House of Commons

Committee of Public Accounts

NHS financial sustainability

Fifth Report of Session 2024–25

HC 350

Committee of Public Accounts

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Summary

The NHS must be put on a financially sustainable footing if it is to deal with the multiple challenges it currently faces. These include an ageing population, increasing delays for ambulances and emergency treatment, and growing waiting lists for operations, all of which have led to public satisfaction levels with the NHS reaching all-time lows, and Lord Darzi in his recent wide-ranging review of the NHS concluding that it was in serious trouble. But the NHS's financial position continues to worsen, with local NHS systems overspending by some £1.4 billion in 2023–24, more than double the previous year, due to rising demand, failure to invest in the estate, inflation, and workforce issues.

Given the extent of these challenges, both the Department of Health and Social Care (DHSC) and NHS England (NHSE) seem complacent regarding the NHS's finances. NHSE is also relying on the extremely optimistic assumption that it will achieve unprecedented productivity improvements of 2% each year by 2028–29, as part of the NHS's recovery.

Both DHSC and NHSE tend to blame the NHS's poor financial position on exceptional external factors, such as the Covid pandemic, inflation and industrial action. While these undoubtedly have played their part, there are also well-known issues that are within officials' control. For example, DHSC and NHSE have repeatedly failed to provide information about budgets in good time to local NHS systems and indeed in some cases not until months after the start of the financial year. This disregard for basic principles of sound financial planning is hampering NHS systems' ability to deliver services for their local areas.

The new government sees health as one of its key missions and will present a 10-year plan for the NHS in the first half of 2025. It has set out three big shifts that it wants to see: from hospital to community-based care; from analogue to digital; and from treating ill health to its prevention. These transformations are essential to the NHS's recovery and future sustainability but saying them is not the same as achieving them. We are concerned about the lack of fresh thinking and decisive action we heard from DHSC and NHSE. The scale of government's ambitions is great, but senior officials do not seem to have ideas, or the drive, to match the level of change required, despite this being precisely the moment where such thinking is vital.

Introduction

The Department of Health and Social Care (DHSC) has overall responsibility for healthcare services in England, and for their financial management and sustainability. NHS England (NHSE) receives funding from DHSC to deliver health services and passes most of this funding to Integrated Care Boards (ICBs) which, in turn, plan and commission services from local NHS providers such as hospital trusts and GPs. In line with the NAO report and NHS terminology, we refer to Integrated Care Boards (ICBs) together with their constituent providers as 'NHS systems'.

In 2022–23, the 42 NHS systems in England overspent by a combined total of £621 million. In 2023–24, their aggregated year-end deficit had more than doubled to £1.4 billion. This was despite the government providing £4.5 billion of additional funding during 2023–24 and NHSE underspending by £1.7 billion against its central budgets to offset deficits.

Conclusions and recommendations

1. **Integrated Care Boards' capacity to carry out thorough and timely financial planning is severely hampered by delays in NHSE issuing planning instructions and approving final budgets.** To budget effectively, ICBs need early sight of guidance and certainty about how much money they will have. In 2022–23 and 2023–24, NHSE did not approve ICBs' financial plans until June and May respectively, months after the financial year had begun. For 2024–25, planning guidance about how much funding would be available to ICBs was not released by NHSE until a week before the start of the financial year, due to delays in agreeing priorities and a final budget with DHSC and wider government. NHS bodies and local authorities must work together to deliver a joint strategy, but it is difficult to see how this can be done effectively when local authorities receive their finance settlements by February and their local NHS colleagues' budgets are approved so much later. This Committee has previously expressed concern about late local authority settlements limiting time to plan, but the timetable for their NHS colleagues is even worse. DHSC and NHSE justify slippages in issuing guidance and approving budgets with reference to the amounts of funding involved and external factors, such as high inflation. However, we are not persuaded these are sufficient reason for disregarding fundamental principles of meaningful and timely financial planning.

RECOMMENDATION
DHSC, NHSE and HMT should publicly commit to issue guidance and meaningful indicative budgets to systems no later than Christmas in future, and NHSE should approve ICB final budgets at least a month before the start of each financial year.

