

Health and Social Care Committee

Oral evidence: The work of NHS England, HC 274

Tuesday 9 September 2025

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[Watch the meeting](#)

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

Public Accounts Committee member present: Mr Clive Betts.

Questions 1 - 114

Witnesses

[I:](#) Sir Jim Mackey, Interim CEO, NHS England; Glen Burley, Financial Reset Director and Accountability Director, NHS England; Dr Claire Fuller, National Medical Director, NHS England.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Sir Jim Mackey, Glen Burley and Dr Claire Fuller.

Q1 Chair: Today, the Health and Social Care Select Committee is having a one-off session on the work of NHS England. Before we start, can I ask our guests to please introduce themselves?

Sir Jim Mackey: I am Jim Mackey, chief executive of NHS England.

Dr Fuller: I am Claire Fuller, the national medical director for NHS England.

Glen Burley: I am Glen Burley, the financial reset and accountability director at NHS England.

Q2 Chair: I have the first question. Since the abolition of NHSE was announced in March, what have been the main achievements of the transition programme to date? I would also like you to include in that what the timescale is for the completion of the merger and what you see as the key milestones.

Sir Jim Mackey: I will kick off, if that is okay, and then bring colleagues in. We are just about at the half-year point in this financial year. I just want to go back to that point when all the changes were made, just before the Prime Minister made the announcement.

We were in a planning round that was heading towards a very large deficit. The NHS got a reasonable settlement running into this year, with a £22.6 billion increase in funding, but in the planning round we had first-cut plans with a projected deficit of about £6.7 billion, and £4.5 billion after deficit support. There was a recognition that the NHS was improving but not quickly enough. There was a big disconnect with the population, which was visible through the British Social Attitudes survey etc.

A lot of the first couple of months was really about the NHS, and the leadership especially, understanding that that was not sustainable or acceptable. We needed to change pace. We needed to do some really dramatic things to reset our approach to money, governance, oversight and the operating model. We needed to get everybody together to deal with the problems in hand. We needed to demonstrate to the public that we are all really serious about it and we could deliver the change required and then really set about it.

That first period felt very disruptive. The announcement around the abolition was a big shock for everybody. At that time there was a pretty consistent view that we had ended up with an operating model that was quite confusing at times. It was multi-layered, especially around oversight. If you are in a provider, you often feel like you are being held to account by lots of different layers: the ICB, the region, national colleagues, plus a broader regulatory system. It was too expensive for the context that we are in. We needed to be able to move more quickly



HOUSE OF COMMONS

on delivering change and transformation. Again, some of that was thinking ahead to the spending review and then the 10-year plan that was published subsequently.

Looking back at that period about six months ago, it was very noisy, very disruptive and quite difficult. We all had to confront things that were awkward.

The big success, first of all, was the stepping up of the leadership community. Colleagues right across the country really embraced the challenge. That manifested itself quite quickly through into stronger plans, plans that were more affordable. There is a lot of risk in them—there is an awful lot still to be delivered and a lot of challenges ahead—but the first step was about whether the leadership community could understand this and step up. Yes, absolutely. They did a fantastic job.

Q3 Chair: Just going back to the questions I asked—thank you for the background information—could you give me a few of the achievements of the programme to date? More than that, could you give me the timescales? When are you hoping for this to be finished? Can you start with what you believe are some of the achievements of the programme so far?

Sir Jim Mackey: I will give you a couple of standouts, which I was just getting to. We immediately addressed the financial position. So far, we are broadly on plan through the year. The second half of the year is hard, but the first bit we have delivered.

Then there is the work that we have done on the operating model and especially model ICB, which Glen led with colleagues in the service. That was produced really quickly. I think it was in early May. It was co-designed between national colleagues, regional and ICB colleagues as well. That has also gone through into other aspects of the operating model.

There has been a rebuild of the oversight framework. It is the first time since before covid that we have had a clear and comprehensive approach to the oversight framework. That was in hand before the changes, but it has been refined subsequently.

Moving on, we had several months of really big impact on elective waiting times, where we managed to buck seasonal trends for a few months. We had reductions in list size in April and May for the first time in many years. There are a handful of successes there.

This is ongoing, though. In terms of deadlines for things to be completed, etc., we have the chief execs together next week. That is all really about the next half of the year, getting through a tricky winter and, more importantly, moving into a medium-term planning framework. Again, that is a success.



HOUSE OF COMMONS

We have got through the spending review. We have a clear financial framework. We published the 10-year plan. Again, that was a big success; I think it was generally well received. Now, the NHS has to bring it to life through this medium-term planning process.

Q4 Chair: In the press you have talked about providing an update on the new senior leaders that you will be having this autumn—the team that will oversee the transition and lead the newly structured organisation. What is happening on that front?

Sir Jim Mackey: In the change process between NHS England and the Department of Health and Social Care, a couple of the roles that were out to advert were shortlisted last week and we will be interviewing in the next few weeks. Others are in the pipeline to be advertised for the new joint executive in the next few weeks.

Sam Jones, the Permanent Secretary for DHSC, and I are working with colleagues to see whether in October we can move towards a virtual integrated joint team and then start pulling teams together so that we are working in a more joined-up way ahead of the actual formal consolidation, which will have to happen after the change in the law.

Q5 Chair: You have talked about the plans and the staff. What are the key goals of the medium-term plan that you have in place at the moment?

Sir Jim Mackey: There are a few key objectives in this process. First, I am keen to make sure that we do not dismiss what the NHS has achieved so far. This could have been a really catastrophic year financially, but the first response has at least given us a decent start to the year. We still have to finish it, obviously. We wanted to move into a period where we could demonstrate financial sustainability over the medium term. We have three-year plans for everybody in the NHS for the first time in many years. That is a key objective.

We also want to deliver sustainably on the performance objectives and constitutional standards, etc., over that period. The spending review is three years of the 10-year plan period.

Alongside that, we want to demonstrate that we can make an impact, make progress and bring to life the longer-term objectives of the 10-year plan. That is about neighbourhood care, the new FT pipeline, some of the work on prevention and the headline things around the shift to technology that were set out in the plan. The medium-term plans will set out not how that happens overnight, but how we will bring them to life over the planning period.

Q6 Chair: My final question is around the estimated savings that will be made. What are the estimated savings that will be made from this merger? What will it deliver financially for us?

Sir Jim Mackey: We are still working through that now. We have active discussions going on with Treasury colleagues about the pace of change,



HOUSE OF COMMONS

how close we can get to the headline objective of a 50% reduction and the handling of redundancy costs, which has been covered in the media. It is quite hard to say what the actual savings will be and when until that has been—

Q7 Chair: When might we know? When might we have an idea? This is a massive plan with lots of changes, but at the moment we cannot see any material benefit in terms of savings.

Sir Jim Mackey: We are quite advanced in the discussions with Treasury. I would hope very soon, hopefully within the next two or three weeks, we will be in a position to be clear on how that works and therefore how the savings flow over the next few years.

Q8 Dr Cooper: I have a very quick question. To go back to financial sustainability, unlike local authorities, NHS trusts run deficits. Where do you see those deficits going? How do you define “sustainability” with those deficits? They obviously vary across trusts. Where are you going to draw the line?

Sir Jim Mackey: We want everybody to be in a balanced position at least over the medium term.

Q9 Dr Cooper: You want everybody in the black. You do not want anybody running any deficits.

Sir Jim Mackey: That is the intention. It is a long way from where we are now. We have had a lot of deficit support in the system recently. We are going to change a lot of the allocation methodology and get back to allocating resources on the formula. We expect every individual organisation, over the medium term, over the three-year plan, to be back in a balanced position.

Q10 Dr Cooper: Just to be clear, in three years’ time, no trust should be running a deficit.

Sir Jim Mackey: That is the objective, yes. It will be very hard from where we are now, but that is the objective.

Q11 Jen Craft: I would like to focus on a fairly specific area around commissioning. We recently held a session at which Helen Hayes from the Education Select Committee guested. She posed some rather interesting questions about the ESC’s SEND inquiry and, rather notably, the absence of health playing into this. They have been finding out time and again that there is a statutory duty on local authorities to provide services that it is not in their remit to provide. Indeed, it is up to local ICBs to provide the vast majority of those support services for children and young people with SEND.

Do you think that a statutory duty on ICBs to provide or at least commission these support services, which children and young people need to meet their education and healthcare plans or their SEND needs, would be helpful?



HOUSE OF COMMONS

Glen Burley: Can I come in on that one? Part of the work that Jim referred to earlier about the new operating model has been to design the new model ICB. Part of that is about moving the ICB role into strategic commissioning and being clear about their other responsibilities. As part of that, we have been reducing the running costs of ICBs and providing guidance on best practice in a number of areas. SEND is one of those areas where we have issued best practice guidance. The accountabilities sit with the ICBs from an NHS perspective in this model. That has not changed. Those responsibilities will stay with them.

- Q12 **Jen Craft:** A lot of local authorities and a lot of schools would say that ICBs are not really pulling their weight currently when it comes to meeting the needs of people in the SEND system. They do not commission strategically. The professionals that are at use in the health service are not actively and effectively meeting the need that is there. Would a statutory duty on ICBs to assess and meet need, similar to what local authorities have, be useful?

Glen Burley: Part of the statutory responsibility is to be responsible for the oversight of SEND. Part of what we have issued now is that best practice guidance looking at how we can use the right skills within the NHS to work with partners in local authorities and education. We have set that out probably for the first time in terms of the guidance that has been issued to them. As I said, the statutory responsibilities have not changed.

Dr Fuller: Before I did this job, I was a chief exec of an ICB in Surrey. Prior to that, I was the chief exec and clinical chair of a number of varying sized CCGs across Surrey.

The SEND responsibility and accountability in ICBs, as Glen said, is absolutely there, but we deliver that and improve lives for children by working together in a really local way. One of the benefits of the work that is going on is the rationalisation of what we mean by strategic commissioning and the clarification of how you bring together local professionals to have that conversation. This is bringing together schools with health and the local authority to have that conversation about the local landscape and how best to deliver that accountability to improve children's lives.

- Q13 **Jen Craft:** I hear what you are saying. There is a current statutory framework around it and a current duty on ICBs to assess the need in their area. However, a lot of professionals in the education sector and particularly in local authorities would argue that that is not sufficient to get ICBs to meet that need. For example, on a really individualised basis, if you have an education and healthcare plan as a result of a tribunal, there is now a legal duty on the local authority to meet the things set out in the EHCP. However, the ability to meet that need quite often falls outside of the LA's ability; it will fall on healthcare services.

