terms of make or buy.

Q44 **Anna Dixon:** In your own risk assessment, you have said that respiratory is the most likely. Are you making provision for domestic supply in future of specific types of PPE, recognising that it could be any of the mechanisms of transmission?

Professor Sir Chris Whitty: The basics of gloves, gowns, aprons, masks and visors in different numbers—so, to be clear, many more gloves and aprons than visors, for example—are going to be likely, not in all but in the great majority of pandemics or major epidemics that we can face. Andy can probably go through some of the numbers in terms of where we are at the moment, but we should aim to have the capacity to respond, not to a full pandemic, which would require an extraordinary cost in storage, but for the first three or four months, to be able to scale up and buy ourselves time to have a full-spectrum response.

Q45 **Chair:** I am going to ask a question that I have asked before in this Committee, and which you hinted at it in your answer, Sir Chris. Part of the problem with both PPE and vaccines—and indeed a lot of other equipment—is that they go out of date. There seems to be an attitude in the NHS of saying, “We will wait until it goes out of date and then dispose of it”—burn it, basically. Why is there not more thought, as it is coming towards going out of date, given to either finding another market for it or



even, necessarily, giving it away? I am sure that a lot of people could use this equipment. Just to burn it does seem to be an awful waste.

Andy Brittain: If I may answer, there are two things here. With the size of the original covid pandemic stockpile that we had, we did look at things like that. We looked at giving it away for free. In fact, we had a free PPE scheme up until 1 April 2023 or 2024; I would need to check on that. We also looked at donating to countries. We exhausted those routes before we resorted to the waste hierarchy and using energy from waste, as I mentioned. That was with the covid legacy stockpile.

With what we have now—so the current pandemic stockpile—Mr Kelly may have more detailed information than I do, but it is run by SCCL, which is part of the NHS. SCCL is looking to move to more dynamic stockpiling to do exactly the sort of thing that you are talking about. Rather than allowing things to go out of date, it is about getting stock in, holding it and then shifting it to be used in the NHS, wherever possible. It is to avoid exactly the problem that you have mentioned.

Professor Sir Chris Whitty: I would just add one important technical point. Nowhere, except as donations, do things have only two or three months to run, because it is hardly possible for them to use it. It costs them more than any benefit. You have to give them a long enough run at it.

Q46 **Mr Betts:** I want to raise a couple of issues. First, just coming back to the covid vaccine stockpile that you have, I have my covid vaccines on a regular basis. I am immunocompromised, so I get priority, as other people do in that situation. I have always had a brilliant service. I went to the Woodhouse pharmacy recently; I have been to different places. In the past, my partner has always had entitlement to a vaccine as well, on the basis that, if he catches it, it passes on to me. I am immunocompromised, so that is a concern. This time, he was told, "No, it has been changed. You cannot have it for free". You have all this covid vaccine sat there doing nothing, but you are reducing the number of people entitled to it. Is that logical?

Professor Dame Jenny Harries: It will be for each individual vaccine and cohort, and the cost-effectiveness. Each of the programmes for things such as covid or flu is reviewed on an annual basis. They are independent recommendations by the Joint Committee on Vaccination and Immunisation. Although UKHSA will gather all the scientific evidence sitting behind it, it is JCVI that makes those recommendations. It will look at what the likely beneficial or harmful impact is for individuals in different risk cohorts and age groups, which is why you will see, for each of the national programmes, different effectiveness.

Since covid started, it has changed hugely in terms of the impact that it has had, even for those who are immunosuppressed. If you have had a vaccination, you are very likely to have either had covid itself already or developed some immunity from the vaccine. All those things are looked



at and, for the reasons that I was just explaining, about making sure that we are cost-effective and use public resources effectively, those cohorts are defined with that benefit in mind.

Professor Sir Chris Whitty: Can I just add two clinical points? First, we are much more confident now that people who are immunosuppressed are protected by the vaccines than we were. Secondly, the virus has changed. Initially, vaccination gave quite a lot of protection in terms of transmission. With the current versions—so, the subsequent omicron variants—although the protection for individuals who are vaccinated is still very strong for severe disease, the transmission-reducing potential of the vaccines has gone down quite a lot. That is a function of the virus, not of anything else.

Q47 **Mr Betts:** Thank you for that. That seems a very logical response to something where, as a lay person, you wonder why.

Just coming on to science and research, which I know is extremely important and has been mentioned before, you have, Dame Jenny, this building out at Harlow and some long-standing interest in doing something with it, but uncertainty about what is going to happen to it and where, in the long term, your science infrastructure and your key buildings are going to be, whether it is going to be at Harlow or somewhere else. Have we got any further towards deciding that?

Professor Dame Jenny Harries: Mr Brittain might want to come in, but I will start. The important thing here is recognising a strong responsibility to ensure that the country has the right critical infrastructure for the health protection agency to work appropriately. It is part of the national security system as well as the health service.

As you allude to, this goes right back to 2006, so two or three predecessor organisations, when it was first flagged that some of our high-containment laboratories particularly, as well as other supporting laboratories, would need to be replaced. That is now quite a critical decision in terms of timeframe, because it takes a long time to build these highly specialised units, but, equally, to commission them into service. They have to be, for obvious reasons, tested really hard.