2. **Despite having last published a plan in January 2019, and the major disruption caused by Covid to the NHS since, DHSC and NHSE are yet to recognise the scale of transformation needed to make the NHS financially sustainable. The Government's desire to publish a new 10-year plan is a golden opportunity to take significant decisions for the longer-term benefit of the nation's health and the sustainability of the NHS. Yet there seems a lack of readiness amongst senior health officials to take the radical steps needed.** DHSC's and NHSE's approach

to NHS finances is typified by short-termism. NHSE needed £4.5 billion in extra funding from the government in 2023–24 to deal with issues such as staff pay and industrial action. DHSC has continued to prop up day-to-day spending by raiding precious capital budgets, reallocating £0.9 billion in 2023–24. We welcome the fact that new HM Treasury rules mean it will no longer be able to do this in future. There is a confidence among the NHS's senior leadership that in the event of a significant challenge, such as another pandemic, government would provide all the extra funding the NHS needed. It appears that no one at the top of DHSC and NHSE has been preparing the NHS for the future for example by putting together a revised strategy or plans as part of the recovery following the pandemic when it was clear that the Long Term Plan 2019 was no longer valid. The Government's aims to shift towards prevention, community and digital are not new, with previous plans and strategies having similar objectives but often failing to deliver as intended. Officials acknowledged that these changes are difficult and should take place only slowly, over the long term, and not at the expense of patients now. Even as they write the new 10-year plan for the NHS, DHSC and NHSE have not convinced us that they are ready to give the three big shifts desired by government the priority they need. This left the impression that there was no real urgent motivation and readiness to drive the change in the NHS that is needed. The DHSC and NHSE have become addicted to moving money from capital to revenue to cover day-to-day pressures. It is welcome that this behaviour will no longer be possible in future, thanks to a change in Treasury regulations.

RECOMMENDATION

a. As they develop the ten-year plan, DHSC and NHSE must take a more planned and disciplined approach to ensuring that enough funding is allocated to those activities that can make the NHS fit for the future, particularly preventing ill health, community healthcare, and digital technology. They should measure, track and report what they spend in these areas, and what they are achieving, so Parliament and the public can assess progress over time, and should take actions to strengthen longer-term strategic financial planning.

b. The Department and NHS England should not look for loopholes to get round the new regulations and instead should prepare for how it will manage its finances properly without access to the safety valve of moving money from capital to revenue.

3. **NHSE displays a remarkable complacency about the realisation of future NHS productivity improvements, which, if achieved, would be unprecedented.** According to official ONS measures, long-term productivity gains in the NHS averaged 0.6% a year over the period 1996–97 to 2018–19. But productivity subsequently fell and has yet to recover fully. The NHS has 19% more staff compared to before the pandemic but is only seeing 14% more patients. Workforce issues such as sickness and absence continue to impact productivity. NHSE is confident that the annual productivity gains that it has committed to of 2.0% by 2028–29 can be achieved because it contends the last two years have been affected by ongoing disruptions such as industrial action, and that further recovery is still possible, particularly through technology-enabled change. However, NHSE was unable to convince us that it has a detailed plan to achieve the promised productivity gains, and it does not yet fully measure and capture productivity in important areas, such as mental health and community services.

RECOMMENDATION

NHSE should set out in detail which specific actions and initiatives it expects to contribute to the unprecedented increase in productivity it has committed to, and by how much. This should include specific measures to address poor staff retention and sickness rates, which contribute to low productivity.

4. **In some cases, NHSE's payment mechanisms can mean that local systems do not receive financial recognition when they prioritise hard-to-reach patients.** GP surgeries receive a payment for every child vaccination. This vaccination funding mechanism favours areas where parents are more willing to inoculate their children, while areas with higher levels of vaccine hesitancy, which may be more deprived areas, receive less funding and therefore have fewer resources to carry out much-needed activities such as outreach and education, potentially leading to even fewer patients being vaccinated in those areas. NHS Providers notes that tackling wider determinants of health must involve the specific targeting of poor health in the most deprived areas.

RECOMMENDATION

NHSE should review current payment systems and processes to ensure they incentivise local systems to work with those most in need of help.

