Layla Moran MP
Chair, Health and Social Care Committee
House of Commons
Palace of Westminster
London
SW1A 0AA

28 February 2025

Dear Layla,

Re: Work of NHS England evidence session, 29 January 2025

Thank you for your letter requesting further information following my appearance alongside Julian Kelly and Duncan Burton before the Health and Social Care Committee on 29 January.

Ahead of meeting the Committee privately on 4 March to discuss NHS England's 2025/26 planning guidance which was published the day after the Committee hearing so couldn't be covered in that session. I have responded to each of your questions below.

Q1: Providing the Committee with details of the "factual inaccuracies" in the Public Accounts Committee report on NHS financial stability.

In keeping with usual procedure, we will formally respond to the Public Accounts Committee (PAC) through the Treasury Minute process. The PAC report raised valuable points, but we were clearly not explicit enough in our evidence session particularly on the role and powers of NHSE, or the position on productivity both historically and how we intend to achieve future productivity gains. The latter we have detailed below in answer to your question.

We will share our formal response to the PAC with your committee when published.

Q2: List of ring-fenced spending areas in the new planning guidance and a list of areas where spending is no longer ring fenced.

In line with the Government Mandate, the 2025/26 priorities and operational planning guidance sets out a smaller number of national priorities for 2025/26 with an emphasis on improving access to timely care for patients, increasing productivity and living within allocated budgets, and driving reform.

In agreement with Government, we are giving local systems greater control and flexibility over how local funding is deployed to best meet the needs of their local

population by releasing most funding ring fences. We and Government have been clear that this does not imply those areas previously ringfenced are no longer important, but it is a shift away from central control to local ownership in line with the Government Mandate. Service Development Funding (SDF), which is already deployed to frontline service providers, will be rolled into core allocations.

The tables below set out the SDF which was distributed to systems in 2024/25. This is split into tables to show:

i. The areas of SDF moving into core allocations. This will increase the freedoms systems have to allocate their resources.
ii. Arrangements for the areas of SDF in 2025/26 that remain ring-fenced ("maintain in SDF")

The areas of SDF moving into core allocations in 2025/26

Programme	Bundle
Community Services	Community Services Transformation
CYP	CYP Transformation (excluding Complications of Excess Weight funding which remains in SDF)
Diagnostics	CDCs
Learning Disability & Autism (LD&A)	Community / Keyworkers
LD&A	Autism
LD&A	Hearing Screening
Maternity	Enhanced Continuity of Carer
Maternity	3 Year Delivery Plan
Maternity	Ockenden II Workforce
Mental Health	Mental Health Adult Crisis
Mental Health	Children and Young People Mental Health including Eating Disorders
Mental Health	Mental Health Adult Community
Mental Health	Mental Health Support Teams in Schools (MHST)
Mental Health	Mental health, learning disability and autism inpatient quality transformation
Other SDF	Medical Examiners
Prevention and Long Term Conditions	Universal bundle
Prevention and Long Term Conditions	Targeted bundle (except HIV Opt-Out testing funding)
Prevention and Long Term Conditions	Long Covid CYP
Primary care	Primary Care Transformation
Primary care	GPIT - Infrastructure and Resilience

Primary care	Dental Screening in special residential schools
Primary care	Eye Health in special schools

Areas remaining in SDF 2025/26:

Programme	Bundle	25/26 arrangements	Rationale
Cancer	Cancer Alliances core and targeted	Maintain in SDF	Alliances are separate to ICBs
CYP	Complications of Excess Weight (was part of CYP Transformation bundle in 2024/25)	Maintain in SDF	Agreed funding for pilots
Elective	Elective Validation Sprint Funding	Maintain in SDF	Funding for specific projects aligned with the Elective Reform Plan
Innovation	Research Engagement Network programme	Maintain in SDF	Ringfenced funding from DHSC
IT & Tech – SDF system funding	Mix of central run costs and targeted local funding linked to HMT approved business cases	Maintain in SDF	HMT requirement
Maternity	Independent Senior Advocate	Maintain in SDF	Agreed funding for pilots
Maternity	Genetic Risk Services	Maintain in SDF	Agreed funding for pilots
Mental Health	DWP Talking Therapies	Maintain in SDF	Ringfenced funding from DWP
Mental Health	IPS additional funding	Maintain in SDF	Ringfenced funding from HMT
Mental Health	NHS Talking Therapies for Anxiety and Depression	Maintain in SDF	Ringfenced funding from HMT
Other SDF	Accelerating Urgent and Emergency Care Prediction and Prevention	Maintain in SDF	Non-recurrent completion of existing work
Other SDF	Children's Hospices	Maintain in SDF	Ringfenced to ensure funding reaches hospices

