

Health and Social Care Committee

Oral evidence: The Work of the Department, HC 236

Wednesday 8 July 2026

Ordered by the House of Commons to be published on 8 July 2026.

Watch the meeting

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

Questions 1-153

Witnesses

[I](#): Rt Hon James Murray MP, Secretary of State for Health and Social Care; Samantha Jones, Permanent Secretary, Department for Health and Social Care; and Sir Jim Mackey, Chief Executive Officer, NHS England.

Examination of witnesses

Witnesses: James Murray MP, Samantha Jones, and Sir Jim Mackey.

Q1 **Chair:** Welcome to this one-off session of the Health and Social Care Committee. We are pleased to welcome our Secretary of State, James Murray. James, thank you so much for being with us today. We also have Sam Jones and Sir Jim Mackey, who are well known to this Committee. Thank you so much for coming back.

Minister, if you do not mind, I will get cracking. Obviously, you are relatively new in post—it has been a few weeks now. You have come from the Treasury. This Committee spends a lot of time lamenting that the Treasury does not fully understand the health and social care landscape. Now that you have gone native, as it were, what is your perspective on that?

James Murray: Thanks for having me along to the Committee this morning. Having seen it from both sides, I recognise that the extra investment put into the health service and into social care as a result of decisions that the Chancellor has taken in the first two years of Government has been critical to improving the performance of the NHS. What I saw from the Treasury side, which I now see from the Department of Health and Social Care side, is that more funding alone is not the answer for the sustainable health service of the future that we want.

When I was on the Treasury side, I was very conscious of the importance of productivity improvements, reform and modernisation in using digitisation opportunities and shifting to prevention, neighbourhood health services and all the shifts that you will be well aware of. I was very conscious of that from a Treasury point of view. Coming over to the Secretary of State in the Department of Health and Social Care side of the equation, that has been even more supercharged in me. We have a very strong funding settlement; we now need to make sure that the reforms, modernisation and investment happen to improve services while improving productivity and keeping costs under control.

To give you one example, the technology investment that was secured in the SR is about £10 billion over three years, in various different technology programmes. One of those programmes, which I went to see the pilot of last week in St George's in south London, is ambient voice technology. Clinicians wear a little microphone that makes automatically AI-generated notes of a conversation between a clinician and a patient. The clinician looks at them and signs them off, so there is still a human eye going over them. That can save a clinician 47 minutes on average per shift; that means that they have more time to see patients, which is good for patients' wellbeing as well, and it can improve the productivity of the health service as a whole. Although it is at pilot stage now, we will be rolling that out across the NHS across the whole of England by 2028. If you look at what that could achieve, one of the studies that has been done



HOUSE OF COMMONS

on the benefits shows that, if you had it in every emergency department, you could have 9,000 more A&E consultations a day.

With simple maths—projection maths, rather than detailed maths I would stand by in a few years' time—that is about 3.4 million more consultations a year, from a baseline of about 28 million consultations in A&E now, so it is a significant increase, and that is a result of that technological improvement.

Q2 Chair: I do not think that anyone would dispute the huge opportunity, but you will also be aware that many clinicians listening will be saying, "Well, that is all very well, but the wi-fi doesn't bloody work." A lot of the basics of digital technology do not work, which will stifle that.

I want to move on to the things that you are interested in—you mentioned digital. My question is, if I forced you, which of the three babies would you love the most? It sounds like you are picking the same one as the former Secretary of State—AI and digital, which is fine—but the three shifts are across three areas. How would you RAG rate the three areas of the 10-year plan?

James Murray: To come back quickly on that wi-fi point, because it is a serious one, one of the things that I have done as Secretary of State is to draw together the oversight of all the tech programmes right across the NHS. One part of our work is to look at the minimum foundations that trusts need to be able to take on board those technologies, and wi-fi access or the basic plumbing of digital capacity is really important.

Chair: Printing a PDF is top of the list I often get. I asked you to RAG rate the three shifts.

James Murray: RAG rate the three shifts—it is a tricky one when you say, "Pick your favourite of your three children."

Chair: I think you have already done it.

James Murray: I suppose one of the reasons why I started with technology is that, in some ways, the path on that is the most defined, because we know some of the big programmes that will bring great benefit. The challenge is to make sure that, first, those programmes are rolled out right across the country and we get the local area—

Chair: The colour you would give it would be—red, amber, green?

James Murray: I am not going to give it an exact rating like that. It would be too much of a simplistic response for me to give, but I can talk about it in detail.

Q3 Chair: Let us move on to the other shifts then.

James Murray: To talk about the shift towards prevention, I think prevention varies depending on what we are seeking to prevent. With certain aspects of lifestyle and determinants of ill health, we know better what we need to do. Smoking is a good example, where we have the



HOUSE OF COMMONS

Tobacco and Vapes Act 2026 and a long history of using taxation to reduce smoking levels. We know what we need to do to reduce smoking, and it is successful, and we know what we need to do to go further, by making sure that we have a smoke-free generation. All that is clearer in what we need to do.

On other aspects of prevention, obesity is one where I think we need more focus in the years ahead, because as a country, particularly with the number of young people who are now growing up overweight or obese, we risk it being something that stays with them throughout their life. The ideas on that are there—we know what we want to do on nutrient profile modelling or with bans on advertising certain foods to young people. We know what some of the tools are, but I think that is where we need to develop them further. That is probably a focus.

Q4 Chair: We look forward to you responding at some point to our inquiry, which is near conclusion. What about the shift to the community?

James Murray: On community, again, certain parts of it are more defined, while other parts are less defined. I think that the overall idea is something that everyone agrees with—I do not think that anyone would disagree that having more health services delivered closer to people in the community, rather than in hospitals or acute settings, is a good thing.

One of the things that I have prioritised as Secretary of State is to be clear about what the priorities are for delivery there, so which groups of people do we want to make sure we are getting more services to in their local area and community. One really good example for me is frail people, older people—we need to make sure that they do not end up in hospital in the first place, of course, and that they can leave hospital easily and with the right support outside.

Q5 Chair: You will know from our “Healthy Ageing” report that we have plenty to say about that, but some of it involves local government. I will leave it for other colleagues to pick up some of those threads.

I tend to agree with you that we can be using money better, but I also want to ask you about where some of the money in the NHS is going, so let us move on to the UK-US—it’s not a trade agreement—entente that has been signed. A whistleblower from NICE came to my office who believes fundamentally—they say that many colleagues in NICE are also very disquieted—that it would be better if we scrapped that deal and instead focused on the basics of what the NHS does well. We have not had much scrutiny in the House, and reports of health economists suggest that as a result of this deal, we may end up with large numbers of excess deaths. Let me ask you a very simple question, Secretary of State: do you know, just in this spending period, how much this deal is expected to cost your Department?

James Murray: We are clear about what the likely ranges are—

Q6 Chair: You have been given £1 billion by the Treasury—fine. I suppose what I am getting at is, do you know the number? Has your Department



HOUSE OF COMMONS

done the projection for this spending period? How much will it actually cost us?

James Murray: The Department routinely models finance over the spending period—

Chair: Yes, but what is it?

James Murray: The Department will model different scenarios for what happens with the finances—

Q7 **Chair:** Sir Jim, do you know?

Sir Jim Mackey: There is not an exact number. As James said, there is—

Chair: What is the range then?

Sir Jim Mackey: I will have to come back to you with a number. Sam is closer to it than I am.

Q8 **Chair:** Sam, would you mind?

Samantha Jones: We will come back with the exact number. Also, if I may, as appropriate, without betraying the confidentiality, I would very much appreciate understanding a little more about the information you have received from the whistleblower—without betraying confidentiality.

Q9 **Chair:** You have had the long and the short of it. Fundamentally, there is a huge amount of disquiet over this deal. I am just trying to get down to some quite reasonable scrutiny of how much it is going to cost.

Samantha Jones: On 3 July the pilots were announced, as you know. To be able to answer your question directly, we need to understand what cost is coming out as a result of those pilots. We have to pilot it first of all. That was what was announced at the beginning of July. That is work with industry, with the Department and across Government, to be able to answer your question directly. There is, of course, also the work on the NICE thresholds in the way that you describe. I think you are referencing some analysis in the *BMJ* and others—

Chair: There are several that point in that direction.

Samantha Jones: We do not recognise that analysis.

Q10 **Chair:** Do you have your own?

Samantha Jones: We have a significant amount of analysis as part of the deal in entirety—

Q11 **Chair:** Is there any plan to publish any of that?

Samantha Jones: We have previously committed to keeping the Committee updated on the findings of the pilots and the analysis as it comes through. I defer to Secretary of State on how much detail and at what stage.

Q12 **Chair:** I hope you can understand the disquiet, because of the suggestions



HOUSE OF COMMONS

in the independent analyses of this deal—the IFS has suggested £9 billion by 2036. The Library has done this quite broad brush, but the deal itself says that we want to spend 0.6% of GDP on it; therefore, if we project that on to the OBR forecasts, we are actually looking at closer to £14 billion. If we are going to spend less in that scenario, we are almost hoping for a recession. We are in a bizarre situation where this is billions of pounds, and you will know full well what else we could be spending that money on. Secretary of State, do you know what even a central figure is of the projection of the deal?

James Murray: As I and Sam said, a lot of modelling goes on at the Department for Health of the various scenarios over the coming years. The pilots, which we have announced, are an important part of contributing towards the evidence base—

Q13 **Chair:** Sorry to interrupt you, but you are giving the same answer again. Am I hearing that this deal was signed without an impact assessment being done? I understood that there was one.

Samantha Jones: The accounting officer assessment, as you would expect from every Department, has been done appropriately; I can assure you of that. Some of the sensitivity is around some of the commercial arrangements—

Q14 **Chair:** What exactly is it about the commercial arrangement that we can't know? These big questions are reasonable questions that taxpayers and our constituents want to know. What is commercially sensitive about the questions I have been asking? Presumably they will have been part of that process. Yes, it would have been very broad brush. I totally accept that the margin of error would have been massive on the graph, if there was one, but it is entirely reasonable that we would have those numbers, is it not?

James Murray: You and I have spoken about the relationship between the Secretary of State, the Department and the Committee being one of trying to share information wherever possible. I am happy to go away and come back to you with what information we may be able to share in the future. But I think it is right that you recognise the constraints on what we can and cannot share, and what it is appropriate to share in the public domain.

Q15 **Chair:** There is precedent and we have done it in other Departments, too, where you would be able to share the whole thing unredacted with the Committee under pain of confidentiality. I am seriously concerned about the lack of scrutiny that this deal has received from those of us who understand the impact it might have on the frontline. Is that something you'd be willing to consider?

James Murray: Let me take that away. I am not going to commit to what we are going to do now. But let me take that away as a suggestion that you have put to me. I would not dismiss the commercial implications of having figures in the public domain, but, as I said, within the boundaries of what is appropriate I am keen to make sure we share what information



HOUSE OF COMMONS

we can on the right terms. I am happy to take that away and we can write to you.

Samantha Jones: It would be useful, subject to that from the Secretary of State, in the context of the broader life sciences delivery plan, making sure this is within the impact on the economy more broadly, and the impact on medicines that people have already received as a result of the deal. In that broader context, from a life sciences perspective and access to research, it would be very useful as broader.

Q16 **Chair:** Fine. Help me, Sir Jim. Do you know the figure? Have you worked out what the trade-offs are going to be?

Sir Jim Mackey: This was something led mainly by the Department. We were clearly involved in the projected impact on the SR and our ability to perform. All those things were live issues last year. As I remember it, there was a significant degree of uncertainty around some of the big costs—

Chair: No problem.

Sir Jim Mackey: —and the timing, so it would be foolish to give you a number when we were working with such big ranges and over such a long period of time moving out of this SR and into the next.