5. **Given the constraints on public spending, it is highly likely that re-focusing attention from sickness to prevention cannot be achieved without re-allocating existing NHS funds in the same direction.** Senior ICB leaders report a continued lack of progress with the government's long-standing aim to move towards preventing ill health rather than

treating it. Furthermore, the public health grant used by local authorities to commission preventative measures such as health-visiting and drug and alcohol services is expected to fall in value by £193 million (5%) over the period 2022–23 to 2024–25 (at 2022–23 prices), despite government's commitment in 2021 to maintain it in real terms. However, DHSC does not view providing more resources for prevention as a substantive part of the solution. Instead, it considers that a shift towards prevention might be achieved through longer-term legislative and culture change to tackle issues such as obesity, physical activity and poor air quality alongside a shift in the way GPs advise patients. Both DHSC and NHSE see the 10-year health plan as an opportunity to crystallise their prevention ambitions, but the lack of a precise definition of what even counts as prevention spending will make assessing progress against this vital policy aim impossible. Local areas would value more flexibility about where they can direct their resources to achieve greatest impact, including how they fund measures to prevent ill health.

RECOMMENDATION

a. DHSC, NHSE and HMT should define what counts as health prevention spending for the whole of government within the next six months, and track that spending annually, using 2024–25 as a baseline year.

b. DHSC and NHSE should set out the funding increases required for prevention and give local systems the flexibility and autonomy they need to direct this funding where it can have the greatest impact.

6. **NHSE's long-held ambition to move more care from hospitals to the community has stalled.** There would have been more investment and progress in mental health and community services, particularly GP surgeries and dental services, in 2023–24 had NHSE not redirected funding to prop up the day-to-day spending of local NHS systems. Despite carrying out 15% more elective activity compared to before the pandemic, the NHS is less productive overall once the activities of mental health trusts, community trusts and GPs are considered. NHSE makes trade-offs between spending that will yield benefits in the longer term and spending to meet current priorities, and it acknowledges funding increases for mental health and community services are slow. NHSE recognises there is value in considering whether best use is currently being made of funding for Continuing Healthcare assessments and the Better Care Fund, intended to support joint working between the NHS and social care.

RECOMMENDATION
NHSE should ensure that, year on year, a greater proportion of its funding is spent in the community, in line with its own policy ambition. Any review of Continuing Healthcare funding and the Better Care Fund, DHSC and NHSE should not make changes that will see these community-based funds redirected to hospitals.

7. **Despite ambitions to improve productivity through the introduction of new technologies, the switch to digital in parts of the NHS has been glacially slow.** Digital and technological improvements could have a transformative effect on the NHS. However, NHSE's investment in technology over the period 2022–23 to 2024–25 stalled because funding was redirected to mitigate ICBs' spending deficits. For example, a number of NHS trusts continue to rely on outdated IT equipment such as fax machines. The NHS currently lacks a consistent data infrastructure across its entirety and NHS providers vary in terms of technological maturity. NHS providers are often still too reliant on paper records but NHSE says it has a programme to address this over the next 18 months. NHS providers that have implemented electronic patient records have productivity levels that are 13% higher than those without them.

RECOMMENDATION
Alongside its Treasury Minute response, NHSE should write back to the committee setting out its plans to reduce the reliance of NHS providers on paper within 18 months, including key milestones, and the proportion of NHS institutions it expects to be paperless at each milestone. A specific deadline should be set to end the use of fax machines within the NHS.

1 Funding and productivity

Introduction

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health and Social Care (DHSC), NHS England (NHSE), and HM Treasury (HMT) on the financial management and financial sustainability of the NHS in England.[1]

2. We also received and considered a number of written submissions from various stakeholders involved with health and care in England.[2] These submissions raised several common concerns including: continually rising levels of demand for NHS services;[3] the need for sustained capital investment in the NHS;[4] and short-termism in the health and care system undermining the potential for longer-term change.[5]

3. DHSC has overall responsibility for health and care in England. NHSE receives funding from DHSC to deliver health services and passes most of this to Integrated Care Boards (ICBs) within each of the 42 Integrated Care Systems (ICSs) in England. ICBs, in turn, plan and commission services from local NHS providers, such as hospital trusts and GPs. NHSE retains responsibility for commissioning and funding some specialised services nationally.[6]