There was a plan that had been agreed in the time of Public Health England for a science hub to be built at Harlow, which is the infrastructure that you are referring to. There was a review of the case, as you would expect, when the Health Security Agency came into being, when we had time, immediately after the pandemic. That was back in 2022. For a number of reasons, which I am happy to go into, but even quite simple things such as inflation and technical specifications, costs have gone up considerably. Not unreasonably, Ministers wanted to review whether that location or an alternative was the right one.

The short answer to where we are at the moment is that it is under very active review by Ministers. We can be assured of a decision coming



through in the second part of the spending review. We have been working very closely with Cabinet Office, with Treasury, and with other parts of the science system to make sure that there is coherence for all of our science laboratories across the patch.

Mr Betts: So the short answer is that it is essential that we get something in place and it is important that we get the decision quickly.

Professor Dame Jenny Harries: Yes, absolutely, and I am confident that that is clearly understood and is being actively addressed.

Q48 **Chair:** Dame Jenny, do you have an exact specification of what you want to do? Once you get the resources and the money allocated, how long will it take to construct?

Professor Dame Jenny Harries: It depends on what is decided. These are multibillion decisions, which are, quite rightly, cross-Government ministerial decisions.

Chair: It is held in the accounts as an asset under construction of £297 million, so we are talking about a lot of money.

Professor Dame Jenny Harries: It is a technical impairment on the accounts for that year, but, if Harlow is the science hub location of choice, that will come back into the accounts in due course. That is a bit of a technical auditing process. There has been a spend of around £400 million on the Harlow site. There is a visible build there to a certain level. The science hub alternative option, which is a longer-term programme but eventually delivering the same type of approach, would be at Porton. We have a lab there already, and there are opportunities to do that.

They are slightly different specifications. At Harlow, we would go back into business almost straightaway. With Porton, we would replace it with a similar high-containment laboratory, but then refresh other laboratories to support it over a longer period.

In response to your question about whether we are ready, we have done exactly what the NAO suggested, which was to have a long discussion with the IPA team about what the right model for overseeing that was. We took on board the fact that I am not somebody who normally goes and builds large laboratories in countries, and we recognise that.

Having said that, these are so specialist that they do need a lot of very close technical oversight. I have been out to a number of other places, such as South Korea, which has just built a similar laboratory, to discuss not just what was built but what the oversight of that build was. It seems that having the technical oversight is the right model. Canada is also very experienced in this.

We have put in place a new team. We have a new SRO for this, who has been working to provide Ministers with updated costs over the last few weeks, and we have new commercial services ready to go.



Q49 **Chair:** So there are two projects—one at Harlow and one at Porton.

Professor Dame Jenny Harries: There are two options. They are slightly different. They are slightly apples and pears. If you go forward over 40 years, their timescales are very different. The country maintains all the services that it needs in health protection terms, but the buildings happen at different times in different places, and our staff movements would be slightly different.

Q50 **Chair:** Which is the priority—Porton or Harlow?

Professor Dame Jenny Harries: That is, quite rightly, for Ministers to decide, because the two sites have very different options and opportunities. The Harlow site sits much more in the science triangle. There are opportunities there, which, again, we have discussed with the organisation, for MHRA to be on the site as well. Equally, at Porton, we have looking with MOD and DSTL to see how we can work with them on a different type of campus. They have different elements, which Ministers are considering.

Professor Sir Chris Whitty: To be clear, it is likely to be one or the other, in terms of new build, not both.

Professor Dame Jenny Harries: Yes, absolutely.

Chair: But Dame Jenny was saying that they have slightly different functions.

Professor Sir Chris Whitty: The reason that this has been quite a prolonged decision-making process—I will put it that way—is that the pros and cons of them are difficult to judge against one another, and they have different financing profiles. It is quite a technical area. I could give you an hour's worth on this one; you will be happy to know that I am not going to. I will just say that there are some differences and some pros and cons to each. Because it is so finely balanced, it has been quite a difficult decision to take. The sums involved are large, so this is not a decision that you can take without thought.

Chair: We will leave it there, given that it is so technical. We may want to come back to that and ask you questions, but that is really helpful for now.

Q51 **Anna Dixon:** Being conscious of time, I will try to keep questions short and encourage you to be short in your replies. I just want to come on to a couple of issues in the accounts about unapproved payments. There has been a historical issue of ineligible medical practitioners receiving payments. Julian Kelly, what progress have you made on recovering this £2.3 million?

Julian Kelly: On the specifics of the past, there are 14 GPs. There are five from whom we have fully recovered about £100,000; admittedly, they are the smaller cases. There are five that are in progress and worth just over £1 million. There are four cases, worth about £1 million, where



HOUSE OF COMMONS

we will not be able to recover the funding because either we are past the six-year point under the statute of limitations, or the historic teams failed in the process to follow the determination that led to the person being suspended, so we have lost the right to recover the funding.

I will say that we have changed the arrangements and put in place a single national team. Since we did that, we have not had any more cases, although that is still subject to audit by our external auditors.

Anna Dixon: So it was error rather than fraud.

Julian Kelly: Yes.

Anna Dixon: Okay, and you are confident that the new process will work.

Julian Kelly: Yes.