Would it be useful to have a statutory onus on healthcare services? If the EHCP says that a child needs a speech and language therapist, a



HOUSE OF COMMONS

physiotherapist or whatever it is, you would have that duty on health, so that there is that clear, baked-in legal right to it, but on the right people who can provide it.

Dr Fuller: I always worry about making things too rigid and one-size-fits-all, because you then end up going through a bit of a tick-box exercise. I would always rather we focused on the individual child and collectively made sure we had the right services to make sure that child really achieves their potential.

I came in front of this Committee about a month ago talking about early years. Given the shortage that we have of speech and language therapists and occupational therapists, I would really rather we focus on functions and needs rather than roles more specifically.

Q14 **Jen Craft:** I would just put it to you that what we hear from professionals in this space, parents and families is that health is absent from that conversation and that the needs of individual children are quite often not met. Outside of having a statutory obligation on health providers, this is something that falls brilliantly into the three transformational shifts within the whole 10-year plan scope, because all of the things that need to happen can be looked at in the SEND space.

What is the plan to ensure that ICBs really take their strategic commissioning duties seriously when it comes to both the individual duty to provide care to a child and the more planning strategic level?

Glen Burley: Perhaps I can come in on that. The model ICB that I referred to has been co-produced with ICB chief executives and chairs. We are developing that best practice. We are then putting in place a strategic commissioning framework, which will be ready in a month's time, that will set out the functioning of those strategic commissioning ICBs and a development programme for all the teams within those ICBs based on a self-assessment.

Some are absolutely delivering best practice. There is an opportunity to share best practice with others and to bring it up to the highest possible level. That strategic commissioning development programme will take around 18 months to implement.

Q15 **Jen Craft:** Just to pick up on that, you said it has been developed with ICBs and chairs. Was it not co-produced with local authorities and schools as well? Did you look at that framework going wider? Part of the issue seems to be that everything is operating on a very siloed basis. Would it not have been useful for local authorities to have helped to co-produce this?

Glen Burley: The initial work was to create that proposition. Engagement has happened with local authority colleagues subsequent to producing the initial model ICB. Indeed, the guidance documents that I referred to, which have gone out in a number of areas, including special



HOUSE OF COMMONS

educational needs, have been a co-production. We have worked with local authority colleagues on that.

- Q16 **Jen Craft:** In terms of the strategic modelling and transparency, will there be an ability for local authorities, parent carer forums or anything along those lines, to monitor certain metrics around how ICBs are delivering on SEND? That might be diagnosis pathways, timelines for diagnosis or actual waiting lists to see professionals. Is that something that will be open and transparent?

Glen Burley: The oversight framework that we referenced is a move to a rules-based system to identify a number of performance indicators for trusts and ICBs. That will be implemented publicly for ICBs next year. We are working in the background with the ICBs on some of the indicators that we will build in to that.

- Q17 **Jen Craft:** Will that be a specific SEND metric? If you want to look online at how your ICB performs on this, will you be able to see that?

Glen Burley: It will certainly show waiting times. There are so many service lines that we are looking at overall waiting times.

- Q18 **Josh Fenton-Glynn:** Thank you for being with us. Sir Jim, when did the Secretary of State tell you about his decision to abolish NHS England?

Sir Jim Mackey: When I agreed to start this role, it was very much at a point when we were trying to help the organisations work together at a national level and then make changes to the system. I cannot remember exactly when I was told about the abolition, but my memory is that the PM had decided he would make a statement on the Thursday that we had the chief execs together in mid-March. I cannot remember the date. It was 14 March or something like that. A few days before then I was told that his intention was to announce the abolition. We then had to have a bit of a regroup around the plan, the approach and stuff to see how we would go about implementing that.

- Q19 **Josh Fenton-Glynn:** You found out within the week that it was being abolished and then it was announced.

Sir Jim Mackey: Yes, about that.

- Q20 **Josh Fenton-Glynn:** What is morale like in HQ?

Sir Jim Mackey: It is patchy. The organisation has, in recent years, had generally quite poor staff experience results. Colleagues will very articulately describe that they have been reorganised many times in recent years. There is a very strong muscle memory that provokes a lot of emotion for colleagues, if they have been around this a lot. They were very shocked and hurt by the announcement. That is still there and it is still alive.

A lot of colleagues now want to know with a bit more certainty what is happening when and what that means for their future, which is why we



HOUSE OF COMMONS

are trying to get on with this agreement on the redundancy costs and get the joint team together, so we can start describing more clearly how the change process will work with people.

With that said, last week I did six staff engagement sessions of different types. Throughout those sessions, people were generally very professional. They were still very focused on what they were doing and what their job was. They wanted to make a good contribution. They had come out of the shock phase a bit, but they were still very anxious. People are very anxious right across the service.

- Q21 Josh Fenton-Glynn:** You talk about them being shocked and hurt. Did some of the bombastic language that was used, referring to people in NHS England as “blockers”, add to that hurt?

Sir Jim Mackey: The staff have described that that hurt them and upset them. When the Secretary of State has met with colleagues in staff briefings and stuff, he has tried to correct a lot of that. None of it was personally intended as a criticism of everyone. It was a difficult couple of weeks. There are no two ways about that. It just was. It was very awkward for people.

- Q22 Josh Fenton-Glynn:** Is it just a difficult couple of weeks? Does it have a longer tail than that?

Sir Jim Mackey: It will be an ongoing process. We have to make sure we can get through the change as effectively and quickly as we can and, frankly, we have to try to improve the health of the new organisation and make it more effective in the future. This is not going to be over quickly. It is going to be a long, difficult process.

- Q23 Josh Fenton-Glynn:** Is there a bit of a risk of a brain drain, with some of the better staff going?

Sir Jim Mackey: There is always that risk with this kind of change. We have to lose a lot of people to get close to the headcount reduction target and the cost reduction target. We have already lost quite a lot of people, who have largely gone to other jobs within the NHS. We can try to mitigate that as best we can, but people will do what they need to do for themselves and their families. We have to respect that.

- Q24 Josh Fenton-Glynn:** You talked about the issue earlier about the cost of redundancy. How much do we think that is at the moment?

Sir Jim Mackey: I cannot tell you specifically because it is subject to a discussion with Treasury that is very active and live at the moment. There are various scenarios in that as well. I can tell you that we have had over 3,000 applications for voluntary redundancy within NHS England. If we were able to cost all of that fully, which is in process, that is a significant cost with a really significant saving downstream as well.

- Q25 Josh Fenton-Glynn:** Is that coming out of the NHS budget or Treasury?



HOUSE OF COMMONS

Sir Jim Mackey: We are trying to make sure that it comes from the overall envelope over the spending review period, but we have a bit of flexibility over time in terms of the up-front costs versus when the savings are realised. This will save a lot of money. That is the key.

Q26 **Josh Fenton-Glynn:** The estimate was £500 million a year.

Sir Jim Mackey: Yes. It has changed a bit since the first process.

Q27 **Josh Fenton-Glynn:** Has it gone up or down?

Sir Jim Mackey: I am not going to get drawn on that. We are working on a range of scenarios with Treasury colleagues. There has been very constructive discussion in recent weeks and we will be able to resolve it soon.

Q28 **Josh Fenton-Glynn:** One of my favourite documents about the health service was the Institute for Government's 2012 report into the Lansley reforms. There is a key paragraph in it that I keep coming back to, which says that "the 30,000-plus managerial jobs to go will in theory produce savings that over a few years pay back the redundancy costs", which is what we are hoping will happen here. "That assumes, however, that the management jobs will indeed prove to be redundant. In practice the commissioning groups and the board may well discover they cannot do the job on the shoestring they are being offered—so the numbers will creep back up".

That was said in 2012. That is, of course, what happened. Is there a risk of that happening here?

Sir Jim Mackey: There is a risk, but we are all very focused, through the processes that Glen has described, on making sure that we get set up properly at every level, that it all fits properly, that we minimise the overlap and the duplication and that we build something that is more rules-based so everybody is incentivised to keep this in check and it does not grow and drift again.

There are also more safeguards now. One of the problems from that period was people would be made redundant and then immediately get another job somewhere in the NHS. There is protection against that now. That cannot happen anymore because of the redundancy rules, etc.

None of us can guarantee that we will keep a hold of this forever. There is a really strong will to do that. As Glen has described, so far everything has been really well executed in a pretty difficult and complex process.

Q29 **Danny Beales:** Good afternoon. Thanks for joining us. The 10-year plan and the spending review commitments are all premised on quite ambitious productivity improvements in the NHS, beyond what has been achieved previously. How confident are you that the NHS meet these productivity targets?



HOUSE OF COMMONS

Sir Jim Mackey: I am an accountant by profession. I often feel like productivity is some kind of intellectual argument between economists and accountants. That has felt the case in recent years. For me, there is a simple equation about rates of change of activity versus rates of change of cost. The approach has been reset.

On the last published stats, the NHS did quite well last year relative to other parts of the economy. It is slightly ahead of the productivity expectations set out in the spending review. We have an awful lot of heavy lifting to do to be able to deliver that, partly through raising activity levels to reduce waiting times, etc., and the continued cost reduction that we described earlier on. I would say that we have made a good start this year, but we are absolutely not out of the woods yet. This is going to have to be with us for a few years yet and then forever in terms of normal productivity.

Finally, there is huge opportunity. One of the hard things for all of us is when you see the variation system to system and provider to provider. There are hospitals next door to each other with huge variations. Some of the variation on continuing healthcare has been really eye-watering to look at and understand. We are all convinced that the opportunity is there to deliver what is required from a productivity point of view and deliver within the overall financial envelope, but it will be hard work.

Q30 **Danny Beales:** How confident are you that it will be achieved? I hear the opportunity, the context and the challenge. I hear the issues that the NHS has been grappling with and continues to. Sitting here, leading the organisation, are you confident that those productivity savings will be achieved?

Sir Jim Mackey: Yes. I am trying to convey that I am naturally optimistic. I am optimistic. I am heartened by the progress so far; I am realistic about it being very hard. We are having to deliver an awful lot of things very quickly at a rate and scale at which the NHS has never delivered before, but I am taking confidence from the leadership response and the changes that Glen and Claire have described so far to get the operating model right.

Glen Burley: Perhaps I could talk a little bit more about that. We built some productivity measures into that oversight framework.

Q31 **Danny Beales:** Are you referring to the NHS productivity plan?

Glen Burley: The productivity plan has a wider set of indicators, but within the oversight framework the league tables that were published today include elements that link to productivity.