4. DHSC is charged with ensuring that health spending, including that of NHSE, ICBs and other arm's-length bodies, is within the overall budget authorised by Parliament. NHSE must achieve a balanced budget, meaning it should not spend more than DHSC provides. ICBs agree annual financial, capital and operational plans with NHSE on behalf of their wider ICS, and they must ensure their spending plans do not exceed the total available funding provided by NHSE. Each body also has responsibility for ensuring spending is efficient and effective.[7]

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1 C&AG's Report, NHS Financial Management and Sustainability, Session 2024–25, HC 124, 3 July 202

2 NHS financial sustainability - Written evidence - Committees - UK Parliament

3 NFS0003, NFS0005, NFS0006, NFS0007, NFS0008, NFS0011, NFS0012, NFS0013, NFS0015

4 NFS0003, NFS0005, NFS0012, NFS0013, NFS0015

5 NFS0005, NFS0012, NFS0013

6 C&AG's Report, paras 1.2 and 2.2 and Figure 1

7 C&AG's Report, paras 1 and 1.2

5. In 2022–23, the 42 NHS systems overspent by £621 million. In 2023–24, their aggregated year-end deficit had more than doubled to £1.4 billion. This was despite the government providing £4.5 billion of additional funding during 2023–24 and NHSE underspending by £1.7 billion against its central budgets to offset deficits.[8]

Timely financial planning and approval of budgets

6. In 2022–23 and 2023–24, the financial plans of ICBs were not approved by NHSE until June and May respectively, months after each financial year had begun. In addition, planning guidance for ICBs for 2024–25, which sets out the financial and operational objectives they had to fulfil, was not released by NHSE until a week before the start of the financial year, due to delays with NHSE agreeing priorities and a final budget with DHSC and wider government.[9]

7. We asked NHSE and DHSC why there had been such a lack of timeliness with agreeing priorities and a final budget in recent years. NHSE explained that, while it likes to give as much time as possible for detailed planning to take place, it could not do this unilaterally as it depended on agreement between itself, DHSC and HM Treasury on the scale of total funding and priorities for its use. Both DHSC and NHSE pointed out that, given the large amounts of public money involved, it was important there were checks and challenge as part of that process.[10]

8. DHSC also noted that 2024–25 had been especially complicated due to 'external shocks' and, in particular, very high rates of inflation which made budget-setting very unpredictable.[11] It accepted that it was preferable to give longer for local systems to plan their budgets, but said there was a trade-off between how early this took place and the extent to which guidance reflected an up-to-date picture of the wider fiscal and economic environment.[12] It felt that to provide budget figures and guidance earlier in the face of significant externalities would do more harm than good because they would be based on unrealistic numbers.[13]

9. We asked how local authorities and NHS bodies could be expected to work together and deliver a joint strategy when local authorities receive provisional budgets in December, and final ones by February, but NHS

8 C&AG's Report, paras 1.6 and 1.8
9 C&AG's Report, para 2.9
10 Q 57
11 Q 57
12 Q 59
13 Qq 65, 68

colleagues receive their budgets months later.[14] DHSC said it would ideally provide NHS bodies with budget certainty before Christmas each year, but this might not necessarily be exactly the same day as local authority settlements.[15] However, it reiterated that, in the event of big external shocks, a judgement call would still be needed about whether these figures would be realistic and therefore helpful.[16]

Short-term funding decisions

10. NHSE received significant extra funding from the government during the course of 2023–24. This included £2.8 billion to support new pay deals for staff, and £1.7 billion to mitigate the impact of industrial action. Despite this extra money, NHS systems still finished the year with an aggregated £1.4 billion deficit, which was double the £720 million deficit in the plans NHSE agreed with them early in the year.[17]

11. Resilience to shocks is a key element of financial sustainability. We asked how well the NHS would cope financially in the event of another pandemic. NHSE expressed confidence that in the event of another pandemic government would provide any additional funding the NHS needed, as it had done during the previous pandemic. NHSE acknowledged that this had only been possible in 2020 through the suspension of some normal financial rules. It said that, with similar financial arrangements in place, it would not be worried about money in the event of another pandemic and would be more concerned about the resilience and capacity of the NHS workforce to respond to the challenge.[18]

