HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Managing NHS backlogs and waiting times, HC 729

Monday 28 November 2022

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Watch the meeting

Members present: Dame Meg Hillier (Chair); Sir Geoffrey Clifton-Brown; Mr Jonathan Djanogly; Mrs Flick Drummond; Mr Louie French; Peter Grant; Anne Marie Morris; Sarah Olney.

Questions 1 - 114

Witnesses

I: Sir Chris Wormald KCB, Permanent Secretary, Department of Health and Social Care; Matthew Style, Director General, NHS Policy and Performance Group, Department of Health and Social Care; Amanda Pritchard, Chief Executive, NHS England; Sir James Mackey, National Director of Elective Recovery, NHS England; Professor Sir Steve Powis, National Medical Director and Chief Executive, NHS Improvement, NHS England.

Gareth Davies, Comptroller & Auditor General, and Adrian Jenner, Director of Parliamentary Relations, National Audit Office, were in attendance.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Managing NHS backlogs and waiting times in England (HC 799)

Examination of witnesses

Witnesses: Sir Chris Wormald, Matthew Style, Amanda Pritchard, Sir James Mackey and Professor Sir Steve Powis.

Chair: Welcome to the Public Accounts Committee on Monday 28 November 2022. Today, we are talking to NHS England and the Department of Health and Social Care about the monumental challenge that our health service faces, tackling backlogs and waiting times, with backlogs now at 7 million people waiting for treatment and waiting times of over a year going up to, at the end of September, over 400,000 people. This is an extraordinary challenge to deal with. A lot of these problems existed before the pandemic, but covid-19 exacerbated them. Then we have, coming up in the winter, the challenges of the winter and the NHS as usual, the economic climate, and the cost of living crisis, which is increasing bills in hospitals.

The NHS has a plan and we are going to talk about that today, but it is reliant on a lot of factors and is quite a heroic plan, aiming to improve outcomes considerably, so we want to find out from our witnesses today how realistic this is, whether it will deliver and when it will deliver, and when patients on the ground—our constituents—can see a difference.

I would like to welcome our witnesses. From the Department of Health and Social Care, we have Sir Chris Wormald, the permanent secretary, and Matthew Style, director general for NHS policy and performance. From NHS England, welcome to Amanda Pritchard, the chief executive, Sir James Mackey, known to us as Jim Mackey, national director of elective recovery, and Professor Sir Steve Powis, who is the national medical director and chief executive of NHS Improvement. Welcome to you all.

Before we go into the main session, I just want to say again to you, Sir Chris, that we are getting very slow responses from your Department. I have just had an answer to a Treasury minute response, which is two months late and then does not tell us anything anyway, so I just want to put on record that we are still not happy with your responses and we will be taking this up with you outside of this meeting as well. It is not good enough. Parliament needs to be informed of these things. Because of the nature of today's session, I am not going to go into that anymore, but I do know that Sir Geoffrey Clifton-Brown wants to come in on some of the pressures coming up in the next few weeks.

Q1 **Sir Geoffrey Clifton-Brown:** Good afternoon, everybody. Good afternoon, Sir Chris. There are reports in today's press that, if nurses go on strike, the armed forces might be brought in to cover. Have you anything to say on that?

Sir Chris Wormald: The Minister covered this in the media this morning. The Department has not made any what are known as MACA requests to the Ministry of Defence. Of course, in terms of the strikes that *The Times* referred to, the ballots are not even closed yet. *The Times* was correct that MACAs have been used in previous blue light disputes, and was also correct that, rightly, the bar for using MACAs is extremely high, not least because our armed forces have, of course, quite a lot of other things to do, but the key point is that we have not made any MACA requests.

Q2 **Sir Geoffrey Clifton-Brown:** Yesterday, I was sitting next to a very senior gynaecological surgeon who deals mainly with gynaecology relating to cancer. She said that, if nurses go on strike, she will be able to do her list this week, but, after that, she will not be able to complete her list. These are very serious cases. How will the targets that we are going to be discussing all this afternoon be affected by a nurses' strike and, indeed, any other health service strikes?

Sir Chris Wormald: At the moment, that is not a possible question to answer. As I say, many of the ballots have not closed.