Q52 **Anna Dixon:** Another aspect of people and money is special severance payments. Again, the protocol is that these should all get Treasury approval. It seems, again, that NHS providers made some 51 special severance payments, totalling over £900,000, in 2023-24. Five were not approved. Can you just update us on progress on addressing these approvals and, indeed, making sure that it does not happen again?

Julian Kelly: Every case that is not properly approved is wrong. We continue to work with providers and ICBs across the country to remind them of their duties. We do regular training sessions. We have spoken to the individual organisations. In one case, the decision that was made was a better value-for-money decision than if they had just done a normal severance payment, but they did not seek the right approval for it. It is about reminding people exactly what the process is.

I cannot promise that, across an organisation this big, we will not continue to find examples in the future of people failing to follow some bit of process, but we are working absolutely to avoid that as far as possible. Clearly, in terms of the discussion that we had about the changes that are going to go on, we are going to be reinforcing this message.

Q53 **Anna Dixon:** What is the total amount that has been spent across the NHS on not just special severance payments but severance payments in general?

Julian Kelly: It will be here in the accounts. You could probably refer me to the page, but I do not have that number at my fingertips.

Chair: It is table 38 on page 189.

Anna Dixon: I just wanted to get a sense of whether, over time, the use of this is going up or going down. There can be a reason for that.

I also want to come to another related point. I realise that you would not wish to comment at all on an individual case, but the chair of a local trust was removed after raising some serious safety concerns, and he is



HOUSE OF COMMONS

currently going through an employment tribunal, which is why I would not be drawing attention to the specific case. I would like to ask how much the NHS is spending on legal costs to defend itself in such claims.

Julian Kelly: My apologies. I am trying to find the table. We can confirm the precise number outside of here. Individual organisations or boards are clearly responsible for their own governance. We remind them constantly of their responsibilities and duties. Where we discover that something has been done that is untoward, we sometimes get involved, as appropriate, and will take, if it really comes to it, the right regulatory action, or, indeed, carry out the right investigation to make sure that what has been done has been properly understood. I can confirm outside of here the precise numbers.

Anna Dixon: There is not currently a publicly available breakdown of the legal costs as they relate to exit packages and employment tribunals or such things. It would be useful for this Committee if you could follow up and provide us with that, based on the consolidated NHS Providers accounts, so that we can track. In terms of whether it is really a good use of public funds to be pursuing individuals, and the level of those legal expenses, we would be keen to see that, please.

Q54 **Chair:** From tables 38c and 38d on page 191 of the accounts, it looks to me as though, in the latest year, as of 31 March 2024, it involved 4,402 people, at a cost of £118 million. What Anna Dixon's question, and particularly the first part, is getting at is that we know from this morning's announcement that there are going to be very large numbers of redundancies, severance payments and so on. Is there going to have to be a new mechanism for approving this? You cannot have every single one of these people approved by the Treasury. How is that going to work?

Andy Brittain: This is yet to be decided, but, in the past, when we have run similar schemes, there has been an overarching business case for the overall numbers, cost and time of the people we are looking to leave the organisation. The Treasury has approved that envelope, and then processes have been set up inside DHSC and NHSE to manage that and ensure that appropriate governance is in place, so that individual cases are managed on an appropriate and fair basis. I imagine that that will happen again.

Anna Dixon: The fair basis is very important, given the legal costs and so as not to go down the route of having more employment tribunals.

Chair: Yes, exactly.

Q55 **Mr Betts:** In the accounts, there is reference to 240 identified cases where retrospective approval was sought for special severance payments. That seems a lot. What happens if approvals are turned down retrospectively?

Julian Kelly: The technical accounting thing that happens is that the external auditors make a judgment as to whether it is material by value



HOUSE OF COMMONS

or nature. If they judge that it is, that would potentially lead to a qualification on the accounts. In the particular instance of NHS England, I cannot speak for the broader position. The judgment this year is that it is not material by value or nature—i.e. it is not revealing a systemic failure of control, even if there are issues that need to be addressed organisation by organisation.

Mr Betts: Are there any consequences for those who approve these payments, if they are acting outside their remit?

Julian Kelly: It is a judgment about how proportionate the response is in each case. We have had issues such as a systemic failure of control and have taken regulatory action. In some instances, an HR director has given approval before seeking the right authorisations. Depending on the sum involved and what has happened, we will talk to the organisation and make sure that people are spoken to. It is just about working out what the proportionate response is.

Mr Betts: Has any action been taken against anyone for any of these payments that were given without proper approval?

Julian Kelly: We have followed them up in the way that I have just said. In most cases, the proportionate action would be to remind folk of the authorisations that they need to get.

Mr Betts: Some might think that constant reminding is not really working, if they keep occurring.

Julian Kelly: I cannot promise you that you will not have them again in an organisation the size of the NHS. I would just use the example of an HR director who has come in new and done something without having properly understood all the authorisations that are needed. As I said, we would just make sure that proportionate action is taken.

Q56 **Anna Dixon:** We had the final report from the infected blood inquiry in May of last year. As part of that, the new Infected Blood Compensation Authority has been set up. In the meantime, I understand that DHSC remains responsible for making some of the interim payments to infected people and their families. The Chancellor committed the £11.8 billion of funding needed for the compensation scheme in the autumn Budget. How are you ensuring that, with this transition to the new Infected Blood Compensation Authority, all those entitled are receiving payments due in a timely way?