12. Demand for capital in the NHS continues to outstrip supply and the UK lags behind other OECD countries in terms of capital investment in its health system. DHSC has maintained its recent track record of not fully investing the capital funds HMT allocates it and instead reallocating large amounts for day-to-day revenue spending. It transferred £0.4 billion from capital to revenue in 2022–23, £0.9 billion in 2023–24, and it told us that a similar amount of £0.9 billion would be switched during the current 2024–25 financial year.[19] However, DHSC provided assurances that there would be no further transfers of capital to resource funding because the Chancellor has introduced new fiscal rules to prevent this from happening.[20]

14 Q 74, [Final local government finance settlement: England, 2024 to 2025 - GOV.UK]
15 Q 75
16 Q76
17 C&AG's Report, para 1.8
18 Q 7
19 Q 18; C&AG's Report, paras 4.21 and 4.23
20 Q 17

13. DHSC and NHSE told us that they were fully supportive of the new government's aims to shift healthcare spending from treatment towards prevention, from hospitals to the community, and from analogue to digital. However, DHSC contended that these shifts would be hard to do and should take place only over the long term and not at the expense of today's patients.[21] The DHSC also emphasised that a shift towards prevention might be achieved through longer-term legislative and culture change such as the Tobacco and Vaping Bill. DHSC and NHSE acknowledged that the 10-year plan for the NHS was a timely opportunity to set out how the three big shifts would happen, including in terms of changing the balance of spending and investment over time. However, DHSC told us it still intended to prioritise resources on current pressures such as acute services in hospitals. It suggested that if money were needed for something urgent in A&E then that would inevitably be where it would be spent.[22]

Increasing productivity

14. According to official ONS measures, long-term productivity gains in the NHS averaged 0.6% a year over the period 1996–97 to 2018–19. But productivity subsequently fell, both before and during the pandemic, and has yet to recover fully. In March 2024, the government announced that the NHS would receive £3.4 billion of capital investment for digital improvements between 2025–26 and 2027–28. As part of these plans, NHSE committed to achieving ambitious average productivity improvements of 2.0% per year through to 2029–30. NHSE's modelling for the 2023 *NHS Long Term Workforce Plan* similarly assumes NHS workforce productivity will improve by 1.5% to 2% per year up to 2036–37, again far higher than the long-term average.[23]

15. We asked witnesses why NHS productivity continues to be lower than before the pandemic. NHSE told us the NHS currently has 19% more staff compared to before the pandemic but is only seeing 14% more patients. It named several factors as contributing to the ongoing difference.[24] NHSE highlighted that the population is getting older with more complex and acute health needs, meaning length of stay in hospitals are becoming longer, and increased post-pandemic infection control which limits efficiency. NHSE also noted the impact on productivity of workforce sickness levels which, while reduced significantly from a recent peak, still remained higher than pre-pandemic.[25] They pointed to examples where progress had been made such as reducing the use of temporary agency staff and better use of generic

21 Q 29
22 Q 32
23 C&AG's Report, paras 3.11, 3.15 and 4.26
24 Q 12
25 Qq 8, 49

pharmaceuticals. But the rise in average lengths of stay in hospitals, in part due to the lack of availability of social care and community health services, was a factor in preventing a return to earlier levels of productivity.[26]

16. We challenged NHSE on what it would do differently to achieve the ambitious annual productivity improvements it has committed to. NHSE told us annual productivity improvements were currently running at about 1.8% and it was confident that the annual gains that it has committed to of 2.0% could be achieved over the next two years. It contends that the previous two years had been affected by ongoing disruptions such as industrial action, and that further recovery was still possible, particularly through technology-enabled change. One example of such change was the use of large language models to capture notes during GP consultations.[27] However, NHSE also continued to feel that some existing productivity improvements are not well measured at present. It felt that metrics, including that of the Office for National Statistics, do not yet fully capture productivity in important areas such as mental health and community services.[28]