Q17 **Chair:** But even in this SR the modelling we have seen suggests that, although you have been given £1 billion—and I know there was pushback in the hope that the Department would not have to cover the costs of this at all—it could be £1.5 billion to £1.7 billion. That is not cost-neutral to the Department. And it is not at all clear, especially as many of those larger pharmaceutical companies have not turned on the tap with the medicines that everyone was hoping they would send to us. At the moment I struggle to see the logic, from the Department's point of view, why we signed this deal. I can possibly understand why the Treasury did. I can also understand why biomedical sciences and DSIT did. But I thought the point of this Department was to safeguard the NHS and social care. I cannot see the logic for why this was agreed to. I want to better understand the impact it is going to have on people on the frontline, so I will ask you just about this SR. Yes, pilots. But really? Come on, guys. You have a year left. What trade-offs will have to be made? I will ask you one simple question: does the £1 billion cover the projected costs for this SR, Sir Jim?

Samantha Jones: If I may—

Chair: No, thank you. Sir Jim?

Sir Jim Mackey: When we agreed the SR, this was negotiated and added afterwards to the SR and then was a part of the discussions we had that we talked about last year, around how we got through the SR period, voluntary redundancy costs and all those other things. If you take all that in the round, we have what we call a stack, which is our projections for how the money works over the SR period, with the cost of industrial



HOUSE OF COMMONS

actions and settling up the industrial piece with the resident doctors, and so on. There is still an ongoing discussion about that. There is still an overall gap, and we are in discussions with the Treasury. In that context, I cannot remember the specific number for this, because there are five or six other numbers that we were arguing about. It would be foolish to give you a specific number, given all the other moving parts.

Q18 Chair: But I did not ask for a specific number. My question was whether it is more or less than £1 billion. We are playing that game with the cards—is it higher or lower?

Sir Jim Mackey: At the time that we agreed it last year, we all agreed that it was broadly that sort of number, but there was a lot of uncertainty about timing and the profile of specific drugs—when they would hit the service and so on—so it is a number with a large degree of sensitivity.

Q19 Chair: Are you saying that the Treasury is committed to giving you more, if it is more?

Sir Jim Mackey: No.

Q20 Chair: No—quite. I am going to give you the out of writing to us, but I would like it this week. You have just said that you have the number somewhere, and it is among five or six. If you want to share those too, so that we can understand better the picture for this SR, please do. From where I am sitting right now, it sounds as if you are trying to tell me that it is not going to get covered, and I want to understand that. Unless you tell us that it is or is not going to be covered, we cannot do the scrutiny to work out what has got to give in the system.

James Murray: The part of this conversation that has been missing so far is about the huge benefits that innovative medicines can bring.

Q21 Chair: Absolutely. I am not seeking right now to make a judgment; I just want the impact assessment so we can do that thinking for ourselves. At the moment, we are taking you at your word, which is fine, but I hope you understand that the Committee's job is to ask the right questions and decide for ourselves. We are working blind. In fact, the whole of Parliament is basically working blind. It is unacceptable, and the Lords have said the same thing, so please, Secretary of State, take this away. I understand that there are positives—I said that in the speech that I gave in the Backbench Business debate—but there are also big negatives, and right now we have no idea where we are.

James Murray: I was just gently suggesting that if we are talking about the costs and benefits, it is worth putting down a marker for the benefits.

Chair: By all means, please do. Set it all out for us transparently. I would love that.

Q22 Josh Fenton-Glynn: Good to see you, Secretary of State. You are a former Treasury Minister, and now you are Secretary of State for Health and Social Care. Do you think it would be good to base our model for funding the NHS on the value of homes in an area 35 years ago?



HOUSE OF COMMONS

James Murray: That is interesting phrasing, Josh. Thank you for the question. We all know that the provision of social care—particularly adult social care—has not been addressed by many politicians over many years. The Casey commission is at the moment trying to get cross-party consensus on a way forward for the long term—a long-term solution for providing social care sustainably. The conversations about bringing that forward and what the timescale is are really important. It is also important to make progress, even ahead of the long-term solutions being agreed upon, because there is so much that we can do around the fair pay agreement that we have in place, and around valuing our social care workforce more and making sure they have the right training and progression opportunities. Getting a long-term solution is urgent, but there is more that we can do in the meantime.

Q23 **Josh Fenton-Glynn:** But broadly you would hold that the current funding model is not sustainable and does not work?

James Murray: I am not sure it would be right for me to make pronouncements about the funding approach, because that obviously affects the whole of Government. It will be a decision for the Prime Minister and the Chancellor and those across Government to take.

Q24 **Josh Fenton-Glynn:** If you were back as Chief Secretary to the Treasury and you were asked to decide whether we should fund social care based on the value of houses in an area 35 years ago, would you see that as a sustainable model?

James Murray: I know my lane, Josh. I am not the Chief Secretary right now, so I am not going to be tempted on that one.

Josh Fenton-Glynn: I understand. In the session we had a few weeks ago on the Casey commission, Stephen Kinnock, the Minister for Care, was quite clear with us when he said that he “did not agree with the position that the Chancellor and the Prime Minister took in terms of the timeframe that was given to Louise Casey. It needs to be brought forward now.”

Obviously, you were a Treasury Minister and now you are Secretary of State for Health and Social Care. Did you discuss that line with your Minister before he said it at our Select Committee?

James Murray: Actually, one of the first conversations that Minister Kinnock and I had was about what we can do to move quicker on social care. One of the first questions I asked him when we had a meeting of the new ministerial team was, “What can we do to move faster on this?” I think people do have a sense of urgency.

For me, there is obviously a big question around the Casey commission; the timescale for that is obviously a broader decision for No. 10 and No. 11, but alongside that, we need to accelerate some of the more immediate benefits we can give as well and make sure that we are not putting everything on pause—I am not saying that we are, but we need to make sure that we are not putting things on pause while we are waiting for the long-term solution.



Q25 Josh Fenton-Glynn: Do you accept his framing that the reason it is been delayed was because of decisions made by No. 10 and the Treasury?

James Murray: I am not going to get into decisions taken in the past around that. I think where we are now is that there is a strong recognition of the importance of urgency here. As I said, one of the first questions I raised when Minister Kinnock and I were catching up on my first few days in the Department was, "What can we do to accelerate what we are doing in social care?"

There is a real sense of this being one of those big challenges that has gone unresolved for too long and is something that we need to grasp and resolve. I would just reiterate my point that, as well as the longer-term solution, we need to make sure that is not giving any sense that we are not doing everything we can in the meanwhile, too.

Q26 Josh Fenton-Glynn: Moving on to care workers more specifically, Skills for Care found that the median hourly rate for a care worker in March 2025 was £12 an hour, which is 56p above the national living wage, but 31p lower than the pay for an HCA in the NHS. Do you think that is good enough to attract and retain people to the sector?

James Murray: Pay across social care is something that is really important for the Government to address, and I think the fair pay agreement has been a critical step forward in that regard.

Q27 Josh Fenton-Glynn: My understanding, though, is that the fair pay agreement is such that the envelope remains the same—it is just how it is divided. There is no extra money coming from the fair pay agreement.

James Murray: There is extra funding—£500 million—behind that.

Q28 Josh Fenton-Glynn: It is not going to bring it up to HCA levels, is it?

James Murray: I think having £500 million extra in 2028-29 alongside the £4.6 billion extra more broadly that we are putting in is significant. It is not simply fixing the envelope that we inherited and working within that; it is an expanded envelope, too.

Q29 Josh Fenton-Glynn: The average care worker pay is in the bottom 20th centile compared with other jobs. Do you think that is the right place for it or should it be higher up?

James Murray: I think we need to recognise the amazing compassion and skill of our care workers. For too long, care workers have not been valued in the way that they should be, given the work that they do and that so many our families rely on, in a way that does not get acknowledged by society more generally. The hard, difficult and highly compassionate work they do is something that we need to recognise more as a country.

Q30 Josh Fenton-Glynn: Yes. It is not paid as skilled work. It is paid as unskilled work, essentially. You are right that we need to recognise it, but do we need to reward it?



HOUSE OF COMMONS

James Murray: Changing what people get paid is something that will happen through a number of different mechanisms over time. We talked about the fair pay agreement and the extra money going in there. I do not want to make commitments that I could not stand behind in future, but I hope my overall approach to this is clear.

- Q31 **Josh Fenton-Glynn:** Vacancy rates are very high in social care. After five years' experience in social care, you will be earning about 7p an hour more than you would if you had just started. In 2016, that was 33p more an hour. Is that progression and sustainability of jobs something that the Casey commission is looking into, or that it should look into?

James Murray: The work of the Casey commission is obviously independent. Although Baroness Casey has met me, spoken to me and updated me on what is going on, it is independent. I would not presume to say where they will end up on different recommendations.

- Q32 **Josh Fenton-Glynn:** The work is independent, but what they look at is obviously defined by the Secretary of State and the PM, right?

James Murray: The commission was initiated by the Government, as you as you rightly say, but I want to avoid being in a situation where I am, at this stage, commenting on what I think the commission should or should not decide, what conclusions it should come to or what it should prioritise in its recommendations. I think that would undermine the independence of the commission.

- Q33 **Josh Fenton-Glynn:** Broadly, do you think it should look at pay or the sustainability of careers in care work?

James Murray: I am sure it will look at the careers of people working in social care, because the workforce is so critical—it would be very hard to consider the future of social care without considering the workforce. I am not being deliberately evasive on this; it is an important principle that if you have got an independent commission, having the Secretary of State publicly comment on what it should or should not decide undermines the independence of that commission. I am not going to do that.

- Q34 **Alex McIntyre:** Thank you for appearing before us today, Secretary of State. To take you back to the comments you made on prevention, you said our approach depends on what we are seeking to prevent and we know more about some areas than others. I have got a public health professional sitting two seats down from me and I am sure she and others in that sector are watching and probably banging their heads on the table saying, "We know exactly what we need to do, we just haven't had the ambition yet to actually meet that challenge."

The Committee has obviously had a big focus on obesity and diet. I do not want to pre-empt next week's report, but I want to ask a simple question: what is the obesity moonshot?

James Murray: As I said earlier in my comments, when it comes to obesity, prevention is the part we need to focus on more—

- Q35 **Alex McIntyre:** As a Department, what is your definition of the obesity



HOUSE OF COMMONS

moonshot?

James Murray: I think that is the right question to be asking—

Q36 **Alex McIntyre:** So we do not have an answer to that?

James Murray: We are clear that there is no single thing that we can do to reduce obesity—

Q37 **Alex McIntyre:** Sorry, Secretary of State, but I do not want to go into the detail of the policy; a report is going to come out on that. I am asking what definition is the Department setting for the obesity moonshot?

James Murray: In the 10-year health plan, the moonshot is about raising the healthiest generation ever—

Q38 **Alex McIntyre:** In the actual 10-year health plan, it talks about ending the “obesity epidemic”. What does that look like? There are currently 15.8 million people who are overweight or living with obesity in this country. By the end of the 10-year health plan, how many of those people will no longer be obese or overweight?

James Murray: That is where we need more focus in the future. I am clear that the headline—the moonshot, if you like—about making sure we have the healthiest generation ever and, as you quoted, reducing the epidemic of obesity, is the right thing to focus on. In terms of what levers we use and what outcomes we want specifically want, that is where we need more focus.

Q39 **Alex McIntyre:** I am happy to discuss the levers; we have got a whole report discussing what levers could be pulled and the fact that we are probably not going far enough or quickly enough.

What really concerns me is that we are two years in. Obesity is possibly the single biggest lever that we can pull in terms of public prevention. We have said prevention is one of our big three shifts; obesity is one of the biggest causes of preventable illness and disease in this country, and yet a year after the 10-year health plan was published, we still do not even have a simple definition of what that moonshot looks like.

Even if you could come out and say that we are looking to reduce it by 50%, that would be something. But at the moment, it seems that the Department has published the 10-year health plan and not given it a second thought since.

I am going to move on because I have only got 10 minutes and I have a lot to get through, if that is okay.

