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To: ICB Chairs, Provider Chairs

CC: NHSE Board, NHSE Executive

31 March 2025

I started as Chair 3 years ago, appointed by Sajid Javid and Boris Johnson.

I had been announced at Christmas as the preferred candidate and spent significant time reading in and meeting many future colleagues to try to land as informed as possible. I was to bring an outsider view, a corporate/commercial background, experienced in Board governance in large scale private sector companies and knowledge of Whitehall, particularly HM Treasury.

I wanted to bring 3 main areas of focus namely prioritisation and therefore trade-offs, also delivery and thirdly fact base. There is so much commentary on the NHS, so many think tanks, lobby groups for individual causes, huge media interest and continuous political calls for new initiatives and also announcements. Everyone has a view, often contradictory or contextually isolated but it is NHSE, engaging with the SoS, that has to prioritise.

(There is one media trope I wanted to call out immediately which is the utterly misleading statement that the NHS counts for 44% of day-to-day Government spending. This excludes, inter alia, pensions, welfare, interest on the national debt. The government spends c£1250m per annum and the spending on health is closer to 16%…not an undue amount to spend on the health of the nation.)

So, what struck me immediately? The sheer scale of the system is little understood. That it is an ecosystem not a single organisation. Best described as a flotilla not a dreadnought. And within that ecosystem multiple layers of governance and multiple legal contracts…so hundreds of Boards (each with their own legal and fiduciary responsibilities) and thousands of primary practices, private sector suppliers and local authority mutual dependence. A financial system which allocates from NHSE down through the system and which cannot, by law, run at a deficit. So, underperformance in parts of the system need to be compensated elsewhere. There is no sword that cuts the Gordian knot of complexity. There is no silver bullet. Even the 3 shifts underpinning the oncoming 10-year health plan are not new and the real question is what and when it is decided should be done first, to be prioritised and resourced, under each shift. But let me return to the 10-year health plan later.

My view was that we needed to focus on making decisions, working with the system, in pursuit of steady managerial operational improvement. This required us to

concentrate resources (financial and management) on particular priorities because trying to do too much, to meet all the often-passionate siren voices, would be like throwing confetti onto the path. We would not make progress. So, the agenda became one of resourcing immediate system pressures balanced by a small number of “enabling priorities” for the longer term.

What then was the role of NHSE, and particularly as I came into this role in 2022? In essence it is a breakwater between the political world, which works to different timescales and different measures of success, and the health system. So often invisible to the system was the constant ask for new ideas, for announceable initiatives, on a weekly basis. The executive team of NHSE spent much of its time engaged with this. And yet there was also a hard negotiated mandate between NHSE and DHSC, with agreed main priorities, supported by an equally hard negotiated agreement with HM Treasury, the Cabinet Office and very often No 10. So, as well as maintaining broad service what would the political leadership want to see prioritised?

This was made more difficult by 6 different Secretaries of State (each time causing a complete change in the whole DHSC ministerial line up) and 4 Prime Ministers in my 3 years. And if there is one department where ministers arrive with real mission to make a difference, passionately held, it is health.

Key to the performance of the NHS is cross system working. Often a glib statement but in this case, with 230 Trusts, 550 hospitals, 7 regions, 42 ICB’s, 6400 primary care practices (predominantly small private businesses with whom the relationship was an annual, often contested, contract negotiation), community pharmacy, dentistry and many other constituencies. So, what were we facing in early 2022?

1. The Pandemic had provided a massive multifaceted shock to the system and to societal health and societal attitudes. So, recovery back to more normal broad operation was key. At the same time the direct consequences to the lengthened waiting list, up at near 8m and projected to reach possibly as high as 13m if we didn’t act and also new surges in demand, particularly mental health amongst the younger population.