Programme	Bundle	25/26 arrangements	Rationale
People	Retention Exemplars	Maintain in SDF	Agreed funding for pilots aligned with LTWP
Prevention and Long Term Conditions	Hybrid Closed Loop	Maintain in SDF	Funding issued as reimbursement based on actual services delivered
Prevention and Long Term Conditions	Latent TB Infection Testing	Maintain in SDF	Funding issued as reimbursement based on actual services delivered
Prevention and Long Term Conditions	HIV opt out testing (was in Prevention and LTCs targeted bundle)	Maintain in SDF	Delivery of government commitment
Primary care	Pharmacy First	Maintain in SDF	Funding issued as reimbursement based on actual activity delivered
Primary care	GP Fellowships	Maintain in SDF	Funding issued as reimbursement based on actual activity delivered
Primary care	International GP Recruitment	Maintain in SDF	Funding issued as reimbursement based on actual activity delivered

Still in discussion

Programme	Bundle	25/26 arrangements	Rationale
Primary care	Additional Roles Reimbursement Scheme	Final arrangements to be confirmed to reflect agreements reached on GP contract 25/26	

Q3: Steps that NHS England will be taking to monitor the impact of the removal of ringfencing funding, including what metrics you will be using to help measure the impact and the service current performance levels using those same metrics.

Where funding is transferred to ICBs without a ringfence for 2025/26, we will continue to monitor spend at the level of the specific SDF bundle (the individual lines in the table), but delivery will not be performance managed centrally.

We will also continue to collect and monitor relevant metrics, as well as overall spending data.

NHSE will continue to hold systems to account for delivery in line with the Oversight Framework.

To ensure maximum transparency, data on provider and ICB performance will be published –including key metrics such as in primary care, mental health, urgent and emergency care.

Q4: What financial impact/benefit that the NHS forecasts would realise through improvements to the Better Care Fund [Q21] and whether you have any plans to increase this funding?

The Better Care Fund (BCF) policy framework (Better Care Fund policy framework 2025 to 2026 - GOV.UK) is set by the Government and the Fund is jointly managed by the Department of Health and Social Care, NHS England and Ministry of Housing, Communities and Local Government, supported by the Local Government Association.

Under the BCF framework, NHS and local authority funds are pooled and used to deliver a wide range of integrated, community-based care and support, such as intermediate care, and rehabilitation and reablement services.

Activities funded through the BCF make a significant contribution to improving individual health and wellbeing outcomes and supporting a more sustainable health and social care system.

For example, the 2017 National Institute for Clinical Excellence (NICE) guidelines on *Intermediate Care Including Reablement* (Overview | Intermediate care including reablement | Guidance | NICE) found a mean cost saving per person of £610 for nurse-led bed based intermediate care (Page 17 Appendix C3, appendix-c3-economic-report-pdf-4600707954). The central scenario for the lifetime costs for individuals receiving reablement was a mean cost saving per older person of £2,061 (Page 33 Appendix C3). These include health and social care costs and savings and are sensitive to factors such as the timing of the start rehabilitation and length of rehabilitation stay. Such evidence informs the development of national guidance on the use of the BCF.

Over the coming year we will continue to support local areas to maximise the impact of the BCF. The priorities and reporting requirements for 2025/26 have been streamlined, with local areas setting goals, and their performance measured against three new metrics: emergency hospital admissions, average length of discharge delays, and long-term admissions to residential care homes and nursing homes.

Allocations to local areas have now been published for 2025/26 (NHS England » Better Care Fund 2025 to 2026: minimum NHS contributions from integrated care boards). The total minimum NHS allocation to the BCF will be £5.62 billion in the financial year 2025/26, of which a minimum of £2.25 billion must be spent on social care services. In 2024/25, comparable figures were a total NHS minimum contribution of £5.53 billion, of which a minimum of £2.17 billion was the minimum adult social care contribution. The NHS BCF minimum contribution to adult social care is increasing by 3.9% in 2025/26 (£85 million nationally), and other elements of funding are largely remaining at 2024/25 levels.