James Murray: Very quickly, I don’t think it is fair to say that the Department has not given it a second thought since, because I think that if you look at everything it has been doing around nutrient profile modelling and pushing for bans on advertising, all those are really important steps forward. I think that it is not credible to pick a target without having a clear route to get there; it undermines the benefit of picking that target.

Q40 Alex McIntyre: You do not know how to get there if you do not know where you are heading. That is part of the problem: how do you set out a plan? It would be like me saying, "I'm going to set off in my car later. I don't know where I'm going to end up." How do I know which route to take?

James Murray: With respect, Alex, the 10-year health plan sets out the broad target. If you are talking about a specific target, I think it is right to have the specific levers that we would use to get there clearly laid out. Work has happened around—as I mentioned—nutrient profile modelling and the bans on advertising certain foods. There are levers we have started pulling to reduce obesity, but in terms of having a specific target, which is a more detailed level of delivery and granularity under the headline objective of reducing obesity and making sure that the next generation is the healthiest generation ever, the specific targets need to be set out as part of a delivery plan with the levers. That is what I think our focus should be.

Q41 Alex McIntyre: Do you think that we as a Government understand the "spend to save" principle? Do you think the Treasury understands that on, for example, something like obesity, you may need to spend money in the short term in order to save billions, potentially? Looking at obesity, for example, that is currently costing the economy over £100 billion a year. Do you think that we get the balance right of recognising that sometimes we have to spend to save in the longer term?

James Murray: I think the principle is very ingrained in what we do. I know it is a slightly different thing, but we were talking about the tech investment earlier. That is £10 billion in tech over the next three years with £41 billion of benefits over the next decade. I think the principle about investing up front to reduce costs overall is absolutely right. When you talk about something like obesity, it is even more profound, because it is not just the direct costs to the NHS of people being less obese or overweight in the future; it is also all the benefits of helping people to keep in work and to have healthier lives, with all the knock-on impacts that has on other aspects of their lives. I think the benefits of reducing obesity are not purely within the NHS; they are much wider than that.

Q42 Alex McIntyre: As a neat segue into my next area of questions—I only have a couple minutes left—mental health has been in the news recently, not least because of the Milburn review, which shows that mental health is a big driver of young people being not in employment, education or training. We currently spend roughly 11%—I think—of the NHS budget on mental health, but it accounts for 20% of ill health in this country. Are we going fast enough to bring down mental health waiting lists so that we can help support that community back into employment? What discussions are you having with both Alan Milburn and Secretary of State McFadden about how we can support that going forward?

James Murray: Before I come in, can I check whether Sam wanted to come in on that very briefly?

Samantha Jones: I just wanted to come back to obesity and the actions that have already been taken, if I may.

Q43 **Alex McIntyre:** We are going to have a whole session on that. If I may, because I only have two minutes left, I am going to go on to mental health.

James Murray: For me, that work with the DWP and with Alan Milburn and the work that he has been doing is absolutely critical, not just for NEETs and making sure we help young people into work, but to help young people with the rise of mental ill health among them at the moment and the broader pressure on mental health services across the piece. Too often, what happens is that when young people face mental ill health, they might get referred and wait on a CAMHS waiting list for two or three years.

During that time period, they are waiting—they may be hoping they will get a clinical diagnosis and some help at the end of it—and there is a real risk that they might not be seeking work. They might feel they cannot get on with their lives or end up in a situation where they are dependent on benefits, and I think in too many cases that points them to a direction in life that could be better. I think at that point, if we can offer young people a different solution where they get an earlier and, in some cases, lighter-touch intervention to help them to keep going, try and find a job, and work out how to cope with some of the mental health challenges they face while also going to work and keeping active, that will be much better for them, the economy and the public finances, and a much better outcome all round.

The change that needs to happen for young people who are economically inactive as a result of mental health is one of the most critical questions for Government to focus on.

Q44 **Alex McIntyre:** Being very parochial, when will Gloucester residents see those waiting lists coming down? One of the biggest challenges I get in my inbox is that for young people the CAMHS waiting lists are far too long; we are letting down a generation. I appreciate the state that we found them in when we took office a couple of years ago, but when will my constituents see and feel the impact of that action?

James Murray: The point I was making is that the work is twofold: one part is making sure we have more mental health provision, so that people on waiting lists can get seen, but it is also about saying to some young people that going on the CAMHS waiting list may not be the right thing for them.

Q45 **Alex McIntyre:** I get that, but when will we start to see that change happening?

Sir Jim Mackey: A couple of months ago, we worked with the mental health community on a five-point plan to try and make progress on some of these things. On children and young people's mental health waiting times, the objective set was for 50% of patients to be seen within four



HOUSE OF COMMONS

weeks by March 2027. The current figure is about 26%. There is a focus on this; the system is in a terrible state and none of us like where we are, but the leadership community were very clear that this was one of the main priorities and that we should start really going at it in a tangible way.

- Q46 **Danny Beales:** The UK has shocking vaccination levels. There have been a number of outbreaks and deaths from preventable conditions. On 26 January the country lost our measles elimination status, which should be a real stain on our reputation globally and domestically. We investigated this issue as a Committee and questioned the previous Secretary of State and the current Minister responsible for vaccinations. The recent response to the Committee's suggestions for change reiterated that the Department would not look again at the failed 2023 vaccination strategy, which led to these falling vaccination levels. Instead, the message from the Department was that there is a focus on action and not words, so I want to talk about action and specifics today. In that spirit, on what date will we hit the WHO vaccination target again?

James Murray: I do not have that information off the top of my head. I can check with Sam, or we can write to you with that detail.

- Q47 **Danny Beales:** We have asked this before. Is there a commitment to do it and by when?

Samantha Jones: We will come back and confirm that to the Committee.

- Q48 **Danny Beales:** When will spending on vaccination stop falling, as it has done in the last three years for NHS England? Is there a commitment that spending on vaccinations will stop declining?

James Murray: I will write back to you on that one as well.

Sir Jim Mackey: Sam leads on the vaccination plan; but the vaccination plan is more related to outcomes than to how much we are spending on it. However, we will include that in our response.

- Q49 **Danny Beales:** Okay. Well, we are not hitting the targets, and you do not know when we will hit the targets. I would argue that spending is quite crucial: more vaccinations and outreach are the things that seem quite crucial to achieving that aim.

James Murray: Having the right investment is obviously important, but it is not just about that. Some of the work that I am doing with the DFE is about working out how we can boost vaccination rates in schools. That is more about political leadership, co-ordination across the system and getting messages out to schools before the beginning of the next term. That is a really effective lever to pull. I take your point, and we will update you about the funding, but I think the right messages in the system and the right political leadership are important too.

- Q50 **Danny Beales:** It feels as if we have heard about lots of initiatives, pilots and health visiting. That is a great idea, and we support health visitors delivering the programme, but I believe this is taking place in something like six areas. It is painfully slow, having taken two or three years to get a



HOUSE OF COMMONS

small number of areas doing it. We have lost our national elimination status. There are outbreaks and people dying of preventable conditions in 2026. That feels like an urgent issue to this Committee. I may not speak for all my colleagues, but it feels as though the grip in the system and responsibility are the issue.

In the absence of a commitment to a new strategy, and taking the Department at its word that there will be actions and not words, what actions are being taken? When are the deliverables due? What are the dates for change? In your response to us, you said that there was a commitment that every ICB would have a board-level vaccination lead and a structured plan to boost uptake. How many currently have either of those things?

Samantha Jones: We will confirm that. On the point about the grip, as the Committee will have heard, there are four main areas of focus. The first is access to the vaccines. We are not at all complacent about the levels of vaccination. There is the investment in GPs and the QOF—making sure that GPs are incentivised by rewarding them for improvement in vaccination rates. We have the action plan with the Department for Education that the Secretary of State talked about. We are also being very clear about how vaccines are delivered; they have to be delivered locally because local systems and local areas understand from that perspective.

Q51 **Danny Beales:** We are very supportive of that, but we are trying to understand whether local areas are being held accountable. You cannot currently tell me how many local areas have a vaccination lead or a plan. In your responses to us over the last two years, you have leant on the key things that the system should be doing, but you do not currently know how many ICB areas have a vaccination lead.

Samantha Jones: I don't, but we can confirm. I just want to finish talking about the other areas, which are to support and improve the delivery of vaccinations and investing in the data systems transformation. That is part of making sure that people understand through clear, locally owned communication with schools and families and our partnership with charities and influencers. There is a lot of scepticism post-covid, as you will have heard from the CMO and others, so it is about making sure that trusted healthcare professionals are the ones that are having the having the conversations. There are four different areas: the access, the accountability and being very clear, the data and the digital systems, and the communications and the awareness campaign. We will come back to you on the specifics around each ICB.

Q52 **Danny Beales:** Who will be held accountable if there are other outbreaks like those we have seen in the last two years, and people die from preventable, vaccinatable conditions and the vaccine rates in those areas are far below target level and have not been improved? How does accountability work? How will it work?

James Murray: Ultimately, the Secretary of State is accountable for what happens in the Department. The Department, with the Secretary of State, sets the national policy and direction. NHS England will be accountable for



the commissioning and the operational delivery of vaccination services because of the public health functions they would oversee in the vaccination space. The delegation of vaccine commissioning gets put down to the ICB. There are three levels.

- Q53 Danny Beales:** You talk about responsibility and accountability. I think you are right; that is how we understand the landscape of responsibility. My concern is that I am not sure where accountability currently falls. We are not seeing improvement quickly enough. We are not yet able to know when the UK is aiming to get its elimination status back. We do not know how many areas have leads and plans. There are lots of good initiatives and pilots, but I am not clear who will be accountable if in two or three years at the end of this Parliament I am still asking when we will get our elimination status back and why more children have died of measles in this country in 2029. Who will be held accountable for that? How will they be held accountable for that?

James Murray: Overall, the Secretary of State and the Government will always be held accountable for this. Saying that different tiers of Government or the system are accountable for delivering particular outcomes is not me abdicating responsibility as the Secretary of State. The Secretary of State and the Department of Health and Social Care can set the overall strategy and policy direction for what we want to achieve. I mentioned the work we are doing with the Department for Education. That is ministerially led by me and Secretary of State for Education to make sure that we boost our vaccine rates among school-age children. It will then be for NHS England to oversee the commissioning.

If you monitor what different ICBs are doing, you might see individual areas that have a problem. In some ways, the different approaches to accountability can be helpful for people like you, who are looking at it from outside, because sometimes a national average can obscure big regional variations. If you are holding the ICBs to account as well and seeing what they are doing in the local area, that can unmask particular areas where they are not doing what they should be doing.

Sir Jim Mackey: May I answer that as well?

- Q54 Danny Beales:** I have only two minutes left and I have one last question about the 1% contribution of departmental capital budgets to the DIP. Do you know yet what a 1% reduction in the capital budget for the NHS will mean practically, in terms of delivery of the 10-year plan, neighbourhood health and the digital switch?

James Murray: I, like all Cabinet Ministers, recognise that we need to contribute. It is our duty—our top duty—to contribute to national security, and it is absolutely right that I and everyone around the Cabinet table make that contribution. We are finalising the details of how that will be funded, but what I can guarantee is that it will have no impact on frontline services or patient safety.

- Q55 Danny Beales:** Will it affect the new hospital programme? Will it affect the neighbourhood health hub roll-out?



HOUSE OF COMMONS

James Murray: The funding will come from capital budgets, because that is what the contribution is focused on. I can be clear that no projects will be discontinued or taken off existing programmes.

Q56 **Danny Beales:** Wave 1 of the new hospital programme—fine. Current neighbourhood health hubs—fine. But what about future, not yet committed to projects?

James Murray: Because the capital programme for the NHS is a large capital programme, £15 billion, there is flexibility within those budgets, so we will be able to make the contribution to national security, which I think it is absolutely right for us to do, while being able to guarantee, as well as what I have said about frontline services and patient safety, that there won't be any projects that don't—

Q57 **Danny Beales:** There is “flexibility” in the capital budget. Is that projected underspends? Is it ringfenced contingency in the capital budget? What is the flexibility in the capital budget that you are talking about?