Andy Brittain: Given the sensitive nature of this issue, we want to make sure that the transition goes absolutely seamlessly. We are supporting the Infected Blood Compensation Authority to set up and establish its operational functions, and learn from the NHSBSA, which has been running the support scheme since 2017. There is a lot of interaction between the two organisations.



HOUSE OF COMMONS

We have provided the relevant information for the compensation authority to process compensation claims, and have digitised about 7,000 records and transferred those to IBCA to enable them to process things quickly.

We are also supporting them to get information and be in contact with the relevant organisations, and to obtain the necessary information—for example, NHSE and GP records. As part of that, we are agreeing appropriate transfer dates. We will not transfer until we know the compensation authority is up and running effectively to be able to transfer. We are in constant support on that to enable a smooth transition.

It has already started. The compensation authority has made about 11 offers worth £13 million. The transition is starting. We are looking to a date of around March 2026 for the full transition to be put in place. We will continue to offer support to make sure it goes well.

Anna Dixon: What was the date for that?

Andy Brittain: Around March 2026 is the latest date.

Anna Dixon: Who is the accountable officer? We need to make sure there is real clarity on who is accountable for this.

Andy Brittain: I would need to check, but I believe the date for that will be the same.

Anna Dixon: In the meantime it will sit with you, Sir Chris, until that date. Unless colleagues have any supplementaries on that, I would like to move on to clinical negligence.

Q57 **Chair:** Could I be troublesome and just come in here? Andy Brittain, when we were preparing for this, it troubled me to see that only those who are registered with the infected blood support scheme before 1 April 2025 will continue to receive support payments for life. I can understand the reason for putting a cut-off on it. You do not want future people coming in. Is there a chance that anybody who is affected by this before that date will not have registered and then will not be eligible for the payments? If that is the case, what publicity are you making to make sure that everybody who is eligible does register?

Andy Brittain: I absolutely understand the point. I am afraid I do not have the answer to that at my fingertips today.

Chair: Could you write to us?

Andy Brittain: Yes, of course.

Chair: That would be very helpful.

Professor Sir Chris Whitty: There is some transitional arrangement, just to be clear.



Chair: This is potentially really important stuff.

Q58 **Anna Dixon:** It is very important that all those who were victims of this scandal have a right to compensation. Thank you for that.

Moving on to clinical negligence, in the accounts we see very large numbers in terms of the liabilities and costs relating to risks to do with clinical negligence. The provisions here were £58.2 billion as at 31 March 2024. We have previously requested and had correspondence about data that enables us to track trends in clinical negligence claims over time. In particular, it came up in our hearing on the whole of Government accounts that the discounting tends to distort and make it much more difficult to understand whether these liabilities are going up or down.

I would like specifically to ask whether you could update us on whether claims, excluding discounted rates, are going up or down.

Andy Brittain: I can answer that. The causes of this are complex and they include higher payments and legal costs. The number of claims has gone up, but that is mainly because of new schemes being added, such as the clinical negligence scheme for GPs. If you strip that out, the number of claims is pretty static.

As I said, the value of those trending over time is tending to increase, though, because the cases are becoming more complex and therefore the payments are becoming higher. That is the trend.

Q59 **Anna Dixon:** Behind this monetary figure lie tragic incidents of patient harm. We would like to see the NHS really recognising that it should do no harm. I would be grateful if you could say a little more than is in some of the performance reports about what you are doing to reduce patient harm and advance patient safety. Will this remain a priority in the 10-year plan, Sir Chris?

Professor Sir Chris Whitty: Yes. First, all of us would fully agree with that. The ideal number of cases of negligence would be zero. As you say, each of these cases has a tragedy behind it involving a patient, or their parents who have made the claim on their behalf in the maternity cases. There is a lot of work being done to try to improve that the whole time. The chance of getting to zero is low, but we absolutely can and should improve.

It is important to differentiate between the large numbers caused by things affecting a large number of people and the large numbers caused by large amounts of compensation to individuals and therefore cost to the public purse. I will take the second first, this being the Public Accounts Committee.

Over half the cost comes from maternity cases. There are relatively small numbers of them, but the costs per case are exceptionally high. There is an interesting and important question of policy here. Have we got this right in the way it is done? A child who had the same injury due not to



HOUSE OF COMMONS

negligence but a natural accident of the birth process—birth is a dangerous process—would get nothing, because there is no negligence, but would have the same disability for life. That is one question.

A second question, which as a non-lawyer I think is worth considering, is whether the proportion of the funds that you have talked about that goes to legal fees is appropriate. Some 19% goes to the lawyers who bring the cases. Those are very large sums of public money. That is something that should be looked at extremely carefully. Of course, there are some costs for defence as well.

To your fundamental point, the key to this is principally to make sure that we get safety as close to perfect as we can, accepting that absolute perfection is very seldom possible in a complex system of biology such as medicine.

We would all recognise that maternity, in addition to being expensive medically and legally, is an area where we should be improving quality in many parts of the country, though not all. That is not to undermine the outstanding work done by midwives, obstetricians and the teams around them to support mothers, but there are very unwarranted variations in maternal and neonatal outcomes by geography, ethnicity, age and a variety of other things, which, irrespective of the monetary value, absolutely need to be dealt with. You can say the same in many other areas of practice.