Sir Geoffrey Clifton-Brown: But you must have done some modelling.

Sir Chris Wormald: Even for nurses, the RCN has not yet informed us either where strikes will take place because, as you know, not all trusts voted for strikes, and the decisions were taken individually about individual trusts, or the level of what are known as derogations that will be in place, which are the arrangements that health unions usually make to protect the emergency pathways.

Right this second, there are two very big unknowns that mean we cannot model the effects of strikes. That said, of course, when any key workforce takes industrial action in the health service, that has an effect on patient care, and that is most likely to be in the elective space, because, as I say, emergency procedures and the emergency pathways are normally protected by the system, but we cannot model an exact amount. We know it would have an effect, but we would need to know what the industrial action is and, crucially, in which trusts, before we could model what happens.

Q3 **Chair:** Amanda Pritchard, you are in the hotseat for this. When will you know and how quickly do you need to know in order to make sure that you are providing the best service that you can in the circumstances?

Amanda Pritchard: My answer will be very similar to the answer that you have just had from Chris, because the same applies to the NHS.

Chair: That is why I am asking, because it is the NHS that is affected.

Amanda Pritchard: The conversations need to happen at national level, ideally, about the shape of overall derogations. That is yet to take place. The other really important point, just to build on what Chris said, is that there will be local discussions going on between individual trade union

leaders locally and clinical teams, on a patient-by-patient basis, when it comes to it, to identify what services can continue.

Q4 **Chair:** The key thing is how long it will take, once you do know what is going to happen—

Sir Chris Wormald: I can help you here. The trade unions have to give an employer 14 days' notice, so that is the point when they have to have told individual trusts what industrial action they are taking.

Q5 **Chair:** Amanda Pritchard, when you have that, how quickly can you kick in any changes and, crucially, let patients know whether their treatment will be going ahead? Will you be providing guidance to hospitals or will each trust make its own decision?

Amanda Pritchard: This is clearly an extraordinarily difficult set of circumstances. NHS staff do a brilliant job for their patients every day. Clearly, pay is a matter for Government and trade unions. We would wish to see a conclusion to this as quickly as possible, of course, but, in practice, our job, as you rightly say, is to support the NHS locally to be able to run services that have minimum disruption for patients.

The next step will, hopefully, be for us to agree that overall set of principles around derogations with the trade unions. We are doing that jointly with the Department, of course, but then it is going to be for local trusts to work through the details for themselves, with clinical teams and their local trades unions. Part of that will be about making that patient-by-patient decision, so that they can let people know sooner rather than later.

By its very nature, this is going to have to be quite agile, not least because individual members of staff do not have to say whether they are going to come in on the day, so that is something that will emerge slightly as this takes place.

Q6 **Chair:** So it is possible that patients will find out on the day of their procedure.

Amanda Pritchard: No. Things will be planned in advance.

Q7 **Chair:** That is what I am driving at. How far in advance? Are you able to tell us directly?

Amanda Pritchard: Again, that will be local trusts making those decisions, because, as Sir Chris says, we need to know, first of all, which trusts are going to be affected, and then they will need to have those local conversations to work through exactly what shape they should be planning for locally. They will have to work through it on a patient-by-patient basis and will, I am afraid, in some circumstances, be having to postpone patients' care and will want to give people as much notice as possible. What they will not want to do is to go too far in one direction or the other, because that is where they will want to be able to maintain as much service as they safely can.

Q8 **Sir Geoffrey Clifton-Brown:** I do not quite understand, Ms Pritchard, how

this is going to work locally. The local trust is clearly going to want as many nurses in as possible and is going to claim that as much as possible is absolutely urgent, whereas the trade unions and the RCN are going to want as few nurses in as possible to enforce the strike. How is this negotiation to be done?

Amanda Pritchard: Unfortunately, the NHS has some experience of working through these sorts of things locally—not from nurses, of course, but from other groups in the past. That is where a set of national principles is important, but it is a local discussion that needs to take place between the trade unions and the organisation. It will usually be the clinical leaders of that organisation. That is right, because some of this is also about individuals. Just saying, "That category of patient is not urgent" might not be right, because that individual, even if they are coming in for a hip operation, might also have cancer. They will need to look at things in a more sophisticated way than you could do if you were just taking a broad-brush approach nationally.