James Murray: There won't be any projects that do not go ahead. The projects will stay on the list and in the programme; that is not going to be affected. One of the trade-offs is that our ability to bring forward other programmes might be more limited in the future.

Q58 **Danny Beales:** The last Government raided capital budgets to plug short-term revenue pressures in the NHS. We committed as a new Government to ending that approach, which I believe is right. Is this a similar strategy—plugging another gap by raiding capital budgets?

James Murray: No, because doing as the previous Government did, raiding capital budgets to pay for revenue pressures, led to chronic under-investment. This is about making a critical contribution to the defence of our country. I hope no one would disagree with the importance of doing that. It is not about using money in the capital programme to pay for day-to-day spending.

Q59 **Danny Beales:** As the details become firm, will you write to the Committee to outline exactly the currently committed-to programmes, their status and where this money would come from in the existing capital budget?

James Murray: Yes.

Danny Beales: Thank you very much, Secretary of State.

Q60 **Chair:** When will your plans be finalised, so that we can expect a timeline?

James Murray: We are in the process of finalising them at the moment.

Q61 **Chair:** Before summer recess?

James Murray: I need to get agreement across Government, so I will come back to you on that.

Q62 **Dr Cooper:** Secretary of State, you said in your opening remarks that more money alone is not the answer, and I could not agree more, but I do



HOUSE OF COMMONS

think that the right amount of money in the right places could well be part of the answer.

Let's look at the public health grant. For this year, 2026-27, I am sure you are going to tell me that it is £4.4 billion. That is up from £3.884 billion in 2025-26, and it is the first multi-year settlement in a decade, so that is welcome. That is great, but the King's Fund and others say that it still does not restore the real value of the grant to where it was in 2016-17. We are all aware of the underfunding and austerity years, but could you please speak to the question that if local public health funding remains at that real-terms level, is it realistic, from the NHS's perspective, that we can genuinely shift to prevention? Sir Jim and I have talked about this several times in relation to parallel funding. So we will start with an open question. Secretary of State, perhaps you would like to go first, and then Sir Jim and I can get into the funding.

James Murray: As we said right at the beginning, the shift towards prevention is a critical part of the 10-year health plan. For me, part of what is important is spending the money wisely—not just how much and where, but spending it well—and I think that means making sure it is focused on effective interventions. What do we know works in some areas? We should be replicating that in other areas. The focus on value for money must not get lost in this conversation. We need to make sure that the right amount is being spent in the right places, and that it is being spent well.

Q63 **Dr Cooper:** Fantastic, Minister. My colleague talked about spending to save. If we were going along the lines that you just described, we would shift a significant amount of the funding that is currently in the acute sector into the preventive sector to get a return on investment and to spend it well. Is that your understanding?

James Murray: I think part of the answer here is co-ordination between what local authorities spend on public health and what is spent through the health service in the local area. This is part of the reforms through the NHS modernisation Bill. The focus on health and wellbeing boards to bring together local authorities, those responsible for public health and those working in the NHS, and to make sure that budgets are being spent in a co-ordinated way, is a really important way of focusing on prevention further upstream to reduce costs later on.

Q64 **Dr Cooper:** Great. My colleague is going to get into ICBs and who is sitting on the boards quite soon, but I will just come back to the funding issues. Perhaps we can resume our conversation about parallel track funding. If we have a lot of money in the acute sector and historic low spends in the public health area, could you set out how you see that shifting to a point where we are running parallel tracks, or in other words, we are investing in prevention alongside keeping our acute services going? I will ask Sir Jim because we have had this conversation previously.

Sir Jim Mackey: Yes, and it is good to continue the conversation. I see this as at the heart of the neighbourhood work, so it is hard to talk about these things in isolation. This is the approach we are trying to follow now.



HOUSE OF COMMONS

To illustrate, a DGH in a normal place would spend about three and a half million quid on running a ward. If we can get neighbourhood health powered up and the people who should not be in a hospital setting can be looked after more locally, that will save money. That is the gamble that we are making. You know that three and a half million quid in a place—in a council area—would buy a huge amount of prevention. It would buy the services that would be required around frailty to stop patients being in hospital, but there would be money left to make a material investment in prevention.

Q65 Dr Cooper: Okay, so you are basically saying that the money will go into the neighbourhood model. That secondary prevention is also very welcome. Do you know what proportion of NHS England's current budget is spent on prevention?

Sir Jim Mackey: No, not off the top of my head.

Q66 Dr Cooper: Do you think you could find that out? That would be really useful.

Sir Jim Mackey: I can do, yes. There is a second step after the one I was just describing. There is a constant challenge about how long we can allow the service to find new patterns of care so that the money is redistributed and patients end up in the right place rather than the expensive place, as is currently the case. It is a live tension.

The alternative is that we do it entirely allocatively, so just shifting the money. The risk of that is you leave the patients and the deficits in places that have not managed to change their care model. This year is another year where we are beginning to see enough shift and money starting to get into the right places, because patients are in the right places. But I want you to understand that there is a live argument, every day of every week, about how long we can continue with that, versus saying that we will spend less over there and ICBs will commission more over here, and we all have to sort it out.

Q67 Dr Cooper: I understand that there is a choice. From a political point of view, obviously we are committed to reducing waiting times in the physical health setting—we can have another conversation about the mental health setting. Is there a tension between hitting those waiting time targets and meeting our strategic objectives on the shift to prevention?

Sir Jim Mackey: Yes—with everything we do, there are tensions. We talked about this a lot last year. With the amount of financial heavy lifting that we have had to do to get the money back in order, every working day, colleagues are working with tensions and trade-offs. We are absolutely not out the woods yet, and you can feel that. That is what ICB chief execs are talking about, and I talked to mental health chief execs yesterday. There is an anxiety about how long we will be able to withstand this before we start seeing some breakthroughs, and that is what this year is about.

Q68 Dr Cooper: Thank you. That is honest. Secretary of State, if investing to



HOUSE OF COMMONS

save in prevention programmes meant that we had to revisit the waiting list targets for our physical ailments, would you consider that?

James Murray: I don't think it is that binary. We have to—

Dr Cooper: But, according to Jim, the tension is there.

James Murray: I don't want to put words into Jim's mouth, but I think he was saying that there is a tension within budgets—of course there is. There should be tension within budgets, and it would be wrong if there was not, because it would mean that you are spending money too loosely. There is huge tension within the budget because we want to get value for every pound we are spending.

There are two separate points. First, there is one about how we hit the targets we have made, particularly around electives, waiting list times and referral-to-treatment times. Yes, the investment is important, but the reform and modernisation I spoke about earlier is also critical for helping with that. On the other side, making sure that public health money is spent in the right places but also spent wisely is important for bringing down that demand in the first place. I do not see it as a direct trade-off. If you can reduce demand through greater prevention, that is better for the waiting lists.

Q69 **Dr Cooper:** Well, arguably so. There may well also be a tension in the underfunding of public health. You might have to think of a trade-off in that you might have to put more money into prevention. Where does that come from? That is probably for a future conversation.

Time is running out, so I will move on quickly to some issues in the broader prevention world. My colleagues have already talked about obesity, but I will take it one step wider and talk about the health mission. I am not sure where it has got to, but let's park that word and talk about cross-cutting issues in health, particularly the commercial interests that shape so many of today's biggest health challenges.

Secretary of State, I am sure you already know about the cost of unhealthy food, the advertising issues around junk food and the branding loophole we have discussed. There are things such as addictive gambling products and the addictive design of social media platforms. When the Department is making policy, does it now explicitly consider those commercial determinants?

James Murray: Do you mean the challenge we might get from commercial interests in pursuing certain policies?

Dr Cooper: Yes, and also, when you are determining which policy has priority, do you routinely think about these broader issues that are bearing down on our health?

James Murray: If you think about food, for instance—it could apply to other aspects of our lives—the right way to make policy, in my view, is to work out what is effective, what is the right thing to do and how we can best get to the goal we are seeking to achieve. We can then work out



HOUSE OF COMMONS

which stakeholders might have a say in this and how we can work with them to shape policy in the right way, while also being clear on what we want to do.

Engaging with stakeholders does not mean that everyone agrees with you, but it is worth listening, because they might point out some obvious ways in which we could do things differently that would be mutually beneficial. It is about having a clear political direction on this and making it clear that some stakeholders might not be entirely happy with what we are doing. I was responsible for tax for a year, so I know that dynamic quite well.

- Q70 Dr Cooper:** Excellent. I think it is entirely possible that the commercial determinants will say exactly the same. Very quickly, in the same way that you would assess economic impacts incredibly thoroughly, would you look at commercial regulation and assess its health impacts?

James Murray: There is obviously a relationship between them.

- Q71 Dr Cooper:** Is that a yes? Would you look at the health impacts of commercial regulation alongside the economic impacts? Would you look at both?

James Murray: Which commercial regulation are you talking about?

Dr Cooper: Any commercial regulation you might think about—

James Murray: That would not be just for the Department of Health.

- Q72 Dr Cooper:** But in your role as Secretary of State, would that come across your desk? With commercial regulation of food, for example, there is obviously an economic impact of restricting certain foods or advertising, or of allowing supermarkets to behave in a certain way. How far up the agenda is the health impact of those issues?

James Murray: That is why I would look to pursue various changes in regulation, because of the health impacts. I would be mindful of the economic impact as well, and I would look across the piece. With my hat on as Secretary of State for Health, it would be on my desk and I would ask for it to be there because I am asking what we can do to help tackle childhood obesity, for instance. That may involve changing, introducing or amending commercial regulations—

- Q73 Dr Cooper:** But if there is conflict with the economic impact, how does that play out? I know you are new in your role, but you obviously had a previous role.

James Murray: I do not think it is new to say that there are tensions in the choices you take in Government. You always have to balance different factors—that is the job, right?

- Q74 Dr Cooper:** Sure, but our job is to put health first and let the economy follow us. We are just checking in on how it is with you.

James Murray: And my job is to initiate things because of health, but I do not think it would be right for me to ignore all the other impacts of the



HOUSE OF COMMONS

decisions I take. If I ask for a proposal about changing something in the way food is advertised to children, for instance, that will be because I am motivated by improving the health of young people. But I would not take that decision without thinking about the wider context. It is inherent to good government that you think about the broader context.

Dr Cooper: Of course. It is good to hear that health would come first.

Sir Jim Mackey: Just to add to that, if another part of Government proposes a change in the regulation of some part of the economy, and if we were involved in the write-round process, James and colleagues would be very clear in that consideration about what we thought the health impact would be. The call would not be ours, but we would make our views clear.

Dr Cooper: It would almost be like a health mission, wouldn't it?

Q75 **Gregory Stafford:** First of all, the Government promised a workforce plan. That was delayed until the spring; it is now the summer. When is it coming out?

James Murray: It should be published shortly, I say in Government speak. I know that is an irritating answer.

Q76 **Gregory Stafford:** Will that be before the recess?

James Murray: We just need to get agreement for when we can publish it. I think the work is largely done.

Q77 **Gregory Stafford:** Presumably you know whether they are going to publish it before the recess.

James Murray: I cannot confirm a date.

Q78 **Gregory Stafford:** But you can confirm whether it is coming out before the recess.

James Murray: We have to get clearance across Government. As you know, there is various Cabinet Office guidance.

Q79 **Gregory Stafford:** If I am to take it that you do not have clearance yet, it is not going to come out before the recess.

Samantha Jones: As you will be aware, with any potential change from a political perspective, we are required to ensure that any decisions that are taken in the future are taken in that context. It is a permanent secretary and a Cabinet Office responsibility to determine and advise when things from a significant strategic perspective are published. That means I cannot give you a guarantee that it will be published before recess. But as the Secretary of State said, we will make sure that we publish it as quickly as possible.