Q32 **Danny Beales:** We will come on to the league tables. On the specifics of the NHS productivity plan, how would you judge its delivery and implementation so far? Can you share anything about the plans, metrics or where we are against those milestones? Are we on track based on the productivity plan's assumptions? Are we off track?



HOUSE OF COMMONS

In terms of our role, to be assured that we can meet those and we are on track we need more than general words. We need to know, "We have set these milestones at six months and 12 months, and we have met or exceeded them", or, "We have not". Do you have any sense of where we are with the NHS productivity plan and its delivery and development?

Glen Burley: Yes. As Jim said at the start, part of that is linked to the overall financial position of the NHS. These plans underpin the plans that individual boards have signed off through that process.

Being on trajectory on that is important, but that links to the activity levels that we are delivering alongside the financials. Those continue to be at the levels that we expect them to be, including elective care recovery. That is a top-level indicator of that. Particularly over the winter period, when those demands tend to increase, the challenge will be around our ability to contain those levels there.

Q33 Danny Beales: I am not terribly clear on the answer to that. We want to ensure that there is genuine transformation and productivity and it is not just the capping of activity or demand that is pushing down that financial pressure, as can often be the case, and that longer-term investment budgets are not being raided, as has often been seen in the NHS, particularly for capital investment or digital change.

A lot of the productivity improvements and a lot of the 10-year plan and those shifts are premised on investing in digital technology, in capital or in opening neighbourhood hubs, for instance. How can we ensure that investment and, crucially, transformation funding is protected and sacrosanct? Are you monitoring that at trust, ICB and national levels?

Sir Jim Mackey: Just to add to what Glen said about the overall financial position, we will get month 5 results informally next week. We have not published any of that just yet, but so far this year, broadly, the financial plans have held.

Some of the productivity requirements and changes that we have to make are immediate and short term, but quite a lot of them are longer-term measures. For example, the changes to technology will take longer to get the investments in place and produce a productivity impact. We have made some really big changes and improvements this year on things like bank and agency spend and those sorts of things, which have improved workforce productivity.

We have to accept that we have had a very significant growth in workforce since before covid levels. That will take a few years to catch up and regularise. On the metric of outpatients per consultant, for example, we are still a bit behind where we want to be on that. That is one of the big changes that we want to start to see shifting in this next period.

Q34 Danny Beales: I am just conscious of time. There is a lot of downward pressure on ICBs and trusts. You said you wanted to get back in the black. That is the key direction. I just want to be assured on this point.



How do you know that that is not coming at the expense of investment in longer-term transformation? I think about the staffing cuts in ICBs. How are you assured that those are not deep cuts to key transformation areas such as digital expertise?

Sir Jim Mackey: The macro financial rules make it much harder to do things such as capital revenue transfers, which is raiding capital to fund revenue. That is harder now. It is borderline impossible because of fiscal rules and how it plays into the financial position.

We have been quite clear on this and so far we have managed this through the oversight framework. Wherever there is evidence of people making short-term cuts that have a broader long-term impact or are adverse to what we are trying to deliver, we have been able to step in, intervene and support colleagues to adjust that.

Q35 **Danny Beales:** You have been monitoring that. Could you share with the Committee examples of interventions that you have taken where you have seen that happen?

Sir Jim Mackey: Yes, I was just coming to that. At the half-year point, a lot of this stuff kicks in. We are in the middle of a process now where we have spent a lot of last week trying to understand this. We have done well on the money so far and we have done quite well electively, but we are not yet delivering the volumes of activity that we really need to shrink waiting times in the way that we want to. Some of that is industrial action related; some of it is normal seasonal patterns. Some of it is also people making understandable decisions about rates of pay, overtime rates and those sorts of things.

Danny Beales: That is slightly off the track of my question.

Sir Jim Mackey: I do not think it is, if you let me finish. There is that and there are ICBs constraining activity. We are supporting colleagues locally to try to adjust those plans to make sure we deliver what we need to do operationally and financially and we meet those longer-term productivity objectives.

Q36 **Danny Beales:** It would be very helpful if you could share some examples with the Committee of where you have taken intervention where you have seen ICBs or trusts potentially reducing key transformation-based activity or things that might impact productivity. It would be very helpful to see those examples.

Sir Jim Mackey: We will get you some examples.

Q37 **Danny Beales:** Lastly, the league tables, which you mentioned as a key part of the overall framework, came out today for trusts. There are different views about league tables. I do not want to get into that. Clearly, in presenting a large group of trusts as either failing or lower down, there is a risk reputationally in terms of recruitment and retention, people's desire to use a service locally and views and morale in the place.



HOUSE OF COMMONS

What will be different with this system? What will drive change? People want better care. People in my patch will have to go to the hospital locally, whether it is tier 4 or tier 1. I want it to be tier 1. We all do. Someone will always be at tier 4 and tier 1 in a league-based system; it is not an objective measure: are you A or D? You are either top or bottom. How are you going to drive improvement through a league table? How are you going to reassure people that their service is able to be used and is improving? What does the support package for trusts look like?

Glen Burley: We are designing the overall improvement offer to trusts. It is there now, but we are trying to make sure it is more joined up than it has been previously. That will include organisations that are performing well helping others that need some support and providing some of the best practice and then more tailored interventions for organisations elsewhere in the oversight framework.

The oversight framework is looking at a whole range of indicators. It is looking at quality, access, finance and productivity, but it also includes the staff survey. You referenced how staff feel about it. That is one of the key indicators that drives the oversight framework. If staff are not happy within their organisations, that will come up in the framework. That is something that I strongly believe is an area of focus that will help to improve productivity and patient experience.

Sir Jim Mackey: Just to add to that, it is too complex for one single league table to do everything, but it is part of a belief in transparency. If we get more and more information available, it helps local boards understand where they are. They are more accountable locally to staff and the local population. That can help people ask questions. They can see where other people might be achieving on something that they struggle with. There is an improvement value in that in its own right.

I have had a bunch of interactions with colleagues over the last couple of days about this. These sorts of things are difficult and complicated, but, as we have been doing throughout this year, we are building out more and more data and making it available, which improves transparency and accountability with the intention that it helps people improve.

Q38 **Chair:** I am going to ask the next question. It is really around NHSE functions and where they will sit in the future. We still have not had any detail about that. Is there a map of some type being prepared so we know where these functions will sit in the future? Is it possible to get a copy of that?

Sir Jim Mackey: Yes, that is in progress. We will share it with you when it is more complete. There is a process going on to map all current functions into the new structure. After that, there is then a process to try to determine in the Bill which of those things will continue post Bill versus sitting somewhere else in the system or being managed in different ways. That will be something that develops over the next six months or so.



HOUSE OF COMMONS

Q39 Chair: I am going to push you slightly. I know of a product called Sonata. It is a minimally invasive treatment that is given to women with fibroids. This particular thing is being closed down. At the moment, it is causing consternation in the sector.

How are these decisions being taken? That is the first thing that I am asking. Who is making the decisions? What are the principles behind just closing things down? People are not looking at the knock-on effects of what is happening. I need to understand how you get to the position of closing down a service when it is going to have such a fundamental impact on the service in that area.

Sir Jim Mackey: I will start and then Claire will correct me. I can feel her champing to get in. I am not aware of that specific example. If you give us some details, we will look into the specific example and see what has happened.

If those services are locally commissioned, i.e. they are the responsibility of the ICB, it is their decision, as a strategic commissioner, to make sure those contracts that are placed within the NHS and the independent sector deliver what is legally required and meet their local health needs. If they want to change or stop that, there has to be an appropriate engagement and consultation process.

It sounds like the service that you describe cannot just be stopped. We need to understand what is behind that. There is another range of specialised services that are delivered through the national and regional specialised services commissioning function. Again, there is a similar process. There are a bunch of legal requirements. Things are approved to be commissioned and then have to be commissioned across the NHS. To change those things requires an engagement and consultation process.

I will pass over to Claire, but if we can get the specifics, we will look into it and see what has happened in this case.

Chair: That will be my pleasure.

Dr Fuller: I will make another offer to have a look at this. I do not know the service, but it sounds like it is probably part of a suite of gynae services. Some of the stuff that we are doing, particularly the outpatient reform, is looking at how and where we can better deliver services. If you send us the details, we can have a little look at it. It is very much a local decision based on the needs of the local population, so it will sit with the ICB in the role of strategic commissioner.

Q40 Chair: This is a wider question. The problem is that services seem to be closing and, because we have not seen a map of where services are closing, they seem to be quite ad hoc. It looks as if someone has gone along and said, "We could close this one and we could close this one". The problem behind that is there is no plan. It does not look as if it is built in with a bigger plan for the services. The people who are watching it from outside just think it is a cost-saving measure.



HOUSE OF COMMONS

This is the point that I am trying to make. When will we get that map? When will we understand what NHSE is doing? When will we understand when services will be transferred over? When will we understand where these savings are coming from?

Sir Jim Mackey: To make sure we are not at cross purposes, the map that I was talking about was a map of the NHSE and DHSC functions and how they come together. We commit to give you that as soon as it is ready. Within a month we should be in that position. We can meet, go through it and share it with you.

In terms of the map of service commissioning out there, as we rebuild strategic commissioning over time, we would expect commissioners to issue plans and strategic commissioning intentions, be able to engage with the local population over time and provide confidence that there are contracts behind that commission the right volumes and locations, etc. That is a long journey from where we are at just now. We are just starting on that process, as Glen described.

Glen Burley: If I may, as part of redefining the strategic commissioning role for ICBs, we are really clear that ICBs are the commissioners. There is not an inch of the country that will not be covered by an ICB as commissioner. We are transferring some of those specialised commissioning responsibilities into ICBs.

Alongside the model ICB document, we have produced a model region, which identifies the functions of regions. It allows some flexibility for some changes that may still happen around NHSE and DHSC, but we have set out those two layers.

The important layer that we are doing some further work on now is the neighbourhoods functionality and providers. We are trying to work particularly with the primary care colleagues who have volunteered to be involved in a number of pilots across the country to help to shape that.

Q41 **Joe Robertson:** Good afternoon. How can you be sure that the 50% cuts that you are requiring from ICBs will not simply translate into fewer clinics, fewer staff and longer waits for patients?

Glen Burley: One of the main purposes of this—it probably goes back to the Darzi review of the NHS—is to ensure that we spend as much money as we possibly can on those frontline services, to reduce the size of the centre and to be really clear about the functions of commissioners.

We are not just talking about taking cost out. We are also talking about doing things in a more cost-effective way. That strategic commissioning framework and the development programme that we are putting alongside it is aimed at ensuring that those commissioners make sure that their local population's needs are met. This will transfer more funding to the frontline of the NHS. That is the overall objective.