I agree with your underlying point completely, but there are other issues that we need to bear in mind. I know the National Audit Office is intending to do a review of this. That will be a good opportunity for us to look at this in the round. Early in a Government is when they have the time and opportunity to decide either to take a serious look at this or not. It is a complex area with quite a lot of interlocking elements.

Q60 Anna Dixon: I am sorry, Chair. For this part of the discussion, I should have made a declaration of interest that I am an officer of the all-party parliamentary group for patient safety. Certainly, I was going to draw attention particularly to maternity outcomes. As you say, Sir Chris, while they might not be the largest number, they do account for the largest cost.

In my previous life, I did a report back at the King's Fund in 2008 called "Safe Births", which made many recommendations. There have been numerous reports since, yet it does appear we really are still not delivering outcomes in terms of safe births for the majority of women. Certainly, some of those inequalities by race and other factors, which you describe, are still a scandal.

On page 28 of the report, I read about numerous delivery plans, oversight groups, action forums and independent working groups. It seems like a lot of activity with very little result. How can we get a grip on this and do better?



Professor Sir Chris Whitty: I would be very cautious about saying that that activity has no impact. A lot of concentration has gone on safety, thanks to many campaigners, you included. My predecessor but one, Sir Liam Donaldson, did a lot on this. Jeremy Hunt, when he was the Secretary of State for Health, put a lot of emphasis on patient safety, as all Ministers have since.

The fundamentals, though, are really about two things. The first is increasing the probability that a mother gets close to labour and goes into labour in very good health. That is a prevention and primary care thing as well as a secondary care thing. If you do not go into labour in good health, clearly there is a much greater risk.

The second is improving the immediate pre and post-birth outcomes. Some of the outcomes are poor for neonatal. It can happen after the baby is born, due to sepsis or a variety of other issues. Each one of these components needs to be looked at quite systematically.

For a while—this is not a clinical negligence point; this is a general point—I have been worried that the join-up between obstetrics in my profession and neonatal paediatrics is not as good as it should be. There is a potential gap between those two, in which sits the most critical and most dangerous day of anyone's life, which is the day you are born. There are a lot of things we can do on the clinical side with midwives, obstetricians and neonatologists but also with preventive services.

I should say there are two other things that are probably just worth bearing in mind. They are both good things, but they have a risk. First, on average, mothers are older. That does have higher risks than it historically would have done. Secondly, fortunately, many mothers are able to give birth who previously either would not have survived to the point of having a child or alternatively would have been very strongly advised not to have one. Modern medicine allows that to happen, but these are high-risk pregnancies. There are material changes that have happened over time that are a sign of good things rather than bad things.

Nevertheless, there are clearly things that can improve. Each of these cases has been proved in a court to be actual negligence. You cannot argue that something has not gone wrong in these cases, because it has been examined in front of a judge very carefully.

Q61 **Anna Dixon:** I would also just concur with your point about the lawyers. Certainly, I would hope that NHS Resolution would look more closely at how it could reduce the legal component and, indeed, consider no-fault compensation. Is that something that is on the agenda for NHS Resolution?

Professor Sir Chris Whitty: There are two bits to that. No-fault compensation would be a huge change. That absolutely would require a Minister to consider it. There are big pros and cons. There are systems around the world that have done that, but in general they have tended to



HOUSE OF COMMONS

be more expensive overall while arguably making less of a differentiation between those who have the same injury by accident and by negligence. In my view, that is a political choice.

You asked how often the NHS, in a sense, fights a case in court. A very small proportion—less than 1%, from memory—of cases get to trial. Those costs are not there, but there is a hazard to that. There is also an issue of public funds. This money is not coming out of nowhere. It is coming out of other health services and it would otherwise be used for other things. The view of the clinicians might be, “This case was not negligence. It was genuinely a terrible thing that has happened, but it was not due to negligence; it was just a terrible thing that has happened”. That happens a lot in medicine. People die and have injuries with perfect treatment. It is not cause and effect, but because it is a hazardous area.

You have to get that balance right. I certainly would not want to push them to go even further and never take a case to trial. At the moment, the numbers are in fact very small.

Anna Dixon: Thank you very much, Sir Chris. I could go on; I would love to discuss patient safety all day.

Q62 **Chair:** I have one question for you, Sir Chris. We are getting a huge benefit from you being here with your knowledge. If you look at the table on page 309—I do not necessarily suggest you go there—taking a constant discount using the same rate of interest, it looks as though the provision in April 2023 was £69.3 billion and it had gone up to £72.7 billion by 2024. Is that because of the answer that you gave: that these systems are getting ever more complex? Therefore, is it likely that these sums are going to go on increasing? Are there things you can do, with training and one thing or another, to start to limit this huge figure? We are spending £72 billion on clinical negligence. As you say, that is money that could be spent elsewhere.

Professor Sir Chris Whitty: On the technical question you asked, I tried and failed to work this out on the discount rate, which changed.

Chair: This is on a constant basis.

Professor Sir Chris Whitty: No, I know. What I am saying is that there are a variety of ways in which you can calculate it. I decided I would wait for the NAO to do what it does brilliantly and bring clarity to this because accountancy is not my principal skill.