Q80 **Gregory Stafford:** It does not sound like as quickly as possible; it sounds like another delay, but okay. Patient Safety Commissioner Henrietta Hughes wrote to No. 10 to ask what discussions Government are having



HOUSE OF COMMONS

on the redress scheme for victims of sodium valproate and pelvic mesh. We have had two years and there is still no response to the Hughes report. When is that happening?

James Murray: I know this is a very difficult and complex issue, and I have had some briefings on it from the Department. I can understand the frustration of people who want to see a response in public. It is a complex issue, and it is important that we get it right.

Q81 **Gregory Stafford:** When are you going to respond to the review?

James Murray: I cannot give you a date today.

Q82 **Gregory Stafford:** Presumably it is not going to be before the recess. Is it going to come this calendar year?

James Murray: As I said, I cannot give you a date.

Q83 **Gregory Stafford:** It is really difficult for me to understand when you say, "Working at pace", "It's going to come soon", and, "It's shortly." That is not very helpful for us on the Committee. You must understand that those people who have been affected by sodium valproate and mesh, as you rightly pointed out, have a correct expectation that this Government should respond and give them the redress that they deserve. It sounds like you are prevaricating.

James Murray: I do not want people to feel that. I want people to know that I can easily imagine how frustrated they must feel and how they must want to have a public response. I can totally understand.

Q84 **Gregory Stafford:** What is holding it up?

James Murray: The complexity of the issue and getting the response right. It would not be fair or right for me to rush to get something out in public that ultimately is not the right place to be and is not the right solution. We need to get in the right place so that the Government can stand behind anything that we say or publish on this.

Q85 **Gregory Stafford:** The problem, Secretary of State, of not even being able to put a ballpark date on this is that it gives no confidence to those victims that they are going to get any compensation at any point soon. You are not going to give me an answer, but I press you to really think what impact this delay is having on those people, because I think it is a real problem.

James Murray: I take that very seriously. One of the things about being in this role as Secretary of State for Health is that every day, in every decision, I am thinking about how the people who will be affected by that decision must be feeling as a result of a decision being taken or not being taken, or of the decision we take. It is very live in my mind, but as I say, it is important that we get this right. It is complex. I can understand the frustration that people may well be feeling, but it is not right for me to make commitments that I cannot stand behind.

Q86 **Gregory Stafford:** Okay, I will try you on another commitment then. Your



HOUSE OF COMMONS

predecessor made a very clear commitment to roll out access to fracture liaison services in every area by 2030. Is that still the Government's commitment?

James Murray: We are still committed to that, and we are focused on investing in new scanners. There is a lot of capital investment going into DEXA scanners, which can have a huge benefit. They can identify potential fractures early and give people a good overview of what is happening in that regard. But yes, we are still—

Q87 **Gregory Stafford:** Will you publish whatever implementation plans you have for that, so that this Committee can scrutinise whether you are likely to hit that 2030 deadline?

James Murray: I am happy to discuss it with Jim and Sam, and then we can write to you with an update.

Q88 **Gregory Stafford:** Thank you. Moving on, you will be aware that, in March, 351,000 people were removed from NHS waiting lists. What due diligence has the Department done to ensure that those people genuinely did not need to be on those waiting lists?

James Murray: I might ask Jim to come in on some of the detail. However, I will just say more generally, because it is important to give people reassurance and confidence in the system, that the vast majority—I think, over 85%—of the reduction in waiting lists that we have seen in recent months and years under this Government has been because of people receiving the direct care they need. So, those people come off the waiting list because they are getting care from the NHS. However, regarding the actual process, is it okay if I bring you in, Jim?

Sir Jim Mackey: Yes, absolutely. First of all, regarding assurance on the challenge, with the previous Secretary of State and with James, because a lot of this overlapped both periods, we have been through lots of processes of supplying and challenging the data to understand the underlying removal rates and the reasons for the unreported removals, making sure that people who still need care and treatment have not been removed in an undue fashion. That has been an ongoing process for the last several months.

In aggregate terms, in spite of the year-end position, we were still below pre-covid levels of validation. This generally gets labelled as validation, but it is generally a post-period event, which could mean that there has been a clinic somewhere else but the data has not been fed into the main system in time. Some of it is validation, but we ended up with pre-covid levels of normal validation. We know there is still an awful lot of tidying up still to be done.

So, we have been challenged by James, by Wes previously and by other colleagues in the service and, rightly, by the media to be clear that every organisation should have an assurance system on all this, to make sure that they are scrutinising removals appropriately, so that people are not being lost and are not being removed unnecessarily. There are processes



HOUSE OF COMMONS

involved so that patients and clinicians are actively involved, and we test them all the time.

Q89 **Gregory Stafford:** That is helpful, Sir Jim. Thank you. Back to you, Secretary of State. Are you confident in that answer?

James Murray: Yes.

Q90 **Gregory Stafford:** I will move on to my last set of questions. You have had a transition yourself, Secretary of State, from believing that a woman can have a penis to rightly believing that a woman cannot have a penis. I am very concerned about people who detransition or desist from their trans identity. Trans people are clearly a very marginalised group.

The Cass review was clear, with recommendation 25 calling for dedicated follow-up and support for people who detransition. Yet two years later, there is no nationally commissioned NHS detransition pathway. Why is that recommendation not being implemented?

James Murray: First, let me say that, certainly until recently, Dr Cass's work had cross-party support. And I think that with an issue that attracts a lot of strong feeling, having Dr Cass—

Gregory Stafford: I am really sorry, Secretary of State, but I only have two minutes, so I would really like you to answer my question.

James Murray: In terms of the specific recommendations, I can write to you with that detail, unless Sam or Jim has it to hand.

Q91 **Gregory Stafford:** I have been speaking to one detransitioner, who is 23, has autism and complex needs, and whose key worker has to go everywhere with him. Despite those medical needs, he underwent major surgery on the NHS, had his genitals removed in order to affirm a trans identity, despite failing half the capacity tests that were supposed to stop that.

I am really troubled that there seems to be no data being held about people who desist or detransition, and the planned data linkage survey, which would have helped with that, is not going forward. How can you, as Secretary of State, and the Government more widely, claim to be pursuing an evidence-based policy when you are failing to collect really essential pieces of evidence, especially around detransitioners?

James Murray: I fully expect all parts of the NHS to comply with the data linkage study and to make sure the information is available for that. It will provide a different type of evidence from what we will get in the puberty blockers trial, which I know has been the subject of discussion in the Commons recently. The data linkage study is a really important part of the evidence, and I fully expect all parts of the NHS to comply with making sure that information is made available.

Sir Jim Mackey: You said a couple of things in those last couple of sentences that imply a lack of compliance with clinical process—decision-making process. Are you able to share with us the direct details, with their agreement?



HOUSE OF COMMONS

Gregory Stafford: I will have to speak to them and then let you know.

Sir Jim Mackey: Absolutely, but I am happy to test that and make sure it is being complied with appropriately.

Q92 **Jen Craft:** Secretary of State, whose responsibility is it to meet the healthcare needs of disabled children?

James Murray: Ultimately, meeting the healthcare needs of everyone in the country is the responsibility of the Secretary of State—myself in that role—working with the permanent secretary and NHS England’s chief executive. When it comes to children, I do a lot of work jointly with the Department for Education, because it has a strong locus in policy areas as they apply to young people. Working together between DHSC and DfE can be really helpful in unlocking some of the issues where young disabled people are not getting the support they need.

Q93 **Jen Craft:** I note that you did not mention local authorities in cross-governmental working. We recently had an inquiry looking at the “health” in education, health and care plans. We have taken quite a bit of evidence suggesting that, broadly, the Department of Health just does not come to the table when it comes to either commissioning services for disabled children or providing individual services.

I would like to touch on healthcare for children with complex and significant needs—I know that term is quite loose. Unison has written to us to highlight the fact that, according to a 2025 Contact policy briefing, only 4,402 children in England receive continuing care from the NHS, and that more than half of referrals are rejected. That includes families who have to provide intensive clinical care at home such as ventilator support overnight, seizure monitoring, tube feeding and tracheostomy care. Is it right that that burden of responsibility is left with families and is not picked up by the NHS?

James Murray: Jen, I quickly want to go back to your point about local authorities, which play a critical role on the frontline. The Department for Education will work with local authorities. The Department of Health and Social Care works with local authorities as well. I would not want anyone to think that local authorities are not a critical part of providing care and support for young people. On your broader question, I might bring in Jim or Sam to answer the specifics, or we can write to you with more detail.

Samantha Jones: I want to pick up the point about ICBs and accountability. In June, ICBs were asked to submit plans to NHS England with local authorities on their responsibility to ensure that children are looked after appropriately—particularly that there is a very clear accountable route for raising concerns if the process is not followed. NHS England has set that out very clearly. If there are examples where that is not the case—

Q94 **Jen Craft:** It is not examples—we have had this discussion before. It is systemic. There is a systemic absence of Health, particularly with local authority SEND partnerships. As you know, the ICBs are supposed to be



an equal partner in it. The feedback we get is that, by and large, they are not. In delivering individualised EHCPs, it does not seem that Health takes the same responsibility in delivering the healthcare side of specialised educational provision. The specific I am talking to right now is the care of complex or significantly disabled children. Do you think it is fair to say that there is an expectation that parents and carers play a much larger role in delivering healthcare for their children than would be expected from those caring for adults?

James Murray: On a broad point, I think quite a lot of responsibility ends up falling to parents, adults and carers. I think that is a fair point to make. I definitely feel the burden—not a burden, but a responsibility—that falls on parents, carers and guardians to spend so much of their time, energy and effort caring for young people. I can see that dynamic at play. You mentioned the work between DHSC and DfE on EHCPs and SEND provision. One of the first meetings I had in this role was with the Secretary of State for Education and two junior Ministers to try to strengthen the link between the Department of Health and the Department for Education.

Q95 **Jen Craft:** What does that look like in practice? How will that filter down to the ground?

James Murray: It is about making sure that the health components of EHCPs are delivered, as you said, through work with local ICBs or local providers of the services that young people need, rather than the Department for Education and schools being left to implement EHCPs, working with the local authority. The local healthcare system—the local NHS—has a role in that, too.

Q96 **Jen Craft:** I think it currently has a role, but it is just not living up to it. How do we change that going forward?

James Murray: That is what I am saying. That is the political steer and leadership—I have been working with Bridget in Education—that we wanted to bring to this. It is fair to say that we must ensure local NHS systems and local healthcare systems are playing their full role in delivering the health component of EHCPs. That is why it was a priority for me and Bridget to say—

Q97 **Jen Craft:** How will you be doing that?

James Murray: There is now regular oversight of that, involving our junior Ministers. One of our roles as Ministers is to say, “Getting this right is a priority.” We want to see what co-ordination is happening, what the results are on the ground and how we can ensure that we are giving oversight at a national level.

Sir Jim Mackey: There are two aspects of this. One is the CHC rules, how they are complied with and who pays for what. We have been trying over the last year to get more standardisation and more consistency ICB to ICB and so on. I think we are more confident that people are applying the rules properly, but the rules are the rules, effectively.



HOUSE OF COMMONS

On your second point, in my trust life, I would have expected full NHS participation. When I have met council chief exec colleagues, which I do periodically, they have never raised with me our lack of engagement on SEND processes. As Sam has already said—we did this a while ago—I am happy to reinforce to ICBs that they need to make sure people are complying and working in a full partnership way. Separately, if you have examples, it would be good to know where they are, and I can talk to people.

Jen Craft: We can send them on.

Samantha Jones: To build on what Jim just said, the planning framework last year set out very clearly NHS England's requirement for local ICBs and providers to play their full part in SEND delivery and support, so if there are examples, it was the first time it had been set out in the national framework from NHS England.

Q98 **Jen Craft:** I think it is on the individualised cases as well. The EHCP section F statutory requirement is on the local authority, not the ICB, to provide speech and language, physio and OT, for example. Local authorities have said that they would find it helpful to have a similar duty on ICBs, which I will leave for now because I want to move on.