As the Committee will be aware, the Government is conducting a spending review for the period beginning 2026/27 and future allocations for the BCF will be considered as part of this.

Q5: Analysis of the impact of greater funding for social care on the NHS and analysis of bed capacity NHS England would not need to construct if we can deliver improvement on length of stay.

In the session, we discussed the impact of social care funding and its relationship to NHS productivity, including the potential to reduce discharge delays and releasing beds to allow more efficient flow through hospitals, in turn helping to recover A&E and ambulance service performance.

Analysis suggests that around two thirds of bed days lost to delayed discharges are associated with individuals accessing adult social care, community care and/or care home services on discharge. A third of these delays – around a fifth overall - are for individuals accessing adult social care packages on discharge.[1]

Eliminating the lost bed days for just the third of delays for individuals accessing adult social care packages on discharge would reduce average lengths of stay, aid system flow and theoretically deliver an improvement in A&E 4 hour performance. If all other things were equal, including the rate of admissions and rate of flow through hospitals, theoretically this could potentially improve performance by up to 6%.

[1] This analysis is based on an extrapolation of September 2023 – July 2024 data from a sample of 54 NHS acute trusts where data quality has allowed near complete linkage to community contacts sourced from the Community Services Dataset, and adult social care services sourced from the Adult Social Care Client Level Dataset. This is unpublished analysis.

Q6: What are the major workstreams that the NHS is relying on to deliver the productivity improvement targets set out in the 2024 Spring Budget and what contribution that those targets each workstream is expected to make.

Following the very significant drop in productivity during the Pandemic, there has been positive acute productivity growth in each year since 2020/21 - averaging above 2% for the last three years. Though there remains a challenge to fully recover the position, using the ONS annual assessment methodology for measuring productivity, acute productivity is estimated to have grown by 2.4% in the first seven months of 2024/25 compared to the same period in 2023/24.

While data quality makes timely measurement of productivity challenging, in non-acute sectors, including mental health, primary care and community services, internal measures show positive productivity this year.

The 2024 Spring Budget set NHS England a challenge of delivering average productivity growth of 1.9% per year between 2025/26 and 2029/30, rising to 2.0% for the final two years *subject to increased investment for technology*.

We have set up four major delivery workstreams and identified how we expect them to contribute to the required improvement. In addition, we set out specific expectations for systems and providers in this year's Planning Guidance to reduce spend on temporary staffing and support functions; to improve procurement, contract management and prescribing; and to drive improvements in operational and clinical productivity. To support delivery, bespoke data packs for each system and provider have been shared that set out the potential productivity opportunities.

Workstream 1	**Improve how clinical services are delivered**
Productivity contribution	1.0% a year

We have launched a clinical operations improvement programme as part of NHS IMPACT to spread best practice and drive up productivity.

We have published initial versions of improvement guides covering the following topics:

- improving flow through the emergency care pathway (reducing avoidable admissions and optimising admitted care)
- generating greater value for patients from theatres, elective surgery and perioperative care
- generating greater value for patients from outpatient services
- improving medical consultant job planning

These are accompanied by a data-driven improvement tool – called The Model Health System - which allows systems to identify opportunities and track improvement progress over time.

We have set up 16 Learning and Improvement Networks, which bring clinical and operational leaders together to learn from each other and share best practice. These networks are led by NHS CEOs and between them cover the whole of England. They will be used to support the consistent application of best practice, reduce variation and drive improvement initiatives.

The programme is being expanded to train up to 20,000 operational managers, to drive improvement locally. This goes beyond the commitment we made in the Elective Reform Plan to train 8,000 clinical and operational leaders in how to manage elective pathways effectively.

As part of this, we are also using the clinically led and data driven Getting It Right First Time programme to drive forward elective recovery improvement, particularly in outpatients and theatres. Put simply, this means national expert clinicians will be deployed into areas which require intense support to improve.