Q42 **Joe Robertson:** You are reducing the operating costs of the



HOUSE OF COMMONS

commissioners who are responsible for the large majority of commissioned services locally in hospitals. How are they expected to operate on half their previous allocated budget and for that not to be a risk to delivering frontline services?

Glen Burley: We have identified a running cost target for ICBs of £19 per weighted head of population. If you look at what has been happening up until now, there has been quite a wide variation in running cost per head of population. In a lot of cases, that is because of the scale of the ICB. Some of them are serving populations of around 500,000 as opposed to the target that we have now put in place of 1.5 million. With that scale of 1.5 million and above for ICBs, there is an efficiency link and a skillset link to that. They have the ability to commission in a more effective way.

Earlier, Jim referenced continuing healthcare spend. If you look at continuing healthcare spend, it varies hugely by ICB and it does not necessarily correlate with running costs. It is about how they do this using best practice. When we set out that £19 per head, we carefully worked with ICB colleagues to help build that structure and show how it could be delivered. They have now each come up with plans that will deliver within that ceiling. In doing so, we have moved from the 42 ICBs that we had previously to 26 either ICBs or clusters of ICBs to do that.

Q43 **Joe Robertson:** It sounds like merging is the intention behind what you are doing or at least it is inevitably going to happen in some cases. You talk about a population target of 1.5 million. Is there any merging that is too much for you? Is there any population area that a merged ICB might seek to cover that is simply too high? Do you see a maximum size of ICB in terms of population?

Glen Burley: Yes, the biggest ICB is currently 3.4 million and the biggest one will be 4.5 million.

Q44 **Joe Robertson:** Would you allow a merger to go bigger than that in pursuit of efficiency savings?

Glen Burley: It is a combination of things. The biggest one that I refer to is within London, so the geography is smaller than it would be in other areas.

Part of this is about scale, but it is also about making sure we work with the footprint of patient activity and ensuring there is some logic to the flows into tertiary centres. Wherever we can, we map into local government structures.

One of the reasons why we have approved some mergers but have not implemented mergers in the areas where there are clusters is because we are waiting to see how we can best map that into local government structures. That may not be a perfect fit, but that is what we are intending to do when those are clearer in the spring.



Q45 **Joe Robertson:** Talking of local government structures, can you see an endgame where a local devolved mayor area is different to an ICB area and that works? Is the endgame to have a perfect overlap?

Glen Burley: The endgame is ideally to have the best overlap that we can, but there are other factors that have to play into this. For example, if a tertiary centre is providing services to a population within a different mayoral footprint, it can start to get tricky to plan that from an NHS perspective. We are trying to do that wherever we can.

Q46 **Joe Robertson:** How are you doing that in areas of England where we do not yet know what the mayoral combined authority area will be?

Glen Burley: In those areas we have generally gone for the clustering option. We are still keeping the statutory ICBs in situ. They are bringing together and sharing leadership teams to deliver those cost reductions. That gives us time to think about whether, when we know what those footprints are, we can map them differently and move to formal mergers where we can.

Q47 **Joe Robertson:** Even with your best intentions, it sounds like English devolution could hold up the final process.

Glen Burley: We will be delivering the running cost reductions with this arrangement, which will involve clusters. When we know those footprints, there is no doubt that it will be much easier for the NHS to work alongside local government.

Q48 **Joe Robertson:** Clearly, some ICBs are struggling and in some cases potentially declining to continue with the cost-saving programme due to their belief in the impact that it will have. As the deadline for implementation approaches, how are you working with ICBs to address those concerns? What is the ultimate position that you hold, if they fail to deliver those savings?

Glen Burley: Jim may want to come in, but we met with all the new leadership teams of the ICBs last week to talk through the implementation of all of this. It is really important that we manage this transition, particularly some of the functions that they are transferring to regional level, but also some of the functions that they are transferring to providers, working in those clusters coming together.

We have put in place chairs and chief executives. We will be moving to put the executive structure in now. The resolution to the issue that we touched on earlier around funding for redundancies will affect the timing of the implementation of those running costs. We will have to be flexible on that.

Sir Jim Mackey: There is a range here as well. I met with a couple of chief exec colleagues as the week went on. Some can and are getting on with this. They have found a way of making the thing work within the financial envelope. Others are genuinely stuck. We need to unlock the



HOUSE OF COMMONS

redundancy position and then agree a plan with them whereby this gets implemented.

The main concern for everybody so far is that we have an awful lot of people living with the anxiety and stress of the change process. It is not fair or right for any of them, which is why we are trying to resolve it as quickly as we can. As soon as that is resolved, we will then agree with each region and ICB what the rate of change is and how quickly it gets done. The overall objectives and running cost reductions will then be planned and people will be held to account for them.

Q49 Joe Robertson: What is the consequence ultimately for an ICB that fails to deliver on the savings? What are you ultimately saying to them?

Sir Jim Mackey: This change is an ongoing process. We understand that people are doing what they can. They are genuinely at a rate-limiting step. We need the redundancy funding situation clarified. Absolutely no penalty is going to be imposed on somebody who has done their best in difficult circumstances but genuinely needs that to be unblocked.

We also need everybody to be ready to be able to go as soon as it is resolved. From the discussions that we have had, we are pretty confident that people have done the work and worked it through. They know how to execute the plan. We just need to resolve this issue and they can get on with it.

Q50 Joe Robertson: By way of finishing, can I ask you my original question that Glen Burley answered from his perspective? Do you have any concerns about the 50% cuts to operating budgets with ICBs? Do you have any concerns that those could lead to fewer clinics, fewer staff and ultimately longer waiting lists?

Sir Jim Mackey: From the process that we have been through, I am confident that, if people deliver the plans, we have the required safeguards to avoid what you have described. It is very big and complex. Going back to the earlier point, every now and again something will go wrong. A decision will be made that does not quite fit with that or there will be an adverse consequence, but I am confident, from the oversight arrangements that we have and the ongoing discussions and conversation that we have, that we are identifying those and correcting them with colleagues when they arise.

Q51 Gregory Stafford: Just on the back of my colleague's questioning, Sir Jim, back in March you said—this is a quote from the *HSJ*—you thought that some legal duties on ICBs needed to be removed to allow them to balance their budgets. Do you still stand by that? If so, which legal duties are going to have to be removed from ICBs? I think of things such as dentistry and palliative care, which are underfunded already. Are you thinking about those things or something completely different?

Sir Jim Mackey: No. Glen will chip in as well; he led most of the work on the construct of the model ICB. If you take a specific that is not directly



HOUSE OF COMMONS

related to actual service provision, ICBs have had the responsibility, as well as commissioning for the population, for holding a system control total, for holding the aggregate financial position for the organisations in their patch.

It was my view—it is still my view—that it was probably not possible to do all those things together. You can see that in the compromise on the impact on the overall financial position. There are specifics like that, which we are finding different ways of managing. Hopefully, the Bill will change where the legal responsibilities sit more formally. Glen, is there any other detail that you want to follow up with?

Glen Burley: Yes, there is some detail around some of the functions that ICBs have at the moment. An example of that would be medicines optimisation. They have a responsibility for that, but, when you look at the new structure, it would be logical to place that much nearer to patients and to look at neighbourhood or multi-neighbourhood providers, for example.

Q52 Gregory Stafford: Just for absolute clarity, when you talk about legal duties, you are not talking about frontline services; you are talking about administrative functions. Presumably, those administrative functions are going to have to be paid for by somebody. It is not a saving. It might be a saving to the ICB or whatever it looks like, but it is not an overall saving to the NHS budget.

Sir Jim Mackey: Very often, the thing needs to be done, but it is better done somewhere else. We are trying to clarify the role and functions of everybody and every part in the system to make it as efficient as possible.

Glen Burley: Just to be clear on that, though, if an ICB is proposing to transfer one of those functions to another body, those running costs have to move with them. It is not a way around the running cost target.

Sir Jim Mackey: You cannot save the money by transferring the service somewhere else.

Q53 Gregory Stafford: I am sorry, Chair. I want to tease that out, because that is a slightly different answer. Sir Jim, you said that the only way the ICBs were going to be able to balance their budgets was by removing some legal duties, but now you are saying that, if they do remove those legal duties, they do not get to keep the money. How does that balance the books for an ICB?

Sir Jim Mackey: What I was saying at the time—I cannot remember the specific argument—was that we needed to make significant reductions in running costs. That was where the 50% thing came out, the £18.76 and the £19. From that process, I am confident that we have worked out, as Glen has described, where things sit, how the savings are made, etc., and decoupled some of the responsibilities, such as the system control



HOUSE OF COMMONS

total. That largely means that we are maintaining the functions but doing it in a different way and doing it significantly cheaper.

In none of that was there any intention to say that there are clinical services that we will stop commissioning. That was never the intention. This is all about getting better value from the money that we spend.

Q54 **Chair:** Before we move on, Sir Jim, we need you to write to us when you can confirm the implications of the redundancy costs. Are you able to do so?

Sir Jim Mackey: I am.

Q55 **Mr Betts:** Apologies for being late and thank you for allowing me to guest. I was chairing a briefing session for the PAC earlier, which clashed with this. Sir Jim, we are looking forward to seeing you at the PAC on Thursday as well, probably to pursue some of the same issues.

I want to raise one issue that came up at the last PAC session when Chris Whitty was there as the then acting Permanent Secretary. It was the day when the changes to the ICBs were announced. I noticed the mention of mapping services to local government structures. In metropolitan areas, the local government structure that really matters for health is the district council. That is where public health is, where social care is and where housing services are.

At the time, I asked Chris Whitty whether it was important that we kept the local place element of health services within ICBs. I am afraid that what is happening is, as the cuts have come in, all those little bits in the local areas have been cut away and concentrated at the centre. That is not what was intended, but it is happening. How do we get around that? How can we stop the disconnection of local councils delivering services and the health service delivering services?

Sir Jim Mackey: Both colleagues are champing at the bit here. I will go to Claire first and then to Glen.

Dr Fuller: Thanks very much. One of the things that is really helpful and that we keep talking about is the clarification about who does what and across what scale. The thing that we will talk about as part of medium-term planning is the neighbourhood plans, which will come into the health and wellbeing board.

The health and wellbeing board will need to sign off plans that have been put together by that upper-tier local authority. Again, that will involve the public health footprint and more local services. We will be able to describe what happens at a really local level. At the same time, because we will have multiple health and wellbeing boards and multiple plans coming in across the ICB footprint, we will have the advantage of scale. We will keep the locality. We will keep the connection and the relationships with the local authority, but we will still benefit from the scale that we require to deliver more efficient work.