2. A new structure, introducing ICBs as vehicles to get the NHS closer to its local communities and the profile of local need and closer working with our partners, local authorities and the voluntary sector. So, the ICB’s, with separately established Boards, and responsibilities and their close partners, ICPs, were born in July of 2022. Created and supported around a principle of “earned autonomy” they are an important structure to bridge between central direction and local relevant need. In almost 3 years they have emerged generally strongly, albeit the current financial pressures going into 25/26 are very challenging and will require difficult service choices. That said they have now been delegated significant specialised commissioning, in addition to broad commissioning, responsibilities as NHS England has given more direct control to them. Currently however, there are 19 of the 42 receiving direct financial guidance and support. The latest and surprising announced 50%

expense reduction requirement poses a massive challenge to the ICBs, presaging possibly fundamental changes in their roles.

3. On my arrival we faced the huge task of merging HEE and NHS Digital with NHS England. This was largely executed over an 18-month period, resulting in a headcount reduction from 24,000 initially to c15,000, an initial reduction of c35%, and since further reduced to just over 13,000. This was the largest public sector single transformation or headcount reduction ever. It served to de-bureaucratise the centre, to enable the delegation to ICB's and to redirect £500m of savings from the centre to the system. In order to maintain statutorily required governance continuity over the agendas and objectives of the antecedent organisations NHSE set up subsidiary Board sub committees and invited 3 of the NEDs of each of HEE and NHS Digital to join as associate NEDs. This has been a very secure transition. The reduction in headcount has continued so today NHSE has 13,200 staff in post. Again, the recent announcement of a further 50% headcount reduction at the centre will require fact-based execution. Not only does NHSE now oversee all initial and continuous medical and health training, but it also runs live systems – so 270 live systems linking 26,000 organisations and 44,000 IT systems across the health service.

4. The NHSE Board faced a number of timed out departures of its NEDs so we have refreshed the Board over the last 3 years with 7 excellent new colleagues in 2 separate recruitment rounds (albeit each of which frustratingly took 10 months from start to finish). We also operated with 2 Deputy Chairs who carried a heightened governance burden in support of the Chair. The Board operates through 5 formal committees, plus 2 specific committees on Genomics Medicine and on the New Hospital Programme as well as a CFO advisory group given the financial pressures.

5. Planning for winter was a major area of focus, and such planning has been commenced ever earlier in each year to ensure we can establish with government the necessary resource, and to prioritise and signal interventions across the system. This saw a range of engagements from earlier vaccination, to priorities within UEC such as an elderly falls service and a Cat 2B designation, a directed Better Care Fund, the roll out and funding of 5,000 additional beds, targeted support to particular Local Authorities to support the acquisition of care beds and the active management of acute beds creating capacity for the post-Christmas and first half of January surge.

6. Managing the financial outcome has received very strong focus. Recovering from the latitude of the pandemic approach has been an important ingredient. This has required strong NHSE engagement, directly Board to Board, a focus on bank, agency and headcount management and some very difficult priority

decisions over what to invest in. The under investment in capital over the past decade or more has added to the pressure and the technology budget has remained both too small for the long-term ambition but also subject to raiding through the year. And yet the money has been managed with a precision not seen in the private sector but driven by the legal obligation of no deficit. The task was made much more difficult by long periods of industrial action and also bouts of steepling inflation. The recent injection of c£22bn over 2 years in the last budget was hugely welcome albeit it is not available as true investment in that it is more than absorbed by pay and non-pay inflation, increased medicine prices and employer national insurance.

7. Productivity has been central to the thinking. Albeit the current basis of measurement and definitions are only a partial picture, with much of the recent redirected service such as virtual wards, much of primary care and some diagnostic activity not captured, we are seeing improvement in each of the past 2 years. The recent ONS analysis supported our view that in 22/23 NHS productivity ran at 2%, recovering from the wild swings from the pandemic period and this latest year 24/25 has seen a 2.7% improvement in acute productivity. We have also made cost savings of £7bn in 23/24 and over £9bn in 24/25.