One thing that I very strongly welcomed from your predecessor, Secretary of State, was the inclusion of my hospital trust—Mid and South Essex—in the intensive recovery programme. Jim, at a previous session, you spoke about how it was one of the historically failing trusts and said that it is an issue that goes back decades. We have had consistently bad CQC reports on well-led maternity, overall and A&E, and there have been horrific incidents, such as CQC inspectors twice having to alert staff that someone was deteriorating because it had not been picked up—absolutely horrific healthcare.

Has progress been made on that? I have written to you; I understand that these things fall between the gaps, but that was nearly a month ago, and I have not received a response. I am interested in hearing about timelines, what the terms of reference are, and whether you will be looking more at the historical drivers of underperformance and not exclusively the financial state of the trust.

Sir Jim Mackey: I was there two weeks ago, and I met with Adam, the new chief executive; Dawn, who had been acting chief exec; and some clinical colleagues. We did a walk-around and discussed the IRP process specifically. We held off jumping in on the IRP process, because Adam was about to arrive and we felt like the new leadership team needed to own the process. Dawn did a great job while she was acting up as well, but we just wanted to make sure that the new leadership embraced that properly and that we were tailoring our approach to them.

We have been really clear in this process that we do not want any new complex diagnostic processes. The NHS has had a habit in recent times: when you get a problem system or organisation, people generally know what the issues are, but there is a bit of time wasted by commissioning



HOUSE OF COMMONS

another review that tells you what the last one did and so on. The first step is to do a desktop of everything that has been said and known about the drivers, including the quality drivers. Some of those are capital infrastructure; some of their estate is appalling—I saw some of it in real life a couple of weeks ago. There are also recruitment challenges—all those sorts of things. That is all in train. Colleagues are working on it so that in the next couple of months, we—our central team, the region, local commissioners and the trust—can agree that we have a shared understanding of the drivers and then tailor the solutions to it so that we quickly then move into an execution phase.

Q99 Jen Craft: Will there be a public-facing report about the drivers of ill performance? Will people be able to look at and comment on that?

Sir Jim Mackey: In this process we have really tried to shift the approach away from a lot of drama with big, published reports to a more practical, aligned process centred on an agreement with local colleagues about what the issues are. Through that process, there will be reports. I fully expect them to be published and discussed in the public board of Mid and South Essex. There is an emphasis there; I think they should do that with our support, so that they have more ownership of it, rather than me and NHS England publishing a report about them. Our colleagues are working with them on how we address some of those issues. One example is the physical estate. We talk a lot about capital. It is hard to visualise in real life, but I saw a room that had a leak in the roof.

Jen Craft: That is pretty much every ward.

Sir Jim Mackey: It is in that ED. It hits your head when you walk in. Clinical colleagues are working in it, and patients are working in it. It is very hot, so theatres have been down most of the previous week. We are having to work out a way, with quite a tight capital resource limit, to just get some capital to them. There is no question about whether it is needed. We are not in a place where we can say, "Build a new hospital," but we absolutely can deal with some immediate issues. Colleagues are working on that as well. All those things are happening ahead of proper clarity about where the strategy is. Adam, to be fair, has been very clear: the trust's view is that capital is not the only issue, because there are others, but it is going to be a key part of the medium-term plan for recovery.

Q100 Joe Robertson: Secretary of State, you have been clear that you think the puberty blocker trial should go ahead because the Cass review says there is a lack of clinical evidence of the potential benefits of injecting, or administering, powerful drugs for young children. Do you not think that there is a moral and ethical consideration here too? If you do, how can it possibly be right to administer powerful drugs to physically healthy children just because there is a lack of clinical evidence?

James Murray: I think you are right to say there is a lack of clinical evidence, and different clinicians take different views on the risks and benefits of using puberty blockers. I mentioned earlier the work that Dr



HOUSE OF COMMONS

Hilary Cass undertook, and the fact that, until recently, that had wide support from different parties in the House of Commons.

People saw her approach as clinically led and offering a way forward on this subject, which understandably arouses very strong feelings from people who feel differently about it. As Secretary of State for Health, I said when speaking in the House of Commons recently that I found this issue difficult and uncomfortable, and that I felt uneasy in considering the matter. As Secretary of State, I have a responsibility to look at the clinical evidence to make sure that it guides us in delivering health for people in the country.

As this trial involves young people in particular, I felt that I wanted to have the absolute highest level of reassurance about the safeguards that were in place, and I felt that it needed to have a higher level of scrutiny than other clinical trials may have. I also felt that I needed to have the very highest level of understanding. That is why, when the MHRA published its strengthened protocol for the trial, which included automatic triggers for withdrawing young people from the trial, monitoring, clinical interventions and so on, I went through the detail of the safeguards.

On the basis of understanding those safeguards, I then felt confident in saying, "This is going to be one of the most scrutinised clinical trials of recent times. Although this is a very difficult decision, on balance, proceeding very carefully to get the clinical evidence is the way to find a settled way forward."

Q101 Joe Robertson: A lack of clinical evidence on the possible benefits of puberty blockers does not mean it is morally or ethically right to go and gather that evidence by administering powerful drugs to physically healthy children as young as 11, does it?

James Murray: Well, the clinical evidence—

Joe Robertson: I am talking about the moral and ethical considerations of whether it is right to gather clinical evidence that does not exist from children as young as 11.

James Murray: The clinical evidence will be gathered on both the risks and the benefits of using this approach. It is worth saying that this is a very small subsection of young people. There will be young people who question their gender or their identity and resolve it on their own, through their own thought processes or by talking with their friends and family. Within that wider group of people, there is a subset who will have bigger challenges and will need support, which, in many cases, might be counselling, therapy or other forms of support. Within that, there is a question about whether a small subset of that small subset would benefit from having any further medical interventions, including puberty blockers.

There is not a settled view amongst clinicians on this. I go back to Dr Cass, who I think has widespread support—you are nodding, so you agree that she has widespread support—who said that in the situation where



HOUSE OF COMMONS

there is no clinical evidence on risks and benefits, the way to find a settled way forward is to gather that evidence.

As I said earlier, because this trial involves children and young people, the need to test out and be reassured that there were the highest levels of safeguarding for the people involved was critical. That is why, when the decision from the MHRA came through, I spent a lot of time interrogating what the safeguards were and understanding how they would operate in practice and whether they would be sufficient. Going through that process has given me the confidence to say that, although I still remain uneasy, and it is a difficult decision, on balance, proceeding carefully with an extremely high degree of scrutiny is the way to get that evidence.

Q102 Joe Robertson: I do not agree with your decision, but thank you. I will move on to the forthcoming modern service framework for dementia. The head of the Alzheimer's Society, Michelle Dyson, said that it is "not going to be worth the paper it is written on" because the diagnosis target for 18 weeks has been removed. Why have you removed the diagnosis target for dementia when it exists for other killers, such as cancer?

James Murray: I might ask Jim to come in on the detail of the modern service framework, or we can write to you with more information if we have not got it to hand.

Sir Jim Mackey: I will have to come back. I am not aware of the specific reason for that, so I would have to come back on it.

Joe Robertson: Please do write.

Samantha Jones: The development of the modern service framework has included many people—including Michelle of the Alzheimer's Society, formerly of DHSC—from a social care perspective. What the formulation of the MSF will look like from a dementia perspective has not yet been agreed. It will be published at some point this year. Both personally and at the request of the Secretary of State, we have been looking at what further action we can take on dementia and support for dementia, including the challenge recently set out by Baroness Casey. There are a number of things, including dementia drug trials and accelerating access to those trials. With the agreement of the Secretary of State, we have appointed a dementia tsar, so to speak, to hold us to account for the work we are doing on dementia. The MSF is one part of a broader package of measures being taken on dementia.

Q103 Joe Robertson: Thank you. I urge you to include that 18-week diagnosis target because dementia is Britain's biggest killer. Such targets apply to other big killers, such as cancer.

Finally, can I ask about the new hospital programme? Secretary of State, are you committed to phases 2 and 3—that is, the remaining 18 of the 40 sites? Are you committed to delivering those?

James Murray: Yes. All the hospitals in the three waves of the programme remain in the programme, and we are committed to delivering them.

Q104 **Joe Robertson:** That is good to hear. How can you agree to increase the price paid for US drugs when you do not know how much it is going to cost?

James Murray: We know the range of likely impacts of the UK-US pharma deal, but there is still work to do to see exactly how that plays out over time. We had a conversation about that at the start of today's meeting, because there are different factors at play, and it is a range we are dealing with now, so we need to play that out over time.

Q105 **Joe Robertson:** The Government have agreed to pay 25% more for drugs that are already available, without knowing how much it is going to cost. How can you possibly do that? I do not understand.

James Murray: An important part of the deal is to ensure that innovative medicines are available in the UK so that people can benefit from innovative medical interventions.

Q106 **Joe Robertson:** They are already available. You are just paying the US more for them without knowing how much it is going to cost or where the money is coming from.

James Murray: It is important to get new medications coming through, because there are huge benefits for people's health, and economically and socially.

Q107 **Joe Robertson:** I agree with all that, but how much is it going to cost to pay more for US drugs that are already available?

James Murray: We had quite a detailed conversation about that earlier—

Q108 **Joe Robertson:** Yes, and you do not know. I do not understand how you can agree to this if you do not know how much it is going to cost or where the money is coming from.

Sir Jim Mackey: We did talk about this at the beginning, and I do not think we have given a good enough answer, so I will recap on it from my point of view.

At the time when this was all settled last year, the deal was done when it was done. It has been part of our discussions with Treasury since then, in the context of the aggregate financial position. At the time, we had the £1 billion estimate, but, as I said earlier, the estimates have been moving around quite a lot—they change week to week.

If the main concern is whether the deal means we will have to deprioritise our performance or progress on other things, we have been very clear in all our discussions—James has been very clear, as was Wes previously—that we are committed to delivering everything we have set out to deliver. If the overall financial position becomes unmanageable and impacts on our delivery, we will need a proper discussion with Government about that. That has been ongoing for the last year.

When we discuss VPAG, the numbers will be different from when we did the estimates last year because a lot of things have changed, but the



HOUSE OF COMMONS

overall context around it—industrial action, other pressures and, frankly, benefits in the stack and in our medium-term plan—need to be considered in the round. If I were in the Treasury, I would say, “Let’s not talk about one number; you have to look at all the numbers in the round.”

When we have more of a discussion about VPAG, I would urge you to have a look at it in the round with the principle of, “Does this whole thing therefore impact our ability to deliver?”

Chair: Understood. I also note your use of the passive voice in saying when the deal “was done”. That is interesting in itself.

Q109 **Ben Coleman:** Secretary of State, yesterday I accompanied my constituent, Louise Thompson, and former MP Theo Clarke to No. 10 to deliver a petition with 167,000 signatures calling for a statutory maternity commissioner. In the House, you reassured me that the Government would use the current Health Bill to create that position. Is that still your intention? If so, when will it happen? What is the timing?

James Murray: Yes, that is my intention. We want to put the new maternity commissioner on a statutory basis. I think the most likely route to that will be via the Health Bill. Obviously, we have to work up an amendment and work out how we get that into the Bill, so there are some parliamentary logistics to go through, but that would be what I would like to happen.

The reason I am being just ever so slightly careful in my language is that it is dependent on the business managers—

Q110 **Ben Coleman:** When might it happen, if it does happen?

James Murray: We want the Bill to get Royal Assent and be done by, I think, the end of 2026, so if the work—

Q111 **Ben Coleman:** Do you have other options if that is not going to be in the Bill?

James Murray: We would obviously look at other options if it were not in the Bill, but I very much hope that it will be possible to deliver it through the Bill.

Q112 **Ben Coleman:** Thank you.

I move on to another aspect of the Health Bill, which is the role of local authorities on integrated care boards. The Bill as it stands—I am talking specifically about London here—would strengthen the Mayor of London’s role on integrated care boards by removing the current statutory requirement for local authority representatives.