HOUSE OF COMMONS

Q56 Mr Betts: You just mentioned mayoral combined authorities again. That is not where the driver for health sits; it is with district councils in metropolitan areas. I still think we are missing that link. This reorganisation of the ICB level is pushing them out.

Dr Fuller: Again, the 10-year plan talks about neighbourhood working. Neighbourhood working is across geographically sensible footprints of about 50,000. We need to describe plans that will work across that population and geography and then bring them together for that broader bit.

Sir Jim Mackey: We agree completely that the key relationships are between the commissioners and providers of social care. That is largely the place level of individual local authorities. This is even more important as ICBs have become bigger. Those that are aggregated across a bigger footprint will be very dependent on having strong arrangements in place. In some places that works really well, but, back to the point about variation earlier on, in some places it does not. Through our processes of oversight, we will be making sure there are strong enough place-based relationships to maintain those relationships.

Just briefly, as a provider chief exec, I always thought that one of the key relationships was to work very actively with local authority colleagues and make sure plans are synchronised as best they can be.

Q57 Mr Betts: The ICB might say, "We have to cut money somewhere. Instead of having different people in four local authorities, we will put them all at the centre in the ICB, away from that connection with the individual district council". If that is happening, who is going to stop it?

Glen Burley: Maybe I could give an example. The ICBs are clearly responsible for ensuring that those relationships exist, but that is discharged in a number of ways. As Jim said, one way to do that is through providers. If you take Warwickshire, which I am more familiar with, we have three places within Warwickshire. Those place partnerships are really important. Those are being delivered through lead provider arrangements. The NHS trust is convening place and working with district councils as well as the tier 1 local authority.

Q58 Mr Betts: By "NHS trust", do you mean the hospital trust?

Glen Burley: It is a combined hospital and community provider.

Mr Betts: That is not the case in every area.

Chair: I am ever so sorry, Clive. This was actually somebody else's question.

Mr Betts: I do apologise, Chair. Perhaps we can come back to this on Thursday.

Chair: Can I go swiftly over to Ben? We have drifted into his question.



HOUSE OF COMMONS

Q59 Ben Coleman: I can just build on that. I want to ask one question—I will come back to my other questions later—on this whole question of mayors. The 10-year plan foresees mayors being the only local authority representation on the ICB boards. Is that right?

Dr Fuller: Yes. That is what the 10-year plan says, yes. Instead of having a local authority partner member where the mayoral partner is, they will be the partner member.

Q60 Ben Coleman: I am not quite clear what you mean by “mayor”. You have very few—about a dozen—local authorities who have mayors. The rest of the 152 are led by leaders. Are you talking about the Mayor of London being on 42 ICBs? It is 42 at the moment; they are merging, so it might be fewer. Are you suggesting that would be it and none of the local authorities would have any representation on the ICBs in London, or are you suggesting that it would be local authority leaders, and you have called everyone mayors but you also mean leaders of local authorities?

Dr Fuller: When I had my old hat on, I had the Surrey patch. Sitting on our board we had the statutory members. At the time Joanna Killian was the chief exec of local authority. Tim Oliver, as leader of the council, was also there. This is a conversation. Depending on the local landscape, the conversation needs to be had between local members as to who are the most appropriate people to sit on that board.

Ben Coleman: You might say that, but reading the 10-year plan, as I did, I thought, “These people do not understand how local authorities work”. It is a ridiculous comment to say you are going to have mayors when you only have 10 massive regional mayors in the country. You have 12 mayors of local authorities and the rest are all leaders. I read it. What do you mean?

Sir Jim Mackey: Yes, it was a nod to the points that we have just been talking about in relation to alignment to combined authorities over time, recognising that that is not where we are just now. Some combined authorities are more interested in health than others. It is about allowing people over time to get the circumstances in place to fit their local context.

Q61 Ben Coleman: To clarify, the statement in the 10-year plan was at best unclear and at worst wrong. You intend to keep council leaders or cabinet members, if the leaders choose the cabinet member to go, in place on the ICBs for the foreseeable future. Is that correct?

Sir Jim Mackey: Can we go away and clarify this bit exactly? None of us are best placed—

Q62 Ben Coleman: It is a big issue. In my part of the world, we had to fight to get the right people on our ICB. In the end, we had three on the NHS North West London ICB. Having local authority representation on ICBs is not a small thing. According to the 10-year plan, you might be planning to get rid of it at the stroke of a pen. In London there is a lot of



HOUSE OF COMMONS

engagement. The Mayor of London has one level of engagement. He does not have the on-the-ground knowledge that you are going to need the ICBs to have to deliver what we want to deliver.

Sir Jim Mackey: Yes, absolutely. We will come back with a clearer answer, but the 10-year plan was trying to avoid, in the governance structure, having 13, 14 or 15 councils represented in the formal governance structure of the ICB. It is largely a shift towards more alignment with combined authorities.

We completely take the point about the local place relationships with individual local authorities as well. We will come back and clarify the point for you.

Chair: Ben, can you move on to your next question?

Q63 **Ben Coleman:** Yes, absolutely. If you have four ICBs that have come together, you are potentially getting 30 councils involved. Surely the councils should have some say in how they wish to be represented on those ICBs. It should not be a top-down NHS solution. They should be engaged in that conversation.

Glen Burley: Part of this is about looking at the leadership that comes from the health and wellbeing boards. As opposed to that being something that sits on the NHS side, we are suggesting that the health and wellbeing boards are the place where those planning functions take place, particularly with neighbourhood plans going through there.

Q64 **Ben Coleman:** Is not there a lot of overlap between health and wellbeing boards and ICBs?

Dr Fuller: We are increasing the population. Again, I will go back to my old patch. We were quite unusual in having a health and wellbeing board that was almost coterminous with an ICB. As they get bigger, there will be multiple health and wellbeing boards across an ICB footprint.

Q65 **Ben Coleman:** We have eight health and wellbeing boards in NHS North West London ICB because there are eight councils in the ICB. I imagine it is the same for people across the country. One of the challenges that I and other colleagues of mine who sat on these bodies found—this is before being elected—was that the NHS did not seem to have any understanding of how local government worked. I am not sure, from what I have seen and heard today, that that understanding is much stronger or there is an intention to make it stronger. Do you recognise that as a fair comment or do you reject it?

Sir Jim Mackey: I will take your point on the construct of ICBs and the formal governance of ICBs. I do not accept that the NHS does not understand local government or work well with it, but what we are trying to describe is it is done in lots of ways. It is not just done in one way, which is the formal structure of the ICB.



HOUSE OF COMMONS

I was at a trust a couple of weeks ago where the leader for the local place arrangements was a trust director working with colleagues in primary care, the local authority and other partners, etc. There is a mixed picture around the country. Some trusts work with multiple councils; some only work with a small number. ICBs are moving from sometimes only working with a few councils up to 13, 14 or 15. The arrangements have to change and adapt to have appropriate representation and, frankly, not to have 100 people in every formal part of the governance system. We are trying very hard to make sure there is appropriate alignment, but we are just not relying on one single mechanism to do that.

- Q66 **Ben Coleman:** Local authorities are responsible for social care and they are responsible for public health. Public health is absolutely essential to one of the three Government pillars of prevention. How are public health directors being involved as a body in the development of the new system? How are social care directors being involved in this? Is this again, "Here you are. This is what you are going to have to do"? The NHS is not involved, even though they are the people who are relied on hugely to make this plan work.

Dr Fuller: At regional level, we have really good relationships between the regional directors and the regional public health directors. We have been in correspondence and have met with those regional directors.

- Q67 **Ben Coleman:** You say "regional". Forgive me for taking the region of London, but it is the largest one. How many health directors are you talking to in London? Is it just the overall health director? That is Yvonne Doyle for London.

Dr Fuller: I will leave that to Caroline Clarke, who is the regional director for London. She can come back to you on how many of the public health directors in London we have been talking to.

Across the broader footprint, we are talking to the regional public health directors. Across the south-east, Alison Barnett has been working with us on the model region plans to make sure that we have covered off strategic public health commissioning. The local public health directors will have been working with their local ICBs. As we shift towards more strategic commissioning and we work on improving health inequalities and on shared outcomes at a local level, input and data from public health is absolutely essential to make sure that happens.

- Q68 **Ben Coleman:** That is helpful, thank you. You are going to have a number of ICBs, which will be increasingly reduced as they merge, but you will maintain the 152 health and wellbeing boards that exist at the moment.

Dr Fuller: Yes.

- Q69 **Ben Coleman:** What will the difference be in the functions of those? Where will they overlap?



HOUSE OF COMMONS

Dr Fuller: The health and wellbeing boards, from an NHS point of view, will be there to sign off those local joint plans on how we deliver services. They will still keep the statutory functions of health and wellbeing boards. The ICBs will have more of a strategic commissioning role, making sure we are commissioning high-quality services, improving outcomes for the population and improving health inequalities. We will need to do that in a locally nuanced way because populations are very different.

Again, I will go back to my old patch. In the north of the patch, there was much greater deprivation than there was in the south. Differentially, we need to make sure we have really local intelligence, working with the local providers and local people to make sure we get the services right. You have to do this both at a local level and at scale to make sure it works.

Chair: Ben, this will have to be your last question, honestly, or the others will not get in.

Q70 **Ben Coleman:** I thought I was taking the time that I was allotted. Finally, I want to come to the proposed model of neighbourhood health. At the moment, is it for individual ICBs to come up with a plan for this? Lots of ICBs do not have much resource because they have all been cut. If an ICB has the resource to drive this itself, it will drive the neighbourhood service. It might be the local hospital trust or one of the other organisations, such as a GP federation, that will do that. If that is the case, what sort of guidance is the Department issuing on how this should happen?

Dr Fuller: Neighbourhood health means many things to different people. There are really local services that we deliver across a population of about 50,000, some of which are about the NHS working to deliver improved GP access, to reduce down elective waiting lists and to reduce number of non-elective admissions.

There are some things that we need to do. There are some things that local government and broader Government will do under the blanket of neighbourhood health. That is about working with schools, working with housing and working more broadly.

There are some things that we will need to do together to improve the wider determinants of health. We all know that the NHS on its own can only improve health outcomes by 20%. We need to work together, particularly on the most complex and frail people, to make sure they achieve the best outcomes possible. We will need to do that with the voluntary sector.

The reason why neighbourhood health can feel complicated is because it means different things to people at different times.