The patient has always been the primary concern and is at the centre of our obligation. Yet the service has been under severe pressure, both in its insufficient physical, diagnostic or workforce capacity, the pressure on its social care partners, the availability of the independent sector at an affordable price and in fast rising areas of demand. Patient safety and quality of care are fundamental. However, when we get things wrong often the government launches a new inquiry. The result of this longitudinal approach to inquiries has been a pile up of multiple demands on areas of the service, often contradictory or requiring different bases of measurement or definitions. The landscape needs urgent rationalisation but without taking away resources. There are simply too many sources of recommendations or agencies active in the space.

In my first year, we produced the first ever long-term workforce plan in the 75-year history of the NHS. This, with huge support from the Secretary of State and the Health Select Committee Chair, is a seminal piece of work. Training our brilliant medics is a long-term endeavour and we need to model what the workforce needs to look like 10-15 years out, reflecting our belief in technological change, new treatments, a different NHS structure of provision and changes to the skills required e.g. genomics.

We also produced a long-term infrastructure plan. So, a capital plan which whilst not published has been shared with DHSC and HM Treasury and is a bottoms up build of the current picture. It is a base document for the relevant enabling group in the 10-year health plan.

When I have spoken publicly about the NHS I have often talked to 4 main themes:

1. Demand;
2. Capacity;
3. Absolute Record Levels of Provision; and,
4. Innovation.

I also draw out the dependence we have across our structural boundary into social care.

Demand: We know that the population has grown by c15% since 2000, is older, therefore with co-morbidities, and is sicker. Obesity causes muscular skeletal issues (and 28% of the adult population is obese), diabetes 2, cardiovascular issues, triggers at least 13 cancers and gives rise to mental health concerns. We have opened our 30th centre for severely obese children. We are seeing surging levels of demand for our mental health provision. We are seeing fast rising cancers and in an ever-younger population. Many of the causes are outside of our control and are caused primarily by non-health issues…poor housing, deprivation, alcohol, lightly regulated gambling, air quality, ultra processed foods, fats and sugars, social media; particularly in our young people.

There is so much that could be done over the medium term if we better recognised these causes and if government and society were willing to regulate in some areas and provide directed resource in others. In the meantime, the NHS deals with whoever and whatever comes through those gates! The health inequalities agenda is so important but also needs to recognise the material primary cause of inequality which is deprivation. This has been worsened by the cost-of-living pressures so evident across much of our society. The NHS has many specific interventions into communities facing inequality, including proactive community outreach and specifically targeted treatments.

Additionally, adding to demand, our brilliant medical scientists and researchers find ever new ways that our health can go wrong and new treatments.

Capacity: When I started it was the capacity issue that most shocked me. One third the beds of Germany, half the beds of much of Europe, scaled to population. In 2003 we had 144,000 G&A beds in our acute hospitals. In 2010 this had fallen to 122,000 and today is 98,000. And in the same period the population has grown by 15%, is older, sicker, more obese and we have found many more ways the body (and mind) can go wrong and developed more and new treatments for this. Less than half the average diagnostic capacity (MRI, CT, Echo) than the OECD. A very poor physical estate with over £13bn of backlog maintenance, of which over £5bn is critical safety and where we see a continuous interruption of service as the estate fails. And workforce shortages of more than 100,000 and an over reliance on international recruitment. So, we have a strategic supply chain weakness as many other countries are now recruiting internationally from the same pool of countries.

Absolute Record Levels of Provision: I prefer an alternative narrative to the “NHS is broken” which is that we are at times being “overwhelmed”. This is still a major problem, but it is much more reflective of what is going on. So last year 380m primary care appointments up from 320m in 2019. More than the equivalent of 1 in 7

of the population has an appointment every week, half of which are on the same day as requested and 70% of which are physical. We should pay a huge tribute to our GPs and primary care colleagues for the brilliant and fundamentally vital role they play.

3.2m cancer checks and referrals up from 1.3m only 10 years ago. Over 18m elective procedures carried out, around 1.6m per month, compared with 1.3m 7 or 8 years ago, and in doing that holding the waiting lists flat whilst reducing massively the long waiters. And this in a time of industrial action disruption which resulted in the cancellation or rescheduling of c1.5m appointments and without which we should make good head roads. There is a natural waiting list of c3.5m if we were meeting our constitutional standards given population size and that not every follow up can be immediate!