Payment mechanisms that incentivise tackling health inequalities

17. We asked about the equity of NHS funding mechanisms and the risk of perverse incentives, using as an example the distribution of money for childhood inoculations. GP surgeries receive a payment for every child that gets a vaccine.[29] In our view, this funding mechanism favours wealthier areas where parents are more willing to inoculate their children. At the same time, more deprived areas, known for higher levels of vaccine hesitancy, receive less funding and therefore have fewer resources to carry out much-needed activities to boost uptake, such as outreach and education.[30]

18. NHSE informed us that it relies on primary care networks working with their local ICBs to identify harder to reach cohorts. It accepted that local authorities often have better links into communities than NHS bodies. It said many lessons were learned from the COVID-19 vaccination campaign about where take up was good and not so good, and how to reach populations that were not proactively coming forward.[31] In its written submission to this

26 Q8
27 Q 9
28 Q 77
29 Q 45
30 Coronavirus and vaccine hesitancy, Great Britain - Office for National Statistics
31 Qq 45, 46

inquiry, NHS Providers noted that addressing the wider determinants of health had to involve specific targeted improvements in the most deprived areas to tackle health inequalities.[32]

32 NFS0012

2 Three big shifts required for the long-term sustainability of the NHS

19. DHSC described how the new government had set out three shifts that they want to see in the NHS: from analogue to digital; from treatment to prevention; and from acute to community. DHSC said that it wanted "to see those shifts over time, but not at the expense of patients now.[33]

Focusing on preventing ill health

20. Senior ICB leaders reported to the National Audit Office a continued lack of progress with the government's long-standing aim to move towards preventing ill health rather than treating it. One of the most important reasons cited by ICBs has been the focus on other pressing national priorities, particularly elective care backlogs and acute services, which has meant they have had little additional headroom to grow preventative services as they would have wanted to.[34] The public health grant used by local authorities to commission preventative measures such as health visiting and drug and alcohol services is expected to fall by £193 million (5%) between 2022–23 and 2024–25 (at 2022–23 prices), despite government's commitment in the 2021 spending review to maintain it in real terms.[35]

21. DHSC told us it did not view providing more resources, or redirecting them from elsewhere, as a substantive part of the solution to the lack of progress with prevention. Instead, it considers that a shift towards prevention might be achieved through longer-term changes in culture, public attitudes and the legislative environment.[36] There is a role for GPs to advise patients, and hospitals might choose to reach out into communities to carry out preventative measures.[37] NHSE told us it viewed the 10-year health plan as

33 Q 29
34 C&AG's Report, para 4.14
35 C&AG's Report, para 4.20
36 Q32
37 Q 32

an opportunity to crystallise ambitions around prevention, but warned there would be difficult trade-offs to consider between actions which may only deliver a longer-term benefit and actions that meet a priority today.[38]

22. Currently, NHSE does not even track spend and activity on prevention by ICBs at local levels, due to unavailability of data and the lack of consistency about what counts as prevention spending. While DHSC funds some prevention activities that sit outside the NHS, primarily through its Office for Health Improvement and Disparities (OHID), it similarly lacks a precise definition of what counts as prevention spending. This makes assessing the extent of spending and progress against this important policy aim impossible.[39]

23. Local areas would value more flexibility about where they can direct their resources to achieve greatest impact, including how they fund measures to prevent ill health. ICBs were supposed to have greater autonomy in determining how to allocate resources locally compared to their predecessor bodies, including freedom to shape future local health services. However, there is widespread agreement that NHSE's approach to planning and governance, in particular the all-encompassing nature of its top-down guidance, has meant negligible autonomy in the real world for local health systems.[40] NHSE told us there are certain prevention programmes, such as for diabetes prevention or targeted lung health checks, where it made sense to fund activities nationally rather than giving local areas discretion over whether to deliver those services.[41]

Moving care from hospital to community

24. Despite carrying out 15% more elective activity than before the pandemic, the NHS is less productive overall once the activities of mental health trusts, community trusts and GPs are considered.[42] NHSE told us that, while government has had a long-term aim to shift more care and services into local communities, funding increases for these services had often been slow.[43] However, it highlighted how recent capacity investments had been in community services rather than hospitals, for example in 12,500 virtual ward beds in people's homes, and had focussed on the data and technology needed to support moving more care into the home.[44] NHSE acknowledged