Sir Chris Wormald: Could I just add one thing? The discussions are not quite as you characterise them, Sir Geoffrey. Even when they are on strike, nurses remain highly values-driven professionals who are as committed to maintaining the emergency pathways as management is. It is a discussion that is about how we best achieve that end, as it were. It may have some of the connotations that you have described, but I really do not think that that is the driving force when local nurses are discussing with local management how we keep the emergency services running.

Q9 **Sir Geoffrey Clifton-Brown:** It is not going to be the nurses, is it? It will be the RCN representative in the local area and the trust, so the poor nurses are just going to be pawns in the middle, are they not?

Sir Chris Wormald: As I say, when these discussions have happened—I expect that Jim has been party to them, so might want to comment—while there is an industrial dispute, there are still a lot of shared values out there about patients and protecting them.

Chair: We would acknowledge that everyone we clapped for in covid is committed to—

Sir Chris Wormald: Jim, I expect you have done this.

Sir James Mackey: Those discussions are happening now, so organisations are working through where the staff are who might go on strike. The conversations are starting to be had. As Chris and Amanda have said, everybody really cares about the patients, and so, usually in this circumstance, you end up with a lot of agreement on who should and should not be seen. It is not possible to be very prescriptive about that nationally, so it does require a lot of nuance locally. Generally, people have the same interests and understand the difficult position that people are in. It is happening now. People are just trying to work it out now in terms of what they would have to do.

Q10 **Sarah Olney:** During the autumn statement, there has been a cut of £700 million to the NHS capital budget. How is that affecting the Government's plans to open 40 new hospitals by 2030? Also, what does that mean for the backlog of repairs to NHS buildings?

Matthew Style: There are no implications. The Government remain committed to the new hospitals programme and will be confirming their decisions by the end of the year on the next wave of that programme.

Sarah Olney: Did you say no impact?

Matthew Style: We are not expecting any impact this year on that programme and we remain committed to delivering the programme as previously announced.

Sarah Olney: That is despite the cut.

Matthew Style: Yes.

Chair: 40 new hospitals or wings of hospitals.

Sarah Olney: They are still coming by 2030.

Matthew Style: Yes.

Sarah Olney: That is impressive.

Q11 **Chair:** Very slow progress so far, but we are mainly here to discuss NHS backlogs and waiting times, so let us move into that. The original target that you set, which is hugely optimistic, was for an activity rate of 129% above the 2019 activity rate. When you agreed this, Amanda Pritchard, in February 2022, you must have been optimistic then that you could achieve it.

Amanda Pritchard: This is quite a big theme of the NAO's work.

Chair: I am just asking whether, when you agreed these targets in March of this year, you were optimistic that you could deliver them.

Amanda Pritchard: The key thing that we had to make some assumptions about back when we did the elective recovery plan was two big unknown variables. One was the level of ongoing covid that would be in place, and the other was the level of what we were calling at that time bounce-back demand: the number of people who stayed away during the pandemic and who might come forward.

We have been completely wrong on the assumptions about covid. Having made some ambitious assumptions that the level of covid would be low, we have, as I have said before, never had fewer than 5,000 patients in hospitals across the UK at any one time this year. If you look just at England, there have only been three short spells where it has gone below 5,000 over only a 46-day period.

Chair: Covid was higher than expected.

Amanda Pritchard: Covid has been much higher than expected. The consequences of that, of course, are not just beds with patients in who would not otherwise be there—

Chair: It is staff as well.

Amanda Pritchard: Exactly right—it is the impact in terms of staff sickness.

Chair: The other big assumption was bounce-back demand.

Amanda Pritchard: Bounce-back demand has been lower than expected. What has happened is that those two things, to some extent, have balanced themselves out, not in terms of activity but in terms of what it has enabled us to deliver in reducing the overall long waits.

Q12 **Chair:** Are you worried, though, that that bounce-back demand has not happened yet but might still come forward? These are people who did not come forward during covid. You thought they would come forward, but they might still arrive in hospitals.