Our analysis shows productivity has been impacted by enhanced infection control since COVID; delayed discharges slowing hospital flow in part due to pressures on social care; and changes in our workforce mix, with more new joiners compared with experienced staff, more people choosing to work part-time and a decrease in discretionary effort. A focus on efficient clinical operations processes is necessary to tackle unwarranted local variation and equip leaders with the skills and best practice guidance they need to drive improvement.

We have already seen tangible improvements in this workstream. It has been key to driving a 2.4% improvement so far this year - more than double historic NHS productivity trends.

Workstream 2	**Maximising the value of our workforce**
Productivity contribution	additional 0.2%

In line with the ambitions set out in the Long Term Workforce Plan, the focus of this work is to improve staff retention, reduce sickness absence and eliminate reliance on agency staffing, as well as reduce reliance on bank staffing.

Significant progress has already been made in meeting our immediate goals. Agency spending has reduced by more than £1 billion in the last 18 months, with spending falling to historically low levels over 2024/25. We have also seen retention rates improve for substantive staff. The leaver rate in November 2024 was 6.8%,

compared to 7.3% in November 2023 and 9.2% in April 2022 when data was first recorded under the new LTWP methodology.

The ambition is to eliminate agency usage entirely. Next steps include tackling the use of agencies to hire entry level workers for the lowest pay bands, as well as exploring how to stop NHS staff resigning and immediately offering services back to the NHS through an agency. We are also establishing spending controls on bank usage for the first time, given the success in recruiting substantive staff over the last three years.

Workstream 3	**Moving care to the right setting and improving prevention**
Productivity contribution	0.1%

Modelling shows there should be a productivity benefit from the work to shift care out of acute hospitals into community settings. This includes redesigning care pathways and improving prevention and screening which can avoid more costly care later.

The Government has been clear about delivering a shift to prevention, facilitated through the development of neighbourhood health service models, with an immediate focus on preventing long and costly admissions to hospital and improving timely access to UEC. We have set out guidelines for systems to progress this model locally, including delivering the six core components in 2025/26: population health management, modern general practice, standardised community care, local multidisciplinary teams (MDTs), a “Home First” approach and urgent neighbourhood services.

These steps will ensure there is a consistent foundation for the neighbourhood health model in place from which the 10 Year Health Plan can build.

Workstream 4	**Enabling technology and digital transformation**
Productivity contribution	0.7%

We have invested in new tech and digital capabilities in recent years, including: the deployment of patient engagement portals to over 100 acute trusts, which has helped prevent 1.59 million missed patient appointments; the initial rollout of the Federated Data Platform, a major initiative by NHS England to revolutionise how data is used within the NHS, which has delivered an 11% decrease in waiting lists in trusts; new services such as ‘Register with a GP Surgery’ which have improved the patient experience of moving GP practice while lowering the administrative burden for GP practices; critical infrastructure such as fibre connectivity to over 5,500 sites.

The investment in the NHS App and other patient-facing services has already freed up 416,000 hours of GP time, and 99,000 hours of nursing time, in addition to 3.2 million hours of administrative time, through enabling patients to directly manage their secondary referrals and appointments.

Priorities for the coming year, as set out in Planning Guidance include:

- Use of NHS Notify, which enables providers to radically reduce the cost of communicating with patients by shifting from letters to secure App-based ‘push’ notifications. This service has also enabled our new ‘ping and book’ offer for screening for patients.
- Asking every GP practice to enable all core NHS App capabilities, including health record access, online consultations, appointment management, prescription management, online registration, and patient messaging.
- Improving the implementation of existing systems and services, such as e-Referrals and electronic prescribing. As well as emphasising these in planning guidance, we will continue to work with providers to improve delivery.

In addition, we are testing novel technology such as AI and will look to roll out successful initiatives nationally. For example, the committee will be familiar with the work at Great Ormond Street and elsewhere to pilot ambient voice technology which has the potential to radically improve both productivity and experience for patients and staff.

Additional programmes to improve productivity.

On top of these four major workstreams, NHS England is running several national programmes to drive further cash releasing efficiencies. This includes our medicine programme, working with local systems to improve medicine optimisation and encourage use of more cost-effective treatments. For example, switching from original biologic to biosimilar medicines could save the NHS £1bn over five years between 2024-29. We also have an ambitious commercial programme helping to reduce costs by purchasing goods and services centrally and supporting NHS organisations to reduce variation in corporate services.