Your bigger point is absolutely right. You would probably expect the number of complex cases to drift up because of the increasing complexity of medicine and the fact that people who have complex needs are surviving longer. That is a very good thing, but those cases are ones in which medical accidents are more likely to happen. That is not a very large effect, in my view. You are going to get some increase because of



HOUSE OF COMMONS

an increase in the size of the population. That is a straight demographic one. Ageing has an impact as well. Again, that is a more complex one, but it definitely has an effect.

However, there also has been more cost per case, all other things being equal, over quite a long period. That is not fully explained. The basis on which costs for individual cases are calculated, in many cases, includes an assumption that people get all their care from private medical healthcare rather than the NHS. That has always struck me as a surprising approach. These are things that we could look into in more detail after the NAO Report because there are many components to it.

Chair: I gather that the NAO is going to do a piece of work on clinical negligence. We will be coming back to this; there is no question. It is a really important subject.

Q63 **Anna Dixon:** I have a very small supplementary question, if I may, just to get this on the record, particularly given the data coming back. I realise there are a lot of different assumptions behind future liabilities. The Cumberlege review, "First Do No Harm", looked at the pelvic mesh implant scandal, which affected a number of my constituents, mostly women. I would be really keen to know whether there are estimates for the future liabilities from this and other scandals.

Professor Sir Chris Whitty: From memory, the answer is yes, but I am not confident in that and will need to write to you about it.

Anna Dixon: Could we have that in this follow-up note?

Professor Sir Chris Whitty: Yes, we should do that as a follow-up note rather than have me try to do it from memory.

Anna Dixon: It was quite a large-scale scandal. Thank you.

Q64 **Mr Betts:** We are able to ask questions and probe into what is happening in the NHS this morning because we have accounts that give us information. Unfortunately, the information shows that one fifth of NHS bodies had their audits late. They simply were not ready on time. Why is that? Is there anything we can do to make sure there is a significant improvement in future years?

Julian Kelly: We set a deadline, which for the last couple of years has been the end of June. The number of organisations meeting that deadline has been lower than it was pre-covid, but it is improving. Last year, I think I am right in saying that about 83% got in their accounts at the end of June. The previous year it was about 79%. It is improving.

One of the reasons is definitely the overall pressure on the local audit market and the trade-offs that audit firms are making between doing local authority accounts and NHS accounts. None the less, we still anticipate year-on-year improvements. There are some issues that are unavoidable. For example, some organisations are dependent on closing



HOUSE OF COMMONS

out local authority accounts, if they have liabilities with respect to local authority pension schemes.

I am expecting year-on-year improvement. This year we will start closing out 2024-25 with every single organisation having an auditor. At this point last year a couple of organisations were still seeking to get auditors in place. We are in a much better position. I expect to see continual improvement.

Q65 Mr Betts: Are there any failings within the NHS bodies that are causing this or is it all down to auditors?

Julian Kelly: There are no systemic problems on the NHS side. We have had one or two examples where we have had a failure in a team. Not last year, I hasten to add, but a couple of years previously we had an example of a failure within one particular organisation.

In the last couple of years, we had a material problem with one audit firm. It was auditing a number of the organisations, which was why they were late. That audit firm is now doing a much smaller proportion of providers, less than a handful, which is why we will see continual improvement. There is not a systemic problem on the preparing side.

Q66 Mr Betts: The only systemic problem that you have mentioned is probably where you get into pensions. A lot of local authorities are struggling with that as well. Do you look at qualifying the accounts of those particular bodies where you have a problem with the valuation of pension liabilities?

Julian Kelly: No. In some cases, it just takes longer than we would otherwise like to close the accounts. In all instances, we have managed to close the accounts without a qualification. I think I am right in saying that; if I am not, I will confirm outside of here. It does just mean that, in a handful of cases, it takes longer.

We have worked really closely with the National Audit Office to make sure we can still close the national accounts, even if a handful of organisations have not yet closed their accounts. We have alternate assurance procedures in place.

Q67 Mr Betts: You mentioned local authorities there, where clearly there has been a much bigger and more systemic problem with local audit. A lot of that is down to the problems of pensions and other assets in the accounts. Have you been working with MHCLG in terms of developing this backstop position and then trying to improve the whole position of local audit going forward?

Julian Kelly: We have. Andy may want to say more. He is probably even more closely involved there. My team are involved. I do not know whether it is an advantage, but we have been in the position where, because individual providers directly procure their own auditors, we have been able to be reasonably flexible. We have seen new providers come



HOUSE OF COMMONS

into the NHS market. We have probably been more flexible in being able to pay more, frankly, because we have roughly doubled the fee we are paying for audit. We are working with MHCLG, the Department and, indeed, the National Audit Office to make sure that future audit arrangements are sustainable for both the NHS and local authorities.

Andy Brittain: Just to add to that, if I may, we are absolutely closely linked in with MHCLG and the consultation that is out at the moment. For us, the two key parts of that are the proposal to incentivise more key audit partners within firms so they can sign off more audits and the proposal for a local audit office. Both of those should increase the capacity of the market, as it is at the moment, to process NHS audits.

Mr Kelly said that the deadline at the moment is June. I suspect this is where your further questions are coming. To enable a pre-summer recess laying of our accounts, we would need that to come forward to the end of May. We need quite a significant increase in the capacity of the local audit market to process NHS audits.