In diagnostics through most of 2024 the NHS provided 20% more tests than pre-pandemic so nearly 2.5m every month. In A&E 9% more attendances than a year before and at record levels. The same 9% and record levels is also true last year for ambulance call outs.

So absolute record levels of delivery but into fast rising demand!

Much of this was brilliantly captured by Lord Darzi in his report. He was well placed to produce the narrative having been a member of the NHSE Board for a number of years before 2022. The strength of his report was not that it contained any surprises to those of us working in the NHS but that it produced in one place all the issues, cogently captured, including the increasing demand from a sicker society into a system sorely underinvested.

Innovation: The feature that gets lost, in being covered in myriad stories yet not as a continuous theme, is just how innovative the NHS is. Amanda Pritchard has a phrase that captures the continuous evolution of the NHS, “We are no longer the NHS of the iron lung”. Every 5 years or so if you look at the NHS you see that it has evolved again in its offered treatments. It was the first to offer hip replacements, CT scans, combined heart and lung transplants, an IVF baby. And to reflect on some of the more recent innovations: robotic surgery, nanorobotics capable of individual cell repair, AI applied in dermatology, histology, in brain scans, in breast and other screening, cytosponges, liquid biopsies, MRNA Technology and CarT, the cancer vaccine platform. And in the world of Genomics, where we think that in 10 years’ time over 50% of health provision will involve genetic testing or genomics-based treatments and last year we provided over 800,00 whole genome or panel or single gene tests, scanning for 200 cancers and over 7000 rare diseases. And we have completed the 100,000 whole genome test programmes, have launched the newborn genomics programme and are building a national genomics research library, available to researchers. Genomics has the potential to be truly revolutionary.

And the innovation in technology across the NHS with the NHS App, Federated Data Platform (FDP), EPR across primary and secondary, ambient documentation, online consultation in primary care and digital telephony. The world of the NHS, whilst still bedevilled by too many legacy systems, too much paper-based processes, is advancing its technology capability in its interaction with patients. It could do so

much more if technology received adequate consistent funding support but for many years this has not been even close to what is required.

So, turning to **Delivery**.

The last 3 years under Amanda's leadership has seen a remarkable level of delivery. This has been achieved through prioritisation, early engagement on resourcing and then strong cross system driven working. It has involved continuous debate with ministers to persuade them as far as possible to a limited number of priorities and for sufficient time to invest and execute them before adding another initiative.

We have seen, inter alia, CDC's doubled from 89 to 180 in the last two years; SDECs open now in 88% of Type 1 hospitals open 12 hours each day 7 days each week; urgent treatment centres rolled out; rapid response vehicles; Cat 2B categorisation within the ambulance service for elderly falls; 30 centres opened for severely obese children; 15 gambling addiction centres opened; 12,700 virtual wards providing step up and step down treatment within the community pressure on our acute beds.

In winter planning we have engaged earlier each year and pursued very targeted interventions, working across local communities and with local authorities to manage the problem of our bed base being overwhelmed.

We have seen steady operational improvement in nearly all our constitutional measures, with each year improving on the preceding one.

In technology and in spite of wholly inadequate budgets we successfully absorbed NHS Digital and initiated the foundational work on target architecture and on 'engineering principles' to be rolled across the whole system. We turbo charged the revolutionary NHS App; awarded the FDP through an intense procurement to Palantir and we are seeing real benefits (71 trusts have now signed up for various FDP programmes, rising to 100 this coming summer); rolled out digital telephony across 99% of GP practices to help ease the 8am rush; EPRs now exist in over 90% of trusts and close to 100% of primary care. These now need to be engineered for interoperability, but the foundations have been built; ambient documentation is in increasing use and as it gets taken up we will see huge savings in clinician time; AI is widely deployed across screening and scans, in cancer screening in dermatology, in histology, pathology, ophthalmology.

In medical advances we have seen success in liquid biopsies, in new cancer vaccinations; in genomics where we have made remarkable progress. We have introduced a range of new drugs, including recently the obesity drugs.