Q7: Details and timelines for the current pilots evaluating GP telephone triage.

The GP telephone triage pilots are part of a wider programme - the Primary Care Network (PCN) Test Site Programme – which is a partnership between seven ICBs, NHS England and 22 PCNs. These PCNs collectively cover around 1 million people and represent a range of populations - urban, rural, coastal, deprived, and affluent.

The main aim of the programme is to assess the gap between demand and capacity in general practice, and to explore solutions to close any gap. The programme will use data from a range of sources to generate insights into demand for general practice services and GP telephony data, including patient call volumes, missed calls and response times.

The programme will also help to improve our understanding of the different approaches to triage, the impact of demand volumes across phone, online and walk-in, as well as the staffing models being used for triage.

The programme is currently in a baselining phase and will move into the quality improvement phases from April 2025. The programme ends in March 2027. Outputs of the programme will be shared periodically so that all systems and PCNs can learn from the work throughout the duration of the programme.

Q8: Details of the modelling that sit behind the waiting list reduction, for both the size of the waiting list and average length, or confirmation that the Department is not content for you to share that modelling.

Together with DHSC, we have modelled a trajectory towards returning to the constitutional standard of 92% of people waiting within 18 weeks for elective care from referral to treatment. The modelling is based on queueing theory and the statistical relationship between the size of the waiting list (measured by the number of cases where a patient is waiting to start treatment), the rate of activity (measured by the number of patients starting treatment over a given time period) and average waiting times. Analysis indicates the standard can be met when the total number of pathways on the waiting list is just under four million. The precise figure also depends on demand growth, expected case mix and the quality of waiting list management.

The core output of the modelling is the waiting list size. To project the waiting list size, we consider the existing number of cases where a patient is waiting to start treatment and an assumed growth rate of demand for new patients joining the waiting list. We then model the rate at which each patient pathway comes off the waiting list based on the level of funded activity, assumptions about case mix and the impact of transformation.

To reduce the size of the waiting list we need to ensure more patients come off the waiting list than go on it. The waiting list has fallen by over 140,000 over the last year and we are targeting a greater reduction in 2025/26 through: funding activity; ensuring patients receive the right care in the right setting through greater use of advice and guidance; delivering care more efficiently through transformational programmes such as surgical and diagnostic hubs and growth in the use of patient initiated follow-up pathways; and the deployment of operational best practices such

as validating the waiting list to remove pathways where the patient no longer requires treatment.

Our current plans set out a path to make progress towards meeting demand and managing the waiting list size in 2025/26 - getting to 65% RTT performance by March 2026 through both reducing the size of the waiting list and improving waiting list management.

Q9: Timescale for the appointment of a substantive Director of Transformation

Senior recruitment processes and appointments are subject to checks and approvals from Government, and the approach that will be taken has not yet been confirmed.

Q10: Can you confirm our understanding from Julian's answer to the question on the additional £10.6 billion that you do not believe this is sufficient to meet the increased cost pressure you will face this year without achieving efficiency improvements? This based on the sum of the pressure you outlined: Pay settlement (£3.8bn) ENICs (£1.6/1.7bn) non-pay inflation (£1.9bn), GP contract negotiation (£0.8bn) and basic demand growth (£3.5bn) giving a total of £11.6/11.7bn

Subject to the outcome of 2025/26 pay decisions, your summary of our assessment of the pressures facing the NHS in 2025/26 is accurate.

As NHSE's Planning Guidance sets out, NHS organisations will need to reduce costs and improve productivity by around 4% in 2025/26 to manage those cost pressures whilst delivering the ambitions we have agreed with Government.

Q11: Timescale for achieving the final 10% update of the Electronic Patient records.

We are on track to meet our current target of 96% of trusts having implemented an EPR by March 2026 with the remaining 4% (nine trusts) in the process of implementing them. Of these nine trusts, five are planning or undergoing procurement and four trusts are in the process of contracting. To support trusts most challenged with implementing their EPR, NHSE provide the following bespoke support:

- A dedicated digital partnering team that works with trusts to improve their digital maturity.
- A frontline digitisation commercial team that supports trusts' procurement activities.
- An assurance team that supports the development of business cases.