Ben Coleman: I was only trying to get a clear understanding of what it meant to you.



HOUSE OF COMMONS

Q71 Andrew George: Answering one of the fact-based questions earlier from Beccy, Jim, you said there was a requirement to achieve effective operational balance within three years. Do you mean the end of the year 2028-29, or, in other words, by March 2029? Am I right? Is that the three-year financial year?

Sir Jim Mackey: It is starting from next April. The spending review starts next April, so it is the three years flowing from that.

Andrew George: That is March 2029.

Sir Jim Mackey: Just to be clear as well, we need a balance overall, throughout the period. What we want to try to do, through the medium-term planning process, is make sure that every organisation can do that as well, rather than having some in deficit, offset by those in surplus.

Q72 Andrew George: Earlier, Glen you were talking about the £19 per head notional administrative running cost. I believe £18.76 was the figure given. Does that mean to say that the figure at the moment is somewhere in the region of £37 or £38 per head in terms of running costs?

Glen Burley: The £18.76 was converted into £19 when we inflated it into this year, so it is the same number but different years. At the moment, they range between about £22 and up to £50 per head. That £19 calculation is per weighted capitation. That is just an important emphasis there, because that takes account of the needs of the local populations, plus or minus 12% of the range on those.

Q73 Andrew George: It varies according to geographies, demographics and inequalities. There will be variation across the country as a whole.

Glen Burley: There will be. The way that we have sought to implement this and the way those plans stand at the moment is that regions have taken an overview of that. The plans currently deliver that £19 over the full patch of the region and there is a bit of variation.

Q74 Andrew George: Jim, earlier you were explaining the human side of the messaging of cuts to your own staff and the impact of the abolition. How has that affected the way in which you have, in turn, conveyed messages of having to take quite significant cuts and significant structural change to ICBs and their staff?

Sir Jim Mackey: Throughout, we have tried to communicate this in as compassionate a way as is humanly possible. It is a difficult message, because we have a significant cost and headcount reduction. We have been trying to get the balance right: being honest with people that it is necessary—it is necessary, going back to earlier points about our operating model, which had become quite confused and very expensive—but also being careful to explain that it is not a personal criticism of individual colleagues.



HOUSE OF COMMONS

It is not punitive and we recognise the position that we are in. In an ideal world, we would be well into this process now, where people understood their futures and were moving into a different phase, but we are where we are. We are being aware of it and trying to communicate regularly. We will be scheduling another all-staff briefing within NHS England in the next couple of weeks to hopefully give an update on the process and redundancies, etc. It is just trying to get that balance right.

- Q75 Andrew George:** The cost-cutting plans for each ICB have gone through what is called a moderation process. To what extent has that enforced a national uniformity of approach? Have you used that as a learning opportunity to see how the creativity and ideas of some localities could be shared in other areas?

Glen Burley: Yes, it has been both of those things. We have been flexible where we can be, but it has been about ensuring that there is some consistency. Just getting those ICB leaders together to work through this programme has really helped to share best practice. I referenced continuing healthcare earlier. We have some further guidance and some learning from some parts of the NHS, including on the use of AI, to help with those processes. It has been iterative.

- Q76 Andrew George:** Let us move on to some aspects of services, which are at a fairly critical stage, certainly, as far as the discourse here is concerned, there is a lot of concern. One example is dentistry. To what extent are you confident there will not be any slip-ups in the move from one system to another, that it is not going to slip between the cracks and that the demand or the culture for change and improvement will not be lost?

Sir Jim Mackey: We are actively trying to manage this in a real-life, everyday way, with regional and ICB colleagues. One of the things we talked about last week in the meeting Glen described was making sure that everybody is clear who is doing what and that nothing falls between any cracks. That will mean that the transition will have to look a bit different in each region, because everyone is in a different position, but the key is that everybody is involved in the conversation and has absolute clarity, whether that is something that sits with the ICB or the region, if it is in transit or who is doing what.

Having the correct conversations to keep that as a live, challenging process is important. If something did slip through the cracks, then we are expecting people to pick it up and address it. Through our oversight arrangements, we are keeping an eye on it as well.

- Q77 Andrew George:** You are confident that everything is in order and it will be. With regard to the wider issues, talking about the changes to NHS England, are you confident that matters such as pandemic preparedness, aspects that are not currently emergency, urgent issues, are not simply going to be lost or put on the back burner for a worryingly long time?



Sir Jim Mackey: Absolutely, I am. Pandemic preparedness, for example, has been the subject of recent discussion between NHS England executives and with DHSC colleagues. Generally, on emergency preparedness and other really important legal functions, right from the beginning colleagues were very clear with me that we cannot drop the ball on something very important.

We have tested some of that through industrial action, making sure that we had not lost a grip on our emergency response. Just yesterday, we had an incident in the country and the national and local, regional teams responded very effectively.

Q78 **Andrew George:** Finally, I suppose it shows the importance of this Committee that the regional blueprint was published yesterday in time for the Committee. I understand that in that document—I have not had chance to look at it myself yet—there is a re-creation of the seven regions, a bit like the strategic health authorities of the past. To what extent will we have strategic health authorities, as we had previously, and what lessons will be learned from those structures? How will they relate to the ICBs?

Sir Jim Mackey: We currently have seven regions and there was a discussion in the 10-year plan process about whether they needed to be separate legal entities again to make them more like SHAs, with stronger local governance and more of a statutory footing. We decided and agreed not to do that, because we are trying to not have as many different bodies in the NHS, but we recognise that we really need strong regions that can take more local responsibility in the operating model away from the centre, handling more locally. There then needs to be a closer interaction with ICB and trust colleagues in that patch.

We are trying to get the balance right there: picking up some of the benefits of the old SHA structure and building some of that, but also learning. Not everything we did in the past worked perfectly. There has been a common theme through this process—both our change process and the 10-year plan thing—about recognising that, for whatever reason, we have been in a messy period.

Over the years, the NHS has reorganised a lot. Sometimes it has worked really well. There have been aspects of the change that have worked really well and we wanted to learn from that, enhance it and update it, but not fall into the traps of previous times, making similar mistakes.

Q79 **Andrew George:** These will be offices of the centre, really.

Sir Jim Mackey: Yes. They will be part of NHS England.

Q80 **Andrew George:** They will not be collations of the local ICBs, where they come together. It will be your seven offices within the seven Government zones. “Regions” is not the right word. That is what they will be.



HOUSE OF COMMONS

Sir Jim Mackey: That is right, yes.

Q81 **Andrew George:** The ICBs will simply be receiving and communicating through that.

Sir Jim Mackey: Yes.

Q82 **Dr Cooper:** I will pick up a couple of things that you have touched on. You have touched on a lot in the session. The first thing is to go back to redundancy and just be very clear about what you are able to say and put on record. We did hear from local leaders that NHS England initially indicated there was a central pot of money to cover this cost.

Sir Jim Mackey: We never said there was a central pot of money.

Q83 **Dr Cooper:** Let me just finish. The Treasury later confirmed that that did not exist, so is that your understanding?

Sir Jim Mackey: We said right at the beginning that we were going to open a discussion and try to secure central funding.

Q84 **Dr Cooper:** How did the local leaders get this understanding? Where did that come from?

Sir Jim Mackey: We never said there was a guaranteed central pot of money. It was always clear in the conversation that we were going to try to secure that and we have not yet managed to do that.

Q85 **Dr Cooper:** Do you think you might be able to do that?

Sir Jim Mackey: I am confident we will find a solution—

Dr Cooper: Spoken like a true politician there.

Sir Jim Mackey: —across the spending review process but, honestly, it is a very tricky process we have been in for a long time. I really do not want to compromise it by saying too much today.

Q86 **Dr Cooper:** All right, but the ICBs can take some assurance from this. As has been touched on, there are conversations about the ICBs paying for redundancies from local budgets, which would have serious consequences. They can take some assurance that there is hopefully light at the end of the tunnel.

Sir Jim Mackey: As Glen has already said, we had every chief executive and chair of the new ICB clusters in a room and had this discussion last week. There have also been conversations finance director to finance director. Everybody should be crystal clear on what we are trying to agree and what that will mean. There are a couple of different paths, depending on different scenarios. As soon as we have an answer, we will mobilise that and it will be executed.

Q87 **Dr Cooper:** Hopefully, that is clear for the ICBs. Thank you. I want to move on to something else that I am unclear about, which we have discussed with colleagues: ICBs and health and wellbeing boards. Prior to



HOUSE OF COMMONS

this Government coming in and making these substantive changes, health and wellbeing boards and ICBs, in my own personal experience and that of other colleagues, did not always have the best of communication or the most transparent roles, in terms of who did what and where the accountability was.

Given that you have said you are going to continue these two structures, where is the accountability going to lie? Are the health and wellbeing boards essentially reporting up to a regional structure, the old SHA, and ICBs together? Who will be looking overall at what the ICB is doing and what health and wellbeing boards are doing? I do have serious concerns that it has not worked in the past.

Dr Fuller: This is one area, like the mayoral bit, where we need to come back with more clarification for you. The ICBs will report up to regions and the accountability will sit with regions. The strength of health and wellbeing boards has always been their local democratic accountability.

One of the things that we talk about in the 10-year plan is that neighbourhood plans will come to the health and wellbeing board for sign-off, as commissioning intentions did previously in the land of CCGs and also with ICBs. As an ICB and a CCG chief executive, I had to take my commissioning intentions for sign-off at the health and wellbeing board.

Glen Burley: One other change linked to that, within the 10-year plan, is that, up until now, ICBs have had what are called ICPs—integrated care partnerships. Those partnership forums were slightly confused with the functioning of health and wellbeing boards, so we are saying the health and wellbeing board is where those partnership discussions take place.

Q88 **Dr Cooper:** ICP is no longer.

Glen Burley: That is correct.

Q89 **Dr Cooper:** Thinking about strategic commissioning, you have referred to the fact that the ICBs are going to become the strategic commissioners. My colleagues have mooted the question: while strategic commissioning sits with the ICBs, how does that marry with strategic commissioning of social care—and I appreciate the case review is under way—and strategic commissioning of public health, which is absolutely essential to the 10-year plan? How do you foresee the strategic commissioning across those three things working together and where?

Glen Burley: Those still sit with local government colleagues.

Q90 **Dr Cooper:** It does not sit at a regional authority level.

Glen Burley: No. There are lots of other areas, though. If we look at the need to improve prevention, we need to look to the wider determinants of health. We are always going to have this interface between public sector bodies to ensure that we use all those levers to improve the health of the nation. That plays into education, employment and all sorts of



HOUSE OF COMMONS

other factors. It is appropriate that that does sit still within local government. The NHS will always have to work really closely with them.