38 Q 37
39 C&AG's Report, paras 4.15 to 4.16
40 C&AG's Report, para 2.12
41 Q 48
42 Q 12
43 Q 37
44 Q 29

that there would have been more investment and progress in enhancing community services in 2023–24 had it not been obliged to redirect funding to prop up the day-to-day spending of local NHS systems.[45]

NHSE recognised there may be value in considering whether best use is currently being made of the Better Care Fund, intended to support joint working between the NHS and social care, and assessments of continuing healthcare needs outside of hospitals. NHSE said a review of the Better Care Fund might sensibly re-evaluate the structures that currently surround the fund and the content of what its money is being spent on. NHSE reported that it was increasingly seeing improved system working at local level, particularly regarding annual planning processes.[46] However, DHSC acknowledged that there were still many problems underlying joint working between health and local authorities, primarily due to having to integrate a service that answers nationally to ministers and a service that answers locally to councillors, with significant variation evident across the country.[47]

Switching to digital

25. NHSE assesses that sustained increases in capital investment are needed to replace ageing equipment, expand capacity to meet demand, and enable staff to benefit from new technologies.[48] However, NHSE told us its investment in technology between 2022–23 and 2024–25 could have been greater had it been able to use underspend against its central budgets for that purpose, but it had to use those underspends instead to mitigate ICBs' spending deficits.[49]

26. We asked what was being done to improve productivity through the use of new technologies. NHSE told us the NHS currently lacks a consistent data infrastructure and that NHS providers varied in terms of their levels of technological maturity.[50] NHSE said that it was putting modern technology into some of its providers that "have lived on paper". While it still had work to do to complete the programme, its aim was to do so over the next 18 months.[51] NHSE told us that the NHS providers that have already implemented electronic patient records have productivity levels that are

45 Q 3
46 Q 31
47 Q 38
48 C&AG's Report, para 4.21
49 Q 3
50 Qq 79, 80
51 Q 79

13% higher than those yet to implement them.[52] We note that the then Secretary of State for Health first challenged the NHS to go paperless in 2013, setting a target date of 2018.[53]

52 Q 10

53 Jeremy Hunt challenges NHS to go paperless by 2018 - GOV.UK (Press release 16 January 2013)

Formal minutes

Thursday 16 January 2025

Members present

Sir Geoffrey Clifton-Brown, in the Chair

Mr Clive Betts

Anna Dixon

Sarah Hall

Declaration of interests

The following declarations of interest relating to the inquiry were made:

25 November 2024

Anna Dixon declared the following interest: former civil servant at the Department of Health and Social Care, trustee with Helpforce Community and family members employed by NHS.

NHS financial sustainability

Draft Report (*NHS financial sustainability*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 26 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Monday 20 January at 3 p.m.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 25 November 2024

Sir Chris Wormald KCB, Permanent Secretary, Department for Health and Social Care;
Andy Brittain, Director General for Finance, Department for Health and Social Care;
Amanda Pritchard, Chief Executive, NHS England;
Julian Kelly, Chief Financial Officer, NHS England;
Antonia Williams, Director of Public Services, HM Treasury Q1-81

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

NFS numbers are generated by the evidence processing system and so may not be complete.

1	British Dental Association	NFS0004
2	COOK, MR NIGEL D (Retired - Expert Business Efficiency Identification, Management and Delivery)	NFS0002
3	Healthcare Financial Management Association	NFS0013
4	NHS Confederation	NFS0005
5	NHS Providers	NFS0012
6	Royal College of General Practitioners	NFS0008
7	Royal College of Nursing	NFS0003
8	Social Care Institute for Excellence (SCIE)	NFS0006
9	The Association of the British Pharmaceutical Industry (ABPI)	NFS0007
10	The Medical Defence Union	NFS0001
11	The Royal College of Radiologists	NFS0015
12	Triple P UK	NFS0010
13	Wise GP	NFS0011

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2024–25

Number	Title	Reference
1st	Support for children and young people with special educational needs	HC 353
2nd	Condition and maintenance of Local Roads in England	HC 349
3rd	HMRC Customer Service and Accounts	HC 347
4th	Tackling homelessness	HC 352