Alongside funding, NHSE provides a robust support offer to organisations to de-risk and accelerate their implementations, recognising that those still without an EPR are often the most challenged and in need of central support:

- The *What Good Looks Like (WGLL)* policy framework builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services across the whole ICS safely and securely. This is complimented by the Digital Maturity Assessment which helps trusts measure themselves in relation to the standards set out in WGLL, and to develop plans to raise their digital maturity.
- We have defined detailed standards for EPRs in the Digital Capabilities Framework to help trusts procure and deploy EPRs against a set specification.
- We work with suppliers to forecast demand and discuss strategic issues or issues affecting multiple trusts.
- We have a bespoke plan for each of the trusts currently without an EPR to support implementation.
- We are in the process of procuring a partner to provide rapid-response, specialist, “at the elbow” support to trusts to resolve challenging implementation issues, or address specialist resource shortages.

Q12: How we will evaluative the effectiveness of the NHS App and provide the key milestones in the delivery and deployment of the NHS App, including targets for functionality, roll out with providers and uptake amongst patients.

We track the targets for deployment of the NHS App closely and evaluate effectiveness in a variety of ways.

Every month, we produce a National Digital Channels report that tracks:

- The number and percentage of users logging in (10m users, logging in 41.4m times in December 2024, 20.8% of the population aged over 13 years old).
- Volumes and trends of users accessing repeat prescriptions, Secondary Care Appointment Management, Health Records, Primary Care Appointments, 111 online triages, condition pages, service finders and messages.
- The number of transactions using the Online Consultations, Be Part of Research, Vaccinations and GP Registration sections of the NHS App.
- Performance, including productivity savings, operational costs, quality of user experience and journey completion.

The National Digital Channels programme (of which the NHS App is a part) has delivered the following benefits from April to December 2024:

- 1.4m outpatient DNAs avoided as a result of making hospital appointments available via the NHS App equal to £165.3m in cost of appointments.
- 7 million fewer letters across secondary care and national services equal to £4.3m in cash releasing savings; 5 million fewer letters than in FY23/24 year to date.
- 39 million repeat prescriptions ordered online equal to 1.9 million hours saved for administrative staff at GP practices, or £16m in cost of time saved.
- 2.5 million test results related GP appointments avoided - over double the number reported in FY23/24 year to date; equal to 416,000 hours saved or £141m in cost of time saved.
- 148,000 pre-operative assessments completed online, saving 99,000 hours of nurse time equal to £1.5m.

The annex provides a summary of all key NHS App delivery milestones for FY25/26, aligned to the recent Elective Reform Plan and Operational Planning Guidance.

Q13: NHSE's position on the commitment for minimum data-sharing framework and what this looks like in practice.

The Hewitt review emphasised the importance of timely, relevant, high quality and transparent data for the success of ICSs. It recommends that NHSE, DHSC and ICSs work together to develop rules (a minimum data sharing standards framework) to be adopted by all ICSs to ensure that digital systems can "talk" to each other and make it easier for health and care organisations to share the data they hold.

We are working on creating such a framework, which is dependent on and will be supported by two main pieces of legislation:

1. **Health and Care Act 2022**: By the summer of 2025, new regulations will make it mandatory for all health and adult social care providers, including private ones, to follow certain information standards. This will help ensure that everyone is consistent and compliant.
2. **Data (Use and Access) Bill**: If this Bill is passed, it will help with the integration of data across different systems by setting standards for IT and ensuring that IT suppliers follow these standards. There will also be regulatory oversight to ensure better compliance and enforcement.

The framework will be supported through the Federated Data Platform (FDP), a major initiative by NHS England to revolutionise how data is used within the NHS, and its Information Governance Framework. The FDP is a software system that allows individual organisation's systems to "talk" to each other securely. The FDP Information Governance Framework sets out the basic rules for handling information within the FDP, ensuring a consistent and high standard of information management and transparency among Trusts and Integrated Care Boards (ICBs). This has been

published here: NHS England » Federated Data Platform: information governance framework. OPTICA is software, developed in the FDP to streamline hospital discharge planning across health and social care, and is cited in the Hewitt review as an example of good practice.

A minimum data sharing standards framework for ICSs, supported by the FDP and the legislation cited above, will help to streamline data sharing, contributing to improved care and outcomes across the NHS and adult social care systems.