- Q91 **Dr Cooper:** Again, just to be clear, between the ICBs, the health and wellbeing boards and strategic commissioning, for example, where is a director of public health? The director of public health remains at the unitary authority, presumably.

Glen Burley: Yes.

- Q92 **Dr Cooper:** When we are talking about strategic commissioning of public health, if we wanted to do it across a devolved region, that would amount to directors of public health coming together, pooling their budgets. Is that how you envisage it working?

Sir Jim Mackey: What we are trying to explain is that it will still have to work at lots of levels. Every chief executive of a health body has a responsibility to collaborate and work closely with our local authority partners. Most of that is in place. The ICB will be covering more than one place, so they will have commissioning responsibility across that bigger footprint and, where there is a combined authority, depending on how they are made up and what their interests are, there will also be an alignment requirement of the NHS with those bodies.

There are lots of reason why it is complicated, but not every combined authority is the same. Some have more of an interest in these things than others do. The local arrangements are going to have to reflect that and make sure that there is appropriate alignment and engagement between health and the local authority system.

- Q93 **Dr Cooper:** Forgive me. Thinking about it from a population health point of view, when you are commissioning, I understand an ICB and its strategic commissioning. I do not fully understand why you would not seek to align public health strategic commissioning with that. I am failing to see that. At population health level, you are not looking at a smaller individual footprint. Why would you not seek to align those two things together?

Glen Burley: That is a core part of strategic commissioning.

- Q94 **Dr Cooper:** You are still keeping the public health commissioning function at a UA level.

Dr Fuller: It still stays within the local authority, yes.

Glen Burley: That is because of the relationship into the wider determinants of health. That would be the argument for me. It is not just about what we do in the NHS.

- Q95 **Dr Cooper:** Arguably, if your 10-year plan is actually worth the paper it is written on, then you are moving from a treatment model to a prevention model, from a national sickness service to a national health service. Arguably, therefore, you are moving to a population health



model. Therefore, I still do not understand why you are not looking at a strategic population health commissioning model that includes population health.

For things such as sexual health services, I still fail to understand why we are still thinking about commissioning those within a local authority setting. I do not see the logic of it, I have to be honest, apart from it being shifted during the Lansley shift and we are still there. Is there more logic that I am missing?

Chair: Are you still working through it?

Sir Jim Mackey: Producing a 10-year health plan is a big job, first of all. We have had a lot to do to sort the NHS out—colleagues have touched on this today—without the NHS having clever views on what is done within local authorities and what their statutory responsibilities are. We are trying to emphasise that all of these things have to fit. We need to work with colleagues, but not fundamentally dismantle and tamper with local authority legal responsibilities and functions.

It is possible to do what you have described, working with every local authority. Public health colleagues are actually very good at working together, especially on bigger, strategic footprints. I am confident we will be able to make this all aligned. I am also trying to say that we do not have to own everything for it to be better. A lot of this is about a clearer operating model, devolution, having the right things done in the right place, but through the right relationships. That does not mean ICBs have to have ownership of all of those things that we are talking about.

Q96 **Chair:** Sir Jim, at the moment, it just seems that it is not quite there yet. Once this is all sorted out, are you prepared to come back to the Committee and help us understand what you are trying to do? At the moment, Beccy and a number of others have raised some very good points. My issue is I do not know why you have moved things to the combined authority, that strategic authority, when everything you want to commission is lower down. I am struggling to understand myself. To just give you a “get out of jail” card, because these guys are good at what they do, to help us move this on, could you come back to us when we are all clear on what it is we are doing, or you write to the Committee?

Sir Jim Mackey: I would love to come back whenever you want me to.

Q97 **Mr Betts:** It did surprise me that, throughout the discussion that happened, public health had never been mentioned. I know we are saying that the health service does not bother to take back public health. That is a good position, but public health is just so important in terms of dealing with health inequalities, some of those fundamental issues in the community. If the health service really wants to grasp that issue, then it has to have a way of properly linking into public health. I just do not see that vision yet, or that you recognise that.



Glen Burley: We are talking about the strategic relationships here. The operational relationships are much closer and much more local. We have not talked about integrated healthcare organisations here, but integrated healthcare organisations would absolutely need to use public health data in order to ensure that they meet the needs of the communities they serve. Neighbourhoods will be using public health data to ensure that they shape services and close those inequalities.

Public health impacts on all those operational layers, as well as those strategic relationship. It is really quite important that it is not owned by the NHS and the NHS does not feel that it needs to run all of that, because the feeds on public health are from all sorts of parts of the community, and therefore that strategic oversight on scale is important. It is also important how you operationalise that. In many provider trusts now, public health have embedded consultants as part of the decision-making processes.

Q98 **Gregory Stafford:** Just as an aside, I have three ICBs covering my area—Frimley, Surrey Heartlands and Hampshire and the Isle of Wight—and I can tell you, from my experience, that the size of them is inversely proportional to how good they are. Although large ICBs may produce efficiencies, I do not suggest they necessarily improve effectiveness. That is just something to bear in mind.

Going back to this redundancy point, though, although, Sir Jim, you seem to be clear that money will come from somewhere, it is absolutely bizarre to start a process without knowing precisely where that money is going to come from. Putting that aside, clearly several ICBs are not clear where that money is coming from, because they have paused voluntary redundancy schemes or decided to postpone reductions in staff for the 2026-27 financial year due to the uncertainty. When are they going to get clarity about how they are going to pay for these redundancies?

Sir Jim Mackey: As I explained earlier on, we met with ICB chief executives and chairs last week. We have talked through the situation that we are in with Government and the negotiation about how redundancies will be funded and when. We have talked through the fact that there are a couple of paths and scenarios for this to work and committed, as soon as this issue is resolved—which is hopefully in the next few weeks—to go back to them and agree, ICB by ICB, how they can then proceed with their plan.

Some have plans in hand and can progress anyway, regardless. They are confident they can deliver what they need to do and have a clear path towards finishing the process. Many do not, but we have all been absolutely clear about where we stand now, what needs to happen in the next few weeks and then how we will agree we will proceed.

Q99 **Gregory Stafford:** When you get to that point, it would be really helpful for this Committee to understand where that money is coming from. When you are in a position to be able to tell us where that is in the next



HOUSE OF COMMONS

few weeks, it would be good to get that.

Wherever it is going to come from, it is going to be a cost, presumably, to the Exchequer, whether it is directly from the ICBs, from NSHE centrally or from some other pot of the Treasury. That money could have been spent on patient care. Thinking about something else that could have been spent on patient care, I approve and agree with the robust stance that you elicited the last time you were in front of this Committee on strikes. However, there is a suggestion that the strikes recently have cost around £300 million. You have said potentially that is going to have to come from existing budgets. Where is that £300 million going to come from and what patient services are not going to happen to pay for it?

Sir Jim Mackey: Again, one of the discussions we are having with Government is about the overall cost of industrial action. Clearly, it is not that clear how long it is going to go on for. Hopefully, we can get the thing resolved, so it is not an ongoing thing, but bearing the cost of that would be beyond our ability to cope with. It is very significant cost. We are managing an awful lot of other big changes, as we have described. We have a lot of spinning plates. It would be unreasonable for the NHS to do that, and it would have consequences on what we are able to provide.

Going back to your earlier point on redundancies, there will be a payback on the redundancies. There will be a one-off cost, but we will make savings over time. There is a business case there that we are trying to make, where there is a one-off investment. We are handling it as appropriately as we can with colleagues but, usually, within quite a short period—often within a year—it generates net savings and then ongoing savings thereafter.

Q100 Gregory Stafford: What confidence do you have that your negotiations with the Treasury will elicit £300 million or whatever the figure happens to be?

Sir Jim Mackey: It is going to be hard to settle until the thing is settled. We are having very active discussions about how the thing is handled through this year and into next year, if it proceeds into next year. I could not give you a confidence limit on it yet. We have not had a proper discussion on it in the last couple of weeks, for various reasons, but we will be picking it up again next week.

Q101 Gregory Stafford: Is that a dealbreaker for you? If the Treasury were to turn around and say, "No, you cannot have the money to cover this. You have to find it from within existing budgets", is that the point at which you say, "Thank you very much. Goodbye"?

Sir Jim Mackey: Everything that we are trying to achieve here is based on reasonableness test of people feeling like we are trying as hard as we can to make the improvements that are necessary, but it is not beyond the reasonableness of what is deliverable. If we add in a very significant additional cost, such as ongoing industrial action, we are at the point



HOUSE OF COMMONS

there where it is not reasonable to continue to provide what we are currently providing and there will be service consequences.

We would absolutely have to have the conversation about what the price is in terms of service impact and what we are able to provide. I would very much hope that can be avoided.

- Q102 **Alex McIntyre:** Building on my colleague's questions on strikes, it would be remiss of me not to mention that I am an MP in Gloucester and our local trust has the longest ongoing strike in NHS history at the moment, with its phlebotomists. I appreciate that is for the local trust for deal with, but this has come out of a national banding exercise, where healthcare assistants were moved from band 2 to band 3 and phlebotomists were left out of that.

Bearing in mind that it is for the trust to resolve the dispute with the phlebotomists in Gloucester and the wider county, what can NHS England do to help resolve this and get people back to work?

Sir Jim Mackey: This matter was raised with me informally by Unison a few weeks ago. Christina McAnea wrote to me I think last week, and I have colleagues within NHS England working with the trust to understand how best we can resolve the matter. It is a local matter, but we are trying to do our best to bring an urgent resolution to it.

- Q103 **Alex McIntyre:** Touching upon colleagues' questions on league tables, we have all been scrolling through the list today to see where our local trust is. I am very pleased that my local trust is seventeenth on the acute trust list, which is fantastic news and residents should be really assured by that, but there are also concerns about this. We know there are significant challenges in our local trust. For example, maternity care is a real challenge. Surgery has been ranked "inadequate" by CQC. Emergency care has been ranked as "requires improvements". Although we sit seventeenth and are doing very well on some things, there are clearly areas that are still very concerning for local residents.

What measures are being put in place to avoid a situation where trusts that are higher up in the league tables are forgotten about, with the perception that, "Everything is grand there now. We do not need to do anything"?

Glen Burley: One of the reasons why we have produced a more detailed public-facing tool with the league tables is that it gives you that granularity, to look at the whole basket of indicators that we use. Just looking at those bland ratings is useful, but actually it is even more useful to get into the individual services. We talked earlier about patient choice. As a patient, you would want to look at the performance of local maternity services or whatever service you might be choosing. We are increasing that transparency through this process.