But the thing is that, unlike combined authorities such as Manchester, London boroughs have no formal role in the governance of the Greater London Authority, which is with the mayor. That is despite the fact that boroughs have full responsibility—and budgetary responsibility—for adult social care, children’s social care, public health, as you yourself referred to, as well as many, many other areas. The neighbourhood health agenda



HOUSE OF COMMONS

also depends on local authorities.

The London Mayor's role is strategic; he does not have any actual responsibilities. It is therefore very strange that you are removing local authorities from ICBs in London and replacing them with the mayor. Do you recognise the difference between London and combined authorities?

James Murray: I definitely recognise that there is a difference. In terms of the composition of ICBs in different parts of the country, there will not be a single approach that applies everywhere. The focus on having—

Q113 **Ben Coleman:** Yet you are taking a single approach in the Bill.

James Murray: No. There is a requirement about having a mayoral representative where mayoral strategic authorities overlap with the areas that ICBs cover, but there is flexibility in what individual ICBs can do.

Ben Coleman: Not in the Bill.

James Murray: For instance—as I understand it; I might just check with Sam or Jim to come in on this—in the north-west London ICB, the boroughs are agreeing to put in three representatives—

Q114 **Ben Coleman:** They have three; we argued for that. I was on the north-west London ICB. We argued for that and we got that. The statutory right to have those three in north-west London, which is now being merged with central London and 9.3 million people, will go.

The same applies to the other three ICBs in London: local authorities will have no statutory right to be on the ICBs in London, while the mayor, who has no health powers and only a strategic overview, will replace them. I do not see how that will help you deliver the ambitions that you talked about earlier. Have you assessed the unique position of London's governance arrangements? Have you considered that there may need to be bespoke provisions for London?

James Murray: Yes, I am very aware of London's unique position, not least as a London MP myself. I am conscious that we have committed to putting out further guidance about how we will approach different parts of the country, recognising the different arrangements in different parts of the country. That goes to my point of saying that, although there is a clear requirement in the Bill, there will be different ways—

Q115 **Ben Coleman:** But the Bill removes what exists at the moment. It makes it worse when it comes to local authorities.

James Murray: There will be different—

Q116 **Ben Coleman:** We brought an amendment to the Committee considering the Bill, which the Minister opposed. The fact of the matter is that, statutorily, the mayor will have a role on the four ICBs in London—he will somehow split himself into four bits—whereas the local authorities, which have all the budgetary and statutory responsibilities for delivering services, will be removed. Can that be reconsidered?



HOUSE OF COMMONS

James Murray: What I was explaining, Ben, was that, as the Minister of State for Health committed, we will be publishing guidance on how this will apply in different ICB areas. That will set out how it will work in London, as well as in other places in the country, because different places in the country have different arrangements.

Q117 **Ben Coleman:** Is there a possibility that this guidance—there is obviously an issue with other devolved areas; elected mayors do not run unitary authorities. My problem, which I have discussed from the moment I was elected as a Member of Parliament, is that the NHS does not understand how local government in this country works.

The Bill is a fundamental exemplar of this, in that you are removing local government, which understands health and is essential to health, and replacing it with some nebulous—not even existing—strategic position: mayors and so on, which do not even exist in some places. You need to think again. Do you accept that you might have got it wrong and you perhaps need to think again?

James Murray: I would not dismiss the benefit of having mayors or their representatives on ICBs.

Q118 **Ben Coleman:** Nor would I—alongside. Would you consider, therefore, having mayors alongside London local authorities retaining their statutory position? You could have both, but why take local authorities out and put the mayor in?

James Murray: To be fair, Ben, I do need to come back on your last comment, because your language implied that you felt that having a mayor or their representative on an ICB would not be beneficial, but—

Q119 **Ben Coleman:** Forgive me; I should have said “not on their own”.

James Murray: Okay, I apologise if I misheard.

Q120 **Ben Coleman:** I was saying that having a mayor instead would not be beneficial. You could have a mayor alongside. If they are both there on a statutory basis, I could see how that might work.

James Murray: The issue you highlight is very specific to London, because as you point out—

Q121 **Chair:** It's not; it's across the country.

James Murray: There are different issues in other parts of the country, but that is my point—we need specific guidance for specific areas. What we do in London has to respond to the specific situation in London and what we do in other parts of the country would respond to their situation.

Samantha Jones: If I may add, there remains a duty to co-operate between health and local government, irrespective of the point you are making around the Bill. The whole point behind the Bill is devolving as much as possible away from central diktats on it—

Q122 **Ben Coleman:** Forgive me for interrupting you. This is absolute nonsense.



HOUSE OF COMMONS

You are removing the statutory response rights of local authorities. You are not devolving; you are pushing it up to the mayor, who does not have local authorities, which are being pushed out of the picture. How is that improving the democratic accountability and the neighbourhood planning that you wish to do?

Do you accept that you might need to look at this again, both for London and for the rest of the country? It is a simple yes or no. We can write to you and meet you further on this. Could we take it forward with you like that?

James Murray: I am always happy to hear your suggestions.

Q123 **Ben Coleman:** Can I come and meet you with colleagues and talk about that?

James Murray: I am always happy to meet colleagues to talk about this. We think the balance is right in what we are doing, but I am open to scrutiny from yourself, and I would be very happy to discuss it with you further.

Q124 **Ben Coleman** And meet. Thank you so much.

I have a few minutes left. Can I move on to Palantir, which I have discussed quite a lot? Ms Jones, thank you for recusing yourself from any future decision on whether its contract is extended, as has been reported. The *Financial Times* revealed on 16 June that improvements attributed to Palantir rely on a handful of hospitals, and 84% of the out-patient waiting list removals are just Chelsea and Westminster hospital.

The Londoner has published further analysis, which says that Chelsea and Westminster trust's waiting list actually increased by 20,000, rather than decreasing, over three years. A further *Financial Times* piece says that NHS England has admitted that its claims about Palantir are not causally robust, and that you cannot draw conclusions about cause and effect. These are three very serious pieces that call into question Palantir's effectiveness. Are you and your colleagues aware of these three analyses?

James Murray: We have strong analysis from NHS England about the benefits that—

Q125 **Ben Coleman:** No, I am asking if you are aware of these three pieces? Jim, you nodded at that.

Sir Jim Mackey: Yes.

Q126 **Ben Coleman:** Given that you are aware of them, and they raise serious questions about the effectiveness of Palantir, and that you are reviewing whether the contract should end next March or be continued, do you agree that it would be helpful to have an independent audit of Palantir's effectiveness before any renewal decision is taken?

Sir Jim Mackey: Some of this is commercially tricky, so we need to be a bit careful about how far we go. We have a live process running with NHS England to make sure we are objectively assessing the benefits.



HOUSE OF COMMONS

Q127 Ben Coleman: Given that NHS England has only just accepted in June—and suddenly put in seven places on its website—that the claims that it has been making for Palantir are not causally robust, do we need an outside, independent review of the situation?

Sir Jim Mackey: There have been challenges—I have raised challenges personally over the last year—about whether our assessments are objective and can be fully stood up if challenged. There has been an ongoing process that now feeds into this contractual process. Alongside that, we have given consideration to external review of the benefits. There is a process in train for that. The problem is that that will probably not be complete as it is quite a long process.

Q128 Ben Coleman: I know you have the Imperial College London big piece of work; I am not talking about that. I am saying that three serious analyses have been done recently that show that the NHS has consistently—if they are right—overstated the impact and effectiveness of Palantir, and that it resisted any change. Palantir is still making claims. The NHS itself now says you cannot draw conclusions about the cause and effect. Do you not think an external independent review—a rapid review of effectiveness—would be helpful?

Sir Jim Mackey: I had a discussion with the team a couple of weeks ago about the need—again, not Imperial; somewhere else—to have an objective review. My personal view is that it would be helpful and necessary. I do not think that can be done to inform the next step on the procurement process or in this contractual process—

Q129 Ben Coleman: Why not?

Sir Jim Mackey: Because it will take months to do it properly.

Q130 Ben Coleman: You only need to say whether you think—84% of all Palantir's claims about waiting lists refer to Chelsea and Westminster. Doctors at Chelsea and Westminster say waiting lists have actually gone up by 20,000; and the cause and effect is not proven, says the NHS.

Sir Jim Mackey: It is more complicated than that.

Q131 Ben Coleman: Why?

Sir Jim Mackey: Because the benefits case is more complicated than that. The business case is more complicated than that. There are some specific bits of analysis that are disputed in the documents you refer to.

Q132 Ben Coleman: Which would you dispute?

Sir Jim Mackey: I am not disputing them; I am just saying there are other things to be taken into consideration.

Q133 Ben Coleman: If it is not effective, why extend it?

Sir Jim Mackey: I think you are being oversimplistic about the benefits.

Q134 Ben Coleman: I am asking a question to get an answer. If you think it might not be effective, and that is what these analyses are suggesting,



HOUSE OF COMMONS

would you not want to look in more detail before deciding whether to extend?

Sir Jim Mackey: I think we are in danger of getting into tricky territory from a commercial—

James Murray: I think it is worth my jumping in there. There is a review process under way. I appreciate you are pushing Jim and me for answers on this. There is a review of a commercial arrangement under way and that does limit what we can say.

Q135 **Ben Coleman:** Just one more question. On the single patient record, I believe you will have received guidance from the Cabinet Office that you should be looking at British suppliers for AI, one of the four priority areas.

When it comes to the single patient record that you are going to be building, do you intend to encourage UK suppliers and UK SMEs? If so, will you look beyond the Government's data capability procurement framework for bidders, as this is currently mainly overseas companies?

James Murray: I want to see more British firms bidding for and winning contracts with the NHS to deliver all of our tech investment over the coming years. Part of that is through the guidance issued on the back of the Procurement Act, which helps to strengthen the opportunities that British firms have, but it is also about the structure of the contracts. The single patient record will likely be delivered by a lot of different contracts, which actually gives more opportunity for British firms to bid, particularly if they are smaller or growing or have a particular set of skills.

Q136 **Ben Coleman:** Thank you. That is very helpful and promising. Will you therefore look beyond the Government's data capability procurement framework for the bidders or will it only be people on that framework who will have the opportunity to bid? As I say, mostly they are overseas suppliers at the moment, so I think you would need to look beyond it to help British SMEs. Will you do that?

James Murray: The process of having contractors for the SPR is gearing up now, because the legislation is currently going through Parliament. I will definitely look at the point you have raised, because we want to make sure that more British firms are bidding and winning these contracts.

Q137 **Paulette Hamilton:** Good morning. I am going to talk a little bit about maternity and then finish with the cancer plan. I will follow on from Ben. Thank you for answering the first part of this question, but I am going to concentrate on this maternity and neonatal commissioner.

Well done on announcing it so quickly, but it has not been as positive with all parts as we thought it would be, including with a number of agencies, including the Nottingham families. One mother said that all the power and responsibility is now in one person's hands.

How will you ensure that the maternity and neonatal commissioner role will deliver the outcomes that we want it to deliver for women, rather than just becoming another layer of assurance? Also, how do we bring all these concerned families and partners along with us, so it does not fail at its first

attempt?

James Murray: I think your point around families underpins all of this for me. I have spent time with some of the affected families in Nottingham and elsewhere. Their confidence in the process that we are undertaking is critical to making it work and critical to getting the right outcome from the taskforce that I chair and on the action plan by the end of the year. Their involvement is critical to making sure the plan is right, but it is also—

Q138 Paulette Hamilton: You have just highlighted the action plan. The Health Bill is going through, and we will have the action plan by the end of the year. You have highlighted that you are going to try to find a way. Could you commit to us as a Committee that if you cannot find a way by December, you will hold the Bill back on Report so that we can make sure it is joined up and that families feel that we are taking this seriously?

James Murray: Getting the Health Bill through Parliament this year is really important for some of the reorganisation that we are doing at the Department of Health and NHS England, as well as for enabling the single patient records that we were just speaking about to go ahead. I would be very reluctant indeed to slow down the Bill going through.