Q14: What steps is NHS England taking to increase uptake of the flu vaccine amongst children and young people.

The NHS has a strong track record of delivering seasonal vaccination. In 2024/25, to date we have:

- Administered over 4 million flu vaccinations to school-aged children.
- Achieved uptake in primary school-aged children comparable to last season (54%).
- Vaccinated more secondary school-aged children this year than last (44% compared to 41%).
- Administered over 520,000 flu vaccinations to 2–3-year-olds – though uptake for this group is currently 2 percentage points below last season (42% compared to 44%).

Evidence shows that increasing uptake in children’s cohorts has the biggest impact on reducing the circulation of the flu virus. The availability of the children's flu vaccine in GP practices early in the programme enabled a quick start to the children’s programme from September 2024.

To promote uptake this year, we have undertaken data driven performance management to identify and support local areas to improve uptake in schools and the 2–3-year-old cohort. Some School Age Immunisation Service (SAIS) providers trialled expanding their offer of flu vaccination to nurseries located within schools to deliver catch-up clinics in January 2025.

We have worked closely with DHSC and UKHSA to plan and deliver the national ‘Get Winter Strong’ campaign. We sent 3.4 million national reminders to parents of 2–3year-olds, and those aged under 65 years in a clinical at-risk group, who had not come forward for their flu vaccination.

For 2025/26, we have identified the following key opportunities to go further:

- Exploring the use of other providers to expand convenience, including community pharmacy.
- Developing more targeted communications with a particular emphasis on the children's programme, including all those aged 2-3 years old; and
- Flu awareness raising for education leaders to enable further engagement with the programme to support their staff, pupils and parents.

We will also share the lessons learnt from SAIS providers on vaccinating 2–3-year-old children in school nurseries and will ensure national invites are sent to parents of 2–3-year-olds that have not been recorded as vaccinated, timed to support local call/recall systems.

For school aged children, we will work with the Department for Education (DfE) to improve data sharing between schools and SAIS providers; continue to work with local partners to develop targeted local plans for schools with low vaccination coverage; promote existing template materials to ensure consistent and clear messaging; and ensure catch-up clinics are in place where needed after Christmas, alongside the school-based programme, with a requirement for SAIS providers to promote clinics.

We will also survey SAIS providers to further understand the opportunities to use digital channels to encourage uptake in vaccination in schools; and continue to learn from the development of the manage vaccinations in schools (MAVIS) digital tool. The MAVIS tool simplifies the consent process for parents and guardians, improves efficiency of vaccination delivery by reducing administrative burden on providers, and improves the timely, granular, accurate in-year vaccination data.

Q15: How is NHS England ensuring that children's services will receive the attention and resourcing they need in the next Long Term Workforce Plan?
Q16: What specific action are you taking to secure future of the workforce for children's services?

The Government has announced the NHS Long Term Workforce Plan (LTWP) is being refreshed for Summer 2025 to align with the 10 Year Health Plan and other priorities including for Children and Young People (CYP). The refresh is expected to include Health Visitors, Community Nurses, and Registered School Nurses and the process of refreshing the plan will include wide engagement with CYP partners and experts.

Separately, NHSE has recently published new national standards for all neonatal Qualified in Specialty (QIS) education programmes in England. This provides a consistent educational standard for the knowledge, skills and behaviours needed for neonatal nurses. In response to the recommendations in the 2019 Neonatal Critical

Care Review report, NHSE has invested around £60 million to grow the neonatal workforce. This has funded 558 whole time equivalent (WTE) nurses, 98 WTE neonatal nurse quality roles, 42 WTE medical staffing roles and 175 WTE allied health professional roles.

A growing area of focus for children has been mental health support. The NHS is on track to increase the coverage of Mental Health Support Teams (MHSTs) in schools and colleges to 50% of pupils and learners in England by Spring 2025. In addition, NHSE is expanding the community mental health workforce by recruiting and training Children's Wellbeing Practitioners (CWPs), with over 1,600 trained since 2017.

Q16: NHSE has published guidance on "corridor care". Does this mean that corridor care is becoming a de facto part of the NHS's operating model? Should we expect to see hospitals using corridor care when it is not responding to winter pressures?