Regardless of where people are ranked on that overall table, there are improvement programmes going on in all organisations to improve



HOUSE OF COMMONS

performance. In some areas, we are producing national service frameworks, which will help us to identify what best practice is and to allow peers from elsewhere in the NHS to help that performance to improve. I would encourage everyone to have a look at that public-facing tool. We will continue to refine it moving forward, but it does allow you to look at those individual areas.

Q104 Alex McIntyre: Moving on to workforce more broadly, when we had the 10-year health plan we were promised an NHS workforce plan to sit alongside it in the autumn. I am conscious that schools are back and pumpkin spice lattes seem to be everywhere again. Do we have a more accurate date as to when we can expect that?

Sir Jim Mackey: I could not give you an exact date. Colleagues are working on it very actively, but I would be making a date up if I gave you one.

Q105 Alex McIntyre: Are we still expecting it this autumn?

Sir Jim Mackey: Yes.

Q106 Alex McIntyre: In that plan, what can we expect to see that will allow the NHS to deliver on the 10-year health plan's vision of a smaller NHS workforce that is treated better, trained better and has more opportunities?

Sir Jim Mackey: The plan is still being worked through. I do not want to second-guess it, but there is a very strong thrust about taking the shifts that are in the 10-year plan and trying to bring them to life. Previous plans have been very much focused on additional recruitment and maybe not as focused on being a better employer and retention. This plan will have more of an emphasis on trying to be a truly fantastic employer, impact on retention, making working lives better. There will be more of an emphasis on that in the future.

Q107 Alex McIntyre: What engagement have you had with staff and with the unions to work on that part of it?

Sir Jim Mackey: There have been various engagements and interactions with colleagues, working groups around the service and NHS leaders. There have been some union interactions. A lot of the union interactions recently, you will understand, have been more about industrial action and pay settlements, but that is very much part of the process. There is no intention to produce a plan from a dark room that nobody has been involved in. There is quite a strong consensus on the key things that we are going to try to deliver on all this. The hard bit is actually doing it.

Glen Burley: There was a huge amount of staff engagement as part of the 10-year plan exercise and all of that is being played into this.

Q108 Alex McIntyre: In terms of engagement and motivation, my colleague, Josh, touched upon motivation at HQ. What is your sense of motivation across the wider workforce? You mentioned retention. Retention and



motivation go hand in hand. Will there be specific measures within the workforce plan that address the motivation and the fact that it has flatlined in terms of the surveys since covid?

Sir Jim Mackey: Staff satisfaction is a key driver, as Glen has mentioned. In the oversight framework, we have made a start on satisfaction and experience. In my previous lives, I have had a very structured approach to patient and staff satisfaction. I would like to see that replicated across the service. I would hope that would be a component in the plan. A lot of that is about local ownership and local organisations doing what they can to be the best possible employer and make it a fantastic place to work.

There is a risk, when you are doing national jobs—I am back in this world and have been in it for six, seven months or so—that you start to get a very fatalistic view of the world. It is nice to go out and do visits and see people. Then you see people who are absolutely having a wonderful time in their work environment. There are always frustrations—car parking, the food, flexibility of working and all the things that we talk about a lot—but, by and large, NHS people still love what they do. There is a lot of friction in that. There are a lot of things that could make it a lot better for them and make them able to really enjoy what they are doing better. That will be a key part of the plan.

Dr Fuller: The other change to that is that, on a voluntary basis, we have started working across primary care on the staff survey. Previously, it has been something that has just been filled out by trusts, but we have had about a third of practices undertaking it voluntarily. Again, having that real focus on the staff survey and on retention is starting to improve the position in primary care as well. We have seen a real improvement in patient experience of access into primary care over the last year with that focus.

Q109 Danny Beales: As part of this Committee's inquiry into the first 1,000 days of life, we have heard worrying information and testimony about the performance on child vaccination rates. It has been well reported recently, with outbreaks in Merseyside and, unfortunately, children dying from preventable conditions. This is not helped, arguably, by senior politicians recently questioning vaccines' efficiency and scaremongering about them.

In light of this poor performance, is there a need to update the strategy of NHS England, agreed just under three years ago in 2023? Will NHS England be looking again at this issue and what more could be done to increase vaccine rates back to WHO levels?

Dr Fuller: The fall-off in vaccination rates worries us all, does it not? This loss of herd immunity and the fact that people will die from preventable illnesses is not acceptable. We need to have an increased focus, particularly on the childhood vaccines. We have also had new vaccines come in, which will improve people's lives.



HOUSE OF COMMONS

As part of the oversight framework and the work we are doing through regions, we are starting to look in more detail at some areas and how we can improve it. Amanda Doyle is our national director for primary care, community and vaccination services, and she is working with the teams in really local ways on how we improve it. If we come back to our previous conversation about why public health is so important and we take our learning from covid, the only way to improve vaccine uptake is by working with local people and with local communities.

Q110 Danny Beales: Sorry to interject. We are falling behind. The national target was taken out of the planning guidance for vaccination rates and the pace of localism is slow. The pilot of health visitors, for instance, will potentially take a number of years from now to roll out at significant scale. Based on the seriousness of the issue and how far we are falling behind, could you perhaps update us on what the strategy has achieved since 2023 and whether you think it is still an adequate strategy to get us back to where we need to be?

Dr Fuller: There is more work that we need to do on improving the uptake of vaccines nationally, but it is work we need to do at a real local level. The areas that have had the most improvement, particularly in our most deprived communities, have worked with local communities. Last week, I was up in Manchester, Moss Side. They have their neighbourhood health champions, who are going around in the barbers' shops, meeting with local people and encouraging people to have vaccinations. It is that kind of strategy and that kind of local intervention that will drive the uptake.

Ben Coleman: To come back to my ego fix, which is trying to get local authorities more involved, we have talked about vaccination. We have talked about public health, but we will not get the country's health better if it is all just about the NHS. This is being driven by the NHS and full marks for all you are doing; it is a very difficult job for all of you. At some point, are you planning to write to the chief executives and/or the leaders of all the local authorities to tell them about the neighbourhood health plans? Will you talk to them about their role and what your expectations are of them being involved in actually developing the plans on the ground, or is the local NHS going to go and do this and maybe remember to talk to the local authority afterwards?

Dr Fuller: About a month ago, I wrote jointly, with Tom Riordan, to all the local authority chief executives and to all of the NHS chief executives, inviting applications for our national neighbourhood health implemented programme. Today, Tom Riordan and I, again, wrote back out, letting people know which sites had been successful in that process.

As part of the ongoing neighbourhood work, I have met with a number of local authority chief executives, with ADASS representation and with local government representation. This is why I was talking about the bits that the NHS needs to do on its own, the bit that Government, in the broader sense, need to do and the stuff we then need to do together. None of us



can actually achieve what we need to through neighbourhood health working in isolation.

Sir Jim Mackey: To reinforce that, we have been very clear throughout that the NHS cannot solve this by itself, as Claire said. Everybody needs to work locally together with all the relevant partners. There is a lot of interest. There is interest in this, in integrated health organisations and in various aspects of the plan, which is great. There is a lot of enthusiasm in all that. We will be testing, through this medium-term planning process and our other oversight arrangements, to make sure that relationships are good, people are talking to each other, we stress-test the plans, etc., but it has to be locally tailored.

Finally, there is a chief executive colleague I trained with who has been texting me all morning, desperate for a chat about IHOs and neighbourhood health. There is a lot of interest there, which is a great thing. It is not something that is being pushed against people, but getting the balance right with those local nuances is really quite tricky. It is different in central London to rural Northumberland or central Manchester or whatever.

Q111 **Chair:** The last two questions are from me and, honestly, you are going to love them. The first one is about winter pressures, which has always been held by NHSE. They seem to have had the lead role. With things winding up in NHSE and what is going on, where does winter pressure sit at the moment and when will we start to hear about the plans for this winter?

Sir Jim Mackey: Decisions were taken early on in the year to not have a process that requires colleagues to fill lots of forms in and give lots of assurances, but rather is clear about expectations and stimulates colleagues on a regional basis to work with each other, test each other's plans and have the arguments in enough time about problems and gaps, etc. That is taking place now. There was an event yesterday in the north-west. Sarah-Jane Marsh, who leads us nationally, was in a session there. There have been another few sessions around the country already as well.

We are confident that process is taking place and people are actively preparing as best they can. We are, in our chief executives' event next Tuesday, going to talk about expectations of the broader system—primary care, social care, how we will work with each other—and emphasise that it is really important we do this well, building on what happened in industrial action, but also just making sure everyone pulls together and does what they need to do. It is always a tricky time.

From that, we will probably issue a note to NHS leaders, just to clarify expectations of the second half of the year, in which winter management will be a key part. It is still a big part of our national responsibility, but we are trying to emphasise more local ownership through regions, then in local systems. I know this is what Glen is probably doing in his trust life. I



HOUSE OF COMMONS

would actively do this in my trust life. There are lots of local processes to make sure that everybody knows who is going to do what and nobody lets anybody down in that time.

Q112 **Chair:** My last question is about legacy. What will be the legacy of NHS England? The three of you are sat here. I am a great believer in one or two. Could you give me one or two points each? What is the legacy of NHS England? That would be a good way to end this session. Sir Jim, do you want to start?

Sir Jim Mackey: I suddenly feel less enthusiasm than there has been for previous questions. NHS England has had a tough time since it was created. There have been lots of critics. There is a time now for NHS England to really make a mark, getting us to this next phase that gives us the chance to make our population healthier and get a better chance of the best possible treatment when you need it. That is really what we are trying to take forward now.

Q113 **Chair:** That is the legacy you are trying to ensure you leave.

Sir Jim Mackey: Yes.

Q114 **Chair:** What about yourself, Claire?

Dr Fuller: While NHS England has existed, we have had some extraordinary innovations within the NHS and some extraordinary new medicines that have impacted on the way cancers have been treated, new vaccines that will alter the course of the way people's lives are lived. The legacy would be that real focus on innovation, maintaining research and pushing forward the frontiers of medicine.

Glen Burley: There is a bit of a crossover with mine, which is that local freedom to innovate. We have to declutter the system to allow in particular clinicians to be able to do the things they want to do and improve their local services. It is one of our roles to make sure that, when we spot that really good practice, we can share it with others.

Chair: That is fantastic. Thank you all for being here this afternoon. It has been a great session. I would like to thank Clive Betts for attending from PAC. On that note, have a safe onward journey.