Amanda Pritchard: I am sure that Jim will want to say a bit more about this. By now, we have begun to see it probably stabilise a bit, but the area where we have seen our expectations wrong the other way has been the bounce-back demand for cancer checks. We had anticipated that it would be higher than pre pandemic, but it has been 120% pretty much all year, so a 20% increase in demand in a single year.

The good news on that, of course, is that that means that we have now caught up all of that numeric gap of people who did not come forward for checks over the covid period, but, clearly, that has put very significant pressure on the cancer treatment capacity, because it is difficult to see how you would grow oncology services or specialist cancer by 20% in a year. We have seen that emerge as a challenge in the cancer backlog, but the good news is that that significant increase in referrals in this case has meant that we are now diagnosing more people at stage 1 and 2 than ever before, in fact, and we have caught back up with the stage 1 and 2 proportion of people diagnosed.

Q13 **Chair:** You had to make assumptions, but they have not quite turned out as material as you expected. At that time, you did not know that you would have the extra money that was provided at the autumn statement, which gives you just above standstill funding, so how did you work out that you could achieve an 129% activity rate of the 2019 levels?

Amanda Pritchard: The 129% was based on the SR21 settlement.

Chair: So it was not including the new money.

Amanda Pritchard: The autumn statement has allowed us to maintain the funding that was in place for elective recovery. As you will recall, the issue that we were all concerned about when we last talked was about the inflation impact on the NHS. We are now able to say that we have the

ability to maintain that funding, which, at the time, was very targeted to elective recovery, and it allows us to continue with our planned investment.

In terms of activity, what are the risks? They remain three things. They remain what is going to happen with covid and flu, so we are beginning to see some flu in particular picking up, and Steve might want to talk a bit more about that. The second, which we have already touched on, of course, is workforce. We know the real pressures on NHS workforce, full stop, and then the additional challenge around industrial action. The third, which is, again, a bit of an unknown at the moment, is what happens with inflation. At the moment, we are seeing that the NHS budget has been safeguarded around inflation in this area, but that is based on a set of assumptions about what is going to happen in the future.

Q14 **Chair:** You have listed everything that was on the list of our concerns. With all those factors, are you confident that you will meet this 129% activity rate and bring these very big backlogs down?

Amanda Pritchard: At the moment, what we would say is that we are still absolutely aiming for 129% at the end of that period of time. We recognise that we are going to need to reprofile the trajectories to get there, partly because of the impact that we have had this year.

Q15 **Chair:** Do you mean "reprofile" as in some things will be done later? When you were saying "reprofile", what do you mean?

Amanda Pritchard: Again, Jim might want to come in on this, because it is partly about reflecting what has happened this year, which has had a particular effect on inpatient activity. Just as a rule of thumb, we have about 100,000 beds in the NHS, of which about 10,000 used to be used for elective care. It is now, and has been all year, about 8,500, so we have lost a significant amount of capacity from the elective bed base, because of the things I have just mentioned, and I have not even talked about social care or discharge.

The combined effect has been a squeeze on the ability to get through some of the inpatient elective work, but the work that the programme has done, through the innovation and some of the changes that Jim has been leading, has shown that we can do more on things like outpatients. That means that the profile up to 129% is partly about what has happened this year, and partly about reflecting some of those changes.

Q16 **Chair:** Sir James, you are on the frontline as well as doing this work in the centre. If you go out and talk to a man or woman in the street and say, "It is okay. Anyone can deliver 129% of what they delivered in 2019", it sounds like Mickey Mouse numbers, so can you explain how you are going to deliver 129% of activity, given all of these huge pressures on the NHS?

Sir James Mackey: It is very stretching and it is operationally very complicated and difficult—the worst that I have ever experienced in terms of overall complexity. One of the things that we have really begun to understand over the last year is the variation across the country in terms

of how different organisations have been impacted by covid, their ability to recover, and how that plays out in different parts of the country.

I am looking at the last weekly performance report in parts of the country. These are unpublished stats, so it is management information. We are running at 121% in one region on completed pathways of 2019-20 volumes. If you get to that sort of level, it does feel that it is within reach. If you are stuck at 90% to 95%, it feels like a very big stretch.