As I was saying in response to Ben, I am keen for the amendment establishing the statutory maternity and neonatal commissioner to be made through the Health Bill; that makes sense. The only reason why I am not saying that 100% now is that I have to discuss that with people in the House of Commons and House of Lords.

Q139 Paulette Hamilton: Let me stop you there. I have totally forgotten to declare an interest: I am on the reference group.

We are running out of time, so I will move on quickly. What do you feel will help the maternity and neonatal commissioner's role to succeed?

James Murray: It is about making sure that they do not take on all the responsibility for maternity services; they need to work as part of a team. The maternity and neonatal commissioner will work with me to chair the taskforce, but every component of that taskforce is important.

Q140 Paulette Hamilton: It is, but my concern—remember that I am on the reference group: I declare that loudly—is that we are lagging in the two areas. We have the Bill, we are doing this piece of work and we have your willingness, but none of that seems to be joined up in any way. I am worried that if we are not careful families will feel that it has become a talking shop and that the role will get subsumed into everything else that we are doing currently.

James Murray: Let me take that really directly; I hope that I can give you some reassurance on this, Paulette. I think the taskforce and I are meeting next Tuesday, so we are getting on with it straight away now that Donna Ockenden's report about Nottingham and Baroness Amos's national review have both been published. All the national-level recommendations from both those pieces of work, and all the other reviews that have happened in the past, will feed into the taskforce.



HOUSE OF COMMONS

The taskforce will not be held back from getting on with its work by the need to get the commissioner on to the statute book. That work can begin now and we will then get the action plan delivered by the end of the year. The maternity and neonatal commissioner does not need to be on the statute book for that work to begin, if you see what I mean—that work is not being held up by the need to get the commissioner amendment put into law.

But as critical as having that action plan is making sure that it is put into action. That is where the commissioner can also help play a critical role in helping us support the work of the Department for Health and the taskforce to deliver that plan right across the system. The legal necessity of having an amendment does not hold back the work of the taskforce.

Q141 Paulette Hamilton: Brilliant. Baroness Amos's report talked about natural birth ideology. Dr Bill Kirkup decided to stand down from his role as an expert adviser because he disagreed with the wording about the issue; he thought it was not strong enough. Baroness Amos's report had said that natural birth ideology was not an issue. I happen to disagree with that; I absolutely believe that it is a major issue—I declare that as another interest. Do you agree with Baroness Amos's review and findings on the natural birth ideology? Do you believe that it is an issue in maternity care?

James Murray: I think it is definitely an issue—

Paulette Hamilton: She said it is not. She put that clearly in her report.

James Murray: My reading of Baroness Amos's report was that her review did not find evidence as to the national prevalence of normal birth ideology. My reading of it was that it acknowledged that it does exist—it is an issue—but it did not speak to the national prevalence of it. For me, there are two important pieces of context here. First, Baroness Amos's report, although I am hugely grateful to her for doing it, was never expected to be the final word on any of these matters. The recommendations from her report feed into the taskforce, which will consider all the issues, including, where appropriate, normal birth ideology.

Q142 Paulette Hamilton: Let me stop you there. I have concerns with this. Her report says she does not see it as an issue, and an eminent expert then resigns saying he does not agree with her. I am worried that if we are not careful, it will get missed, because she has said she does not see it as a national issue. Do you agree that it is something that we need to look at far more closely?

James Murray: It is definitely an issue that the taskforce can pick up in considering all aspects of maternity care; I think normal birth ideology is likely to be part of that. My personal view, for what it is worth, is that no woman should ever be pushed into a particular type of birth. Women should be able to make the choice themselves. They should be listened to and respected. They should have the full information about the risks and

benefits of different types of birth, but it is for women to make that choice, not to be pushed by anyone into one type of birth or another.

Q143 Paulette Hamilton: Right. Finally, because I do not have much time—although the Chair isn't looking at me too dagger-eyed at the moment—I want to ask one other question, on the cancer plan. I was part of the least survivable cancers taskforce, which looked at the cancer plan, because I am the chair of the APPG, and we have looked at it as a Select Committee too. I welcomed the cancer plan—I really did; I was in No. 10—but many organisations, such as the Royal College of Physicians, have concerns about it related to workforce capacity, sustained investment and the weakness of IT infrastructure. When will you set out a detailed implementation plan that will enable delivery of the plan that you—not you personally, but your predecessor—committed to? When will that come online? There is a lot of doubt out there about whether we can actually fulfil this.

James Murray: From my personal point of view, my oversight of it is already online, because I have a delivery unit at the Department of Health and Social Care and we have separated out the cancer delivery targets as a separate focus within the broader electives targets and so on. Cancer is such an important one to have a focus on from the Secretary of State—from my office and myself personally—so we have separated that out to give it extra oversight, because I want to make sure that we deliver against those commitments.

Q144 Paulette Hamilton: When will we see a completed delivery plan? Is that due at some point, or have I got this wrong?

Samantha Jones: I think we should come back and confirm, because it is how you want to take forward all the different actions.

James Murray: Okay, fine. We obviously have the plan as it is now, and the work that I am doing. Can I write to you to set out that landscape—

Paulette Hamilton: Oh gosh yes.

James Murray: And then maybe we can work out whether you think there is anything we are missing—you can tell me.

Paulette Hamilton: That is fantastic. I will stop there.

Q145 Andrew George: We are now playing extra time; thank you very much for hanging around for it—although, to save time, I may try to play it as a penalty shootout.

Let me pick up the point that Paulette made about the Ockenden review. In an interview on Sunday, you said that senior clinicians refused to take part in the Ockenden review. That was wrong. It was not clinicians; it was managers, wasn't it? Would you like to correct the record on that now?

James Murray: Yes. It was senior leadership in Nottingham who refused to take part.

Q146 Andrew George: On the workforce itself, Samantha in an earlier



HOUSE OF COMMONS

response described the publication of the workforce plan—perhaps diplomatically—as awaiting the bedding in of the Prime Minister. That is my interpretation of what was intended by the way it was presented. The issue is that there has been some speculation—well informed or otherwise—that there will be a shift from the '23 workforce plan, which was looking at larger numbers. This one will place a larger emphasis on AI and technology, rather than increased staff numbers. To what extent is that something that you inherited from your predecessor? Dare I suggest that it may be conveyed to your successor, whatever happens after the end of the month? Are you strongly wedded to it? In your opening remarks, you made it very clear that you are wedded to and enthusiastic about the benefits of technological improvements.

James Murray: In the two years since the Government came in, the number of doctors, nurses and other people working in the NHS has increased. Over the rest of the 10-year plan, the overall numbers will continue to increase because we want to strengthen the health service, but that does not mean that we are not also going fully at AI and other technological improvements that we can benefit from.

To give you one example, I was in Wythenshawe hospital in Greater Manchester recently, and a radiologist said that she has AI scanning X-rays of lungs to identify which ones to prioritise and which marks on those X-rays to look at in more detail. She said that it is like having a second pair of eyes. That does not mean that you do not need radiologists like her, who are absolutely critical to the work that we are doing, but they can do more, do things more quickly and be supported by having AI tools around them. It is about AI tools enhancing what the workforce can do while the workforce continues to be strong.

Q147 **Andrew George:** I entirely accept that point about diagnostic tools, but clinicians on the frontline talk about safe staffing, and particularly about properly trained clinicians—doctors, nurses and so on. There has been a strong push to ensure there is a sufficient number. If anything, the Ockenden review and other reports have identified that there is a risk of insufficient safe staffing on the frontline. Do you recognise that there is a false economy going on within the service itself? People get better quicker if you have the right staffing levels on the frontline.

James Murray: In a way, those are almost two separate questions, although they are intertwined. Having the right staffing levels in particular services, having people with the right training and having the right team structures are critical to making sure services work well. AI and other technological advancements can help to support all that work; they do not supplant the need for it. It is not a direct trade-off. AI can reform the way the systems work.

Q148 **Andrew George:** I am sorry; I moved from AI to circumstances where AI has limitations, particularly on the hospital ward. The RCN and others would welcome a mandate for one registered nurse to seven patients. Very rarely do they ever get to that level of staffing. That would provide both safety and efficiency, and therefore better outcomes for patients and



HOUSE OF COMMONS

quicker turnaround. Patients would get better quicker.

James Murray: I definitely agree that it is right that we think about the right staffing levels in different parts of the service, in terms of staffing numbers, the training that those members of staff have, and who you have in different parts of the system. I will not repeat myself, but AI is effectively separate. It can benefit all that operation, but it does not supplant it.

Q149 Andrew George: Moving on to the current status of the emergency and urgent services, I know that you have been looking closely at what else can be done to address the issues of corridor care and ambulance waiting times. What do you believe are the primary ingredients to resolving those issues? What is working, and what would be the best solution to bring the very existence of corridor care and ambulance waits down in future?

James Murray: The first step is transparency, which is why us publishing the data for the first time last month is so important. If you are going to tackle a problem, you have to name it, show where it is and have some way of monitoring actions to tackle it. The data shows where the concentrations of corridor care were, and almost the majority of incidences were concentrated in 20 trusts across the country. That is a really important signal for the NHS England team that those trusts need particular intervention and support.

Corridor care can be resolved. We see various different hospitals and trusts where they have resolved it and reduced it to zero or near zero. It is a question of making sure that those hospitals where it is significant and where it still exists have the right support that they need to drive it down.

Q150 Andrew George: But the stats are already there. What are the actions where you said they need the interventions?

James Murray: There are teams that go in.

Sir Jim Mackey: We published the model ED document a few months ago. I have slightly lost track, but either yesterday or today we have published a model discharge document as well. We have given structure to the front end; we will give structure to the back end and get them organised around the discharge process.

We have also learned a lot from what people did in the last six months of last year, mainly around really industrialising same-day urgent care, the power and benefits of urgent treatment centres and so on. We are working out how we share that good practice around the country. Sadly, it is one of those things where there is not a single silver bullet; a complicated set of things needs to happen. Through national, regional and local colleagues, we are trying to accelerate the rate at which people implement the model ED in their way and the model discharge. We intervene if necessary where that is not being done, but we also point people to the places that made big improvements like George Eliot.

Q151 Andrew George: And you will go to those places that are struggling and give them assistance.



HOUSE OF COMMONS

Sir Jim Mackey: Yes, and connect colleagues. What has really been helping in the last few weeks is that we encouraged chief executives last week to be curious about that and to watch, through the weekly data, who has made a big improvement. We will make the connections to get clinical teams to go and talk to one another and do that.

Q152 **Andrew George:** Finally, can I ask about safety? The national review proposes to amalgamate the Health Services Safety Investigations Body with the CQC. There was a lot of disquiet about whether that is appropriate. It is a safe space for clinicians to raise concerns, it avoids the necessity of things getting even worse and going for large inquiries and it provides an environment in which there is protected disclosure, which a lot of clinicians are very concerned will not happen if they are working in the orbit of the CQC. Because it is something that you have inherited, James, are you prepared to look at that again and maintain the integrity of HSSIB so that it is a safe place?

James Murray: The Health Bill that is going through Parliament at the moment gives the powers to bring HSSIB into the CQC. The powers need to be activated, because we need to make sure that the CQC is in the right state to incorporate HSSIB. There will be protections around HSSIB, or the successive body to HSSIB, and its work to make sure that it can continue its distinct role within the overall CQC structure.

Q153 **Andrew George:** Are you not worried about the concerns that have been expressed that this may not necessarily give those clinicians on the frontline the confidence that it is a body they can safely work with, where protected disclosure will be genuinely protected?

James Murray: That protection is important. There are also benefits to having HSSIB in the CQC, and them working closer together with that protection in place. I appreciate that some people have different views on it, but there is a strong argument behind what we are doing.

Andrew George: Okay. Thank you very much.

Chair: Thank you very much for staying a bit longer; it is much appreciated. I thank the Committee and those watching.