Mr Betts: Realistically, that is going to depend on the development of the local audit office, is it not?

Andy Brittain: Yes.

Mr Betts: The private sector is not suddenly going to develop and expand significantly. There is a timeframe, then. When is that real capacity going to be there? Do you have any objectives?

Andy Brittain: The proposal is out for consultation at the moment, so I am not sure an actual date has been put on it yet, to my knowledge.

Julian Kelly: I will be straight. I do not think we will get there quickly until such time as you see the increased capacity. I do not have a firm timeframe for when that might be because, as you say, it links directly into what is going on with local authorities. The local auditors are clear to us at the moment that they cannot go faster than the end of June.

Mr Betts: You are very closely connected with the consultation that is taking place.

Julian Kelly: Yes.

Mr Betts: Your views, concerns and requirements have been taken into account.

Julian Kelly: Yes, absolutely.

Q68 **Chair:** We may come back to this. It is a really serious matter because it affects the whole of Government accounts. You are committing to a month earlier each year, but that will take you another five years. We cannot wait another five years to get these accounts done on time. We will probably want to ask some questions and come back to this, but in the interests of time we need to move on. There are one or two things



that I would like to cover, please.

I have some fairly quick questions for you, Mr Brittain, if I may, on a really important subject, productivity. There is a fairly dense table on page 126, but there is not much else. Could you let us have a fairly full note on productivity? The increase in NHS expenditure is probably unsustainable in the longer run. The one way we can probably start to address that is through better productivity. Can I ask you to let us have a fairly full note on that and to pay more attention to it in future years?

Andy Brittain: Yes, of course we will. Just to reassure the Committee, this is absolutely one of the top priorities for the Department, looking into the 10-year plan and the spending review. We are seized of the issue as well. We will provide you with a full note.

Julian Kelly: As we have said before, NHS productivity is recovering. The acute sector is improving by over 2% a year, as we sit here today. For the first time, we are measuring productivity on the non-acute side, with community, ambulance and mental health trusts. Our first estimate this year is that that is improving by over 3% year on year. That is early data and that is going to mature over time.

We are clearly focused on how we improve next year. We have set a very challenging goal for systems. Can we get closer to 4%? We have benchmarked every single organisation. We have shown them where the opportunities are. We have a plan to train 20,000 clinical and operational managers and re-equip them with some of the operational management and improvement skills that we need. We have a plan to invest in putting senior clinical leaders into around 40% of trusts in different intensities to focus on improving flow through hospitals and the productivity for outpatients.

Clearly, we have a plan, for next year, to continue to maximise the benefits of putting electronic patient record systems into every trust. By the way, when you do that, the trust is about 13% more efficient for each admitted patient. We plan to continue to develop the NHS app, which has already saved millions of hours of administrative time, and roll out the federated data platform. The trusts in which we have put it are basically operating on 119 more patients per month per trust. When you aggregate that across the country, as you roll it out, there is a significant gain. We have really focused, concrete actions in place. Recovery is being shown day in, day out.

Q69 **Chair:** That is really helpful. You may well want to come in on this next question, which I was going to ask to Mr Brittain. On this Committee, we are very keen on technological, digital and AI improvements. It was therefore surprising that the only reference I could find in the accounts was on page 337 in one small paragraph. We need to pay much closer attention to this whole area, which is linked to productivity. I do not know whether you want to comment on that, Mr Brittain.



HOUSE OF COMMONS

Andy Brittain: This is another area that we will put more focus on in next year's accounts. I will undertake to do that. As part of the spending review and the 10-year plan, we are absolutely developing a refreshed tech plan as part of the productivity plan, which will be looking to increase and transform productivity going forward over the three-year spending review period. That will include the tech programmes that Julian has mentioned and will look at the extent to which we can roll out AI across the organisation.

Q70 **Chair:** That is really helpful. In table 36 on page 187, you have a reference to agency staff costing £5.6 billion. That is a slight improvement on the year before. Is this still an area that you are bearing down on?

Julian Kelly: In the NHS, agency spend two years ago was £3.5 billion. We are forecasting that we will end 2024-25 with agency spend of just over £2 billion. That is clearly a really material reduction. We will continue to bear down on it. We have set a goal to reduce it by another third next year.

Q71 **Chair:** That is really helpful, Julian. Thank you very much. The final question on my list is about social care. I know the Government have a long-term review on this. In the debate on the estimates a week or so ago, some people were saying that it is going to take far too long to leave it until 2028. I have looked in the accounts. There are a lot of little bits in the accounts, but is there anything that any of you can suggest as to how we can improve delivery for patients through more seamless working on social care, which is largely delivered by local authorities?

It all comes back to the debate that we were having earlier about Government reorganisation and so on. Is there anything in the short term that would help this seamless operation between the two organisations?

Julian Kelly: Viewed from the NHS perspective, a lot of work is already going on. In NHS organisations, the general move has been towards having joint social care and NHS assessment teams within NHS trusts, so you have a single process for assessing the care package that is needed and how it should be delivered to speed up both the process of discharge and getting people where you really want them, which is back home.