We have engaged increasingly with the independent sector, now partnering with them for c8% of health interventions. But we need to partner where they are interested because there are huge areas of the health service where the independent sector has no appetite to engage, given the lack of return they would get for the required investment plus the inability to shape the patient/customer demand.

But in each of the areas of primary access, of UEC, of electives, of cancer referrals and checks we have seen a steady improvement.

And we have enabled the birth of the ICB's, delegating increasingly to them for instance broad commissioning and areas of specialised commissioning. This has been an intensive engagement often involving Board to Board meetings both on operational as well as financial performance.

In mental health we have increased our Board focus, particularly on ADHD and autism, and protected the important mental health investment protocol.

We have engaged with the many partners across patient safety and advocated strongly for the review now being carried out by Penny Dash to simplify the patient safety ecosystem. The roll out of Martha's Rule is but one example of new improved processes in reaction to salutary external findings and lobby.

And perhaps most importantly we have established hugely valuable pilots testing a new model of primary care and separately a new approach to frail and elderly patients. This latter initiative whilst perhaps not the most important element of what the NHS might look like in the tenth year of a ten-year plan, is absolutely the essential first enabling step. It will reduce the often overwhelming pressure (in part through focus on avoidable admissions, and on geriatricians working more in the community and on virtual wards) at the heart of the system, enabling flexibility in redirecting our most expensive financial flows, securing better outcomes for patients and recognising and addressing the single most demanding pressure on our capacity to provide service.

Partnership working has been intense whether with the medical royal colleges, with patient safety agencies, with the NAO, with NHS Assembly or Providers or Confed or the Think Tanks or the very many single-issue health charities or the other health ALBs (NICE, MHRA, UKHSA etc) or with the Race and Health Observatory and so many others.

Importantly all this has been delivered whilst managing the money. So, in each of the past years and with a system recovering from the pandemic, the legal obligation to balance the books has been achieved. And going into this next year 25/26 there is now a balanced picture, signed up to by close to all systems. We know signing up to a plan is not the same as delivering it, but it is the essential initial step. That said the productivity targets and the cash cost outcome required of the NHS in 25/26 by HMG will undoubtedly be very tough to deliver and will take strong control and focus. And there are a handful of systems where the initial plans lack credibility, and which will need to be placed in special turnaround measures immediately.

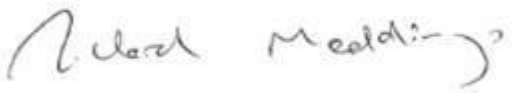
The area of perhaps most frustration has been dentistry. Here we do not even spend the allocated budget of circa £3.2bn. The contract is overly complex, it is based on weighted averages of units of dental activity which serve to mask the actual capacity being deployed and the detail of the range of services provided. Governments have continued to seek to negotiate the complex contract but shifts in tariffs simply incentivise dentists to price differently to their private patients. It will only be fixed if we address the supply problem of insufficient available dental capacity. In LTWP we

argued for tie ins of newly trained dentists, in exchange for amortisation of student debt, thereby creating a workforce wholly available for NHS work for a perhaps a 5-year period. Without addressing the capacity supply problem the issue of NHS dentistry will not be fixed.

So, it has been a remarkable 3 years of delivery and of steady operational improvement. Absolute record levels of health care being provided today from an underinvested capacity and facing fast rising new demand. Solving this cannot be done by the NHS alone but we need to see cross boundary working with a much better invested and run social care system, and a more interventionist government on the broader causes of ill health.

Let me finish by offering my thanks to all of you for your support to me, your counsel and your friendship and your commitment. And not only to you as the Chairs, but all the Boards, the executives and to the brilliant and committed front line staff and support staff who are today providing record levels of healthcare to the population. Keeping patients at the centre of focus. Staying true, in spite of the pressures, to the foundational principles of the NHS. The NHS, free at the point of delivery accessible to all remains the foundation of the caring and fair society we want to see.

Thank you.



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