As our guidance on the *Principles for providing safe and good quality care in temporary escalation spaces* makes clear, caring for patients in temporary spaces is not acceptable and should never be considered as a de facto part of the NHS's operating model. These principles were developed in response to requests from NHS clinical leaders for additional guidance to support point-of-care staff to provide the safest, most effective and highest quality care possible when care in temporary spaces has been unavoidable.

A&E capacity and patient flow through hospitals have, however, both been severely impacted this winter by record levels of demand, including an increase in flu admissions and beds being taken up by patients ready for discharge. NHS staff have continued to prioritise providing the safest possible care for patients, including through expansion of same day emergency care and more care in the community to help avoid the need for hospital admission. In addition, we have continued to deliver targeted improvement support for specific trusts via the NHSE Rapid Improvement Offer (RIO). This intervention has been focused on reducing long waits and 'corridor care'.

Our emphasis remains on taking all possible measures nationally to support trusts to avoid the use of temporary escalation spaces both during winter and beyond. They are only used in extremis and when there is increased demand. In such circumstances their use enables a balance of risk across the system, for example allowing ambulance crews to handover patients in ED quickly, so they can be released to respond to further emergency calls.

We are working with providers to collect data on the use of temporary escalation spaces, to better understand variation and drive improvement.

I hope the Committee finds the information contained in this letter helpful, but if you require any further information or clarification, we would be happy to discuss this on Tuesday.

Yours sincerely,

Amanda Pritchard
Chief Executive Officer
NHS England

Annex - Summary of all key NHS App delivery milestones for FY25/26

Milestone	Announced Timeline	Milestone status
Elective Care Reform Plan: Patients at over 85% of acute trusts will be able to view appointment information via the NHS App.	March 25	Patients can view appointments from 82% of acute trusts in the NHS App; on track to deliver remaining 3%.
Elective Care Reform Plan: Build on the success of digitising appointment letters by making more types of content about patients' treatment available on the NHS App – such as discharge letters.	Dec 25	99.7% of GP practices have the functionality in place to enable documents to be shared with patients via the NHS App; further work is required to ensure all GP practices switch on access to documents including discharge letters. 42 Acute trusts have documents enabled through a patient engagement portal, which includes multiple types of documents depending on trust priorities.
Elective Care Reform Plan & OPG: We will ensure all acute and specialist acute trusts make at least 70% of all elective care appointments available for people to view and manage through the NHS App.	March 26	Currently at 49% of elective outpatient appointments in 82% of trusts being available for patients to view and manage. Initial analysis shows that adoption of core NHS App/ Wayfinder appointment management features, notifications, messaging and questionnaires reduces incomplete RTT pathways by 3 percentage points compared to trusts who do not implement the feature set.
NHS Priorities & OPG 25/26: All providers proactively offer NHS App-first communications to patients (with due regard to digital inclusion), by default through the NHS Notify service.	March 26	All GP suppliers and national programmes for example cervical and breast screening, are expected to be integrated to NHS Notify in 2025/26. Currently, 51 secondary care providers are

		connected and able to offer NHS App-first communications to patients.
NHS Priorities & OPG 25/26: All GP practices have enabled all core NHS App capabilities. These include health record access, online consultations, appointment management, prescriptions management, online registration, and patient messaging.	March 26	Functionality in place across all categories except Online Consultations. 74.4% of Practices have online consultations, with over 95% expected by April 2025. The offer varies at a GP practice level, dependent on what capability is switched on.
NHS Priorities & OPG 25/26: NHS England will develop new features to improve read and response rates for messages sent via the NHS App.	March 26	All GP suppliers and national programmes expected to be integrated in 2025/26. Secondary Care provider targets to be set
Elective Care Reform: NHS England will deliver significantly improved elective pathways by... expanded range of tests, with direct referral from primary and community care, and at least 10 straight-to-test pathways	March 26 – with connectivity through the NHS App to follow	Work underway to prioritise care settings to connect to the NHS App based on their impact on RTT (Mental Health, Community Health, Community Diagnostic Centres, Independent sector etc)
NHSE will work with patients, carers and clinicians to establish a consistent model of 'collective care' approaches, including group appointments and one-stop clinics, so that patients can benefit from this innovative practice – September 2025	Sept 25	ERS/ Wayfinder to scope and prioritise work in Q1 FY25/26