We have seen some progress on that. In 2024-25, length of stay is down by about 2%. That will be in part because of that work. We have done work over the last 18 months looking at how we can improve intermediate care, which is basically providing physical rehabilitation as you are leaving hospital. That is currently commissioned either by the NHS or by the local authority, depending on where you are in the country. It really does matter that we work on that together. We are looking at how we roll that out next year.

We have begun some work looking at how to deal with frail elderly people, who really can be better cared for at home. We are working with seven places in the country to see whether we can create what I am



going to call a best practice pathway, which is absolutely going to involve working between acute trusts, community services and domiciliary care providers. That is work that is going on to see how we can continue to improve things.

Chair: That is really helpful.

Q72 **Anna Dixon:** Likewise, I just have a couple of quick supplementaries. Following up on the point on social care, there does seem to be a breakdown on page 278 of the accounts. I always get my noughts muddled up, but I think the purchasing of social care by the NHS is about £1.4 billion. The feedback from a lot of social care providers is that the NHS is a really poor commissioner and is sometimes undercutting local authority. What you have just said about more seamless working is great, but, where you are a purchaser of social care, can you please do a better job of it?

Chair: You are quite right. You are absolutely right.

Anna Dixon: You can learn best practice from the local authority. You probably do not need to respond to that, Julian.

Chair: I just want to come in on discharge from hospitals. It has been sorted now, but there was such a bad problem in Gloucestershire Royal hospital. The ambulances were queuing up so much that they were even on the helicopter landing point. The helicopter was in the air, having to wait for the ambulances to be cleared. This is a chaotic system. I know it has been resolved—I was going to ask the Prime Minister a question on it yesterday—but there is a real problem with these discharges, particularly in places such as Gloucestershire.

Professor Sir Chris Whitty: Yes, all of us on this panel agree.

Anna Dixon: In that typology of the breakdown of costs—my apologies if I have missed it—I did not really see anything that gave a sense of how much we were spending on palliative or end-of-life care. Indeed, in the performance report, which goes into great detail on many topics with pages of information, there are but four lines, two sentences, on your performance on end-of-life care.

In the interests of time, I will just say that, given the importance and the costs that are spent on people in the last six months of their life, it seems a huge omission that nowhere in this report do we have any accountability for what is being spent on palliative and end-of-life care, or indeed what outcomes that spend is delivering. I do not know whether you would wish to respond to that briefly.

Andy Brittain: I do not have the number off the top of my head, but we will definitely change that for next year. We will add more prominence to it.



Professor Sir Chris Whitty: It is a very large and multi-layered area. A lot of end-of-life care is just good care. There are palliative hospices, which very clearly are end of life for many people, though not exclusively. We all die and we all need end-of-life care. It is central to medicine. To give you a serious answer on this would take a long time, but it does deserve a serious answer at some point. It is not one where a Treasury minute will help. We can give you the numbers now, but, if you want to look at this seriously, it is a big and important subject.

Q73 **Anna Dixon:** Yes. Similarly, on mental health, I was pleased to see on page 22 of your annual accounts that all ICBs did meet the mental health investment standard. I believe there is a commitment to continue with the mental health investment standard. Could you just confirm until what date that commitment has been made?

Julian Kelly: At this point, the money and the planning guidance that we have given is for 2025-26. Clearly, what comes thereafter is the subject of the spending round and then what follows.

Q74 **Anna Dixon:** There is a mismatch, in a way, between the areas where we are interested in knowing what we are spending and what you have in the accountability report, and your typology breakdown, where there are some large categories that just say "clinical services" or "community services". From a transparency point of view, it is quite difficult to understand where money is going in terms of the things that we know to be priorities for our constituents and for the public.

Julian Kelly: We will certainly reflect that in the next set of accounts.

Professor Sir Chris Whitty: We will try to do that, with the caveat that we want to keep it as one volume.

Anna Dixon: No, it is more about the typology. There is more than enough information on some subjects. It just does not truly reflect the priorities that the public and patients have. There are many more things that we could discuss, but I am sure we will have other opportunities, through the Public Accounts Committee, to come back to them. I will defer to the Chair. Thank you, Chair, for indulging me.

Chair: Thank you, all of you, for asking questions. Sir Chris, I entirely agree with you: we want to keep it to one volume. By the time I had got this home last night and brought it back this morning, my arm was well and truly aching. I entirely endorse that.

We have had really broad-ranging discussions this morning. I really do thank all our witnesses. I wish all those departing from any bits of the health service really well in their next endeavours. Sir Chris, thank you very much. We have benefited from your expertise hugely this morning. Whether our next session will be with you or with your successor I am not entirely sure.

Professor Sir Chris Whitty: For myself, I regret to say it is with me.



HOUSE OF COMMONS

Chair: Your loss is our gain. Thank you very much to our witnesses. I am going to do something that I do not normally do. I am going to thank the NAO this morning. This is an enormously big subject. At very short notice it has provided a lot of information. Thank you very much to the NAO team for what you have done today. Thank you to our Committee staff and all members.

Professor Sir Chris Whitty: Chair, could I just put on record the immense gratitude from Andy and me to Julian Kelly and his team? Julian has done an absolutely outstanding job over a long period. It has been really remarkable. You understand that and we understand that, but most people do not. I would like to put that on record.

Chair: I am really grateful that you have put that on the record. That is really helpful. Without further ado, I am going to close the session. Thank you all very much.