I just left a discussion earlier on about how we get close enough to organisations over this planning period to learn from those that have recovered more quickly and take that learning to others that are struggling a bit more.

Q17 **Chair:** Inflation is standard across the country, but workforce is different. My own hospital has just lost half a dozen midwives, for example, who are Spanish and did not return. There are other moving parts. You cannot ship staff around the country. If you have a trust with too few staff because people have left because of exhaustion, covid or whatever, how are you going to make sure that you fill those gaps, or is it just going to be a postcode lottery?

Sir James Mackey: We all have workforce and capacity problems. That has been well rehearsed. Again, what we have been doing over the last year is we have moved patients. In this first phase, it was very surgical, so it was very complicated moving patients around. In the next couple of phases, a lot of it is outpatient-orientated, which can be delivered virtually. If you are a patient in, say, the south-west, it is technically possible now to have a consultation with somebody in the north-east, and we are trying to do that.

That is starting to happen now around the country. You would want everybody to have the right level of capacity to see everybody locally, but it is now technically possible and happening that you can have access, where appropriate, with a clinician in another part of the country.

Q18 **Chair:** Professor Powis, as national medical director, if you have consultants consulting patients not in their area of accountability for that patient's pathway in order to just ramp up the numbers, are you perhaps taking a risk with quality of care?

Professor Powis: Not if you have the appropriate transfer of information and the technology in place that backs up those sorts of interactions. We saw, during the pandemic, a lot of development in terms of mutual aid, and that was one of the positives coming out of the work that we did during the pandemic. Organisations learned how to do those transfers of care, in a sense, or that shared care between organisations. Jim is absolutely right. This is the sort of thing that we need to pursue that will get us closer to that 129%. Clearly, learning from those organisations that are already doing it and assisting those that need some help is the right thing to do.

Q19 **Chair:** As national medical director, how are you going to make sure that

that quality is maintained? There is going to be a drive from Parliament, from Whitehall and from Ms Pritchard's office to make sure that the volume is met. Where do you put your lines to make sure that quality is maintained?

Professor Powis: Fundamentally, clinicians do that every day, day in and day out. They are trained to manage that potential risk and to ensure that quality of care is maintained, but then so are medical directors in trusts, chief nursing officers, regional medical directors and ICB medical directors. That is the core business of what they do.

Q20 **Chair:** What will be the warning signs that come up to you? Can you talk us through what might happen if you feel that something is going wrong? How you would escalate that and say to Ms Pritchard and everybody, "Look, it cannot be done"?

Professor Powis: At a system level, we would know if there were particular services that were established that were not functioning properly. Jim and the national clinical directors in elective care recovery are very close to the teams on the ground that are doing this, so I do not think that it would be a case of seeing individual cases that were not going as planned. Our clinical teams, who are heavily into oversight of this, would spot a service that was fragile or not functioning as planned.

Sir James Mackey: Just to add to that, this all happens on the back of lots of conversations—clinicians to clinicians, clinicians to managers, and clinicians to patients. We know now the organisations and the systems that are going to struggle in the next phase and the phase after that, so we are just working with them to try to be proactive, identify these things, and make sure the right conversations happen. Nobody is going to make clinicians send patients somewhere where they do not think they are going to get good care, and they would not accept that anyway.

Professor Powis: All these services are co-designed with clinicians and, as Jim has just said, I do not think clinicians would go ahead with them unless they felt that they had reached the level of a safe and high-quality service.

Q21 **Anne Marie Morris:** Ms Pritchard, can I turn to the recovery programme and your 13 work streams? What happens to an area of work that is not one of those 13? Are they being deprioritised? Do I need to be concerned that, if you like, there will be a lack of eye on the ball in some of these other areas, which are clearly equally important within the NHS to patients?

Amanda Pritchard: Do you mean in relation specifically to elective recovery or do you mean more widely in other areas of NHS business?

Anne Marie Morris: The most obvious ones are cancer and elective care, but, clearly, there is more than that that goes on within a hospital and there is more than that that patients are concerned about. What happens there? There is no particular focus or target.

Amanda Pritchard: You are absolutely right, and this is not the only area in which the NHS is prioritising attention. We would say that, at the moment, in line with the Government's clear position on this, there is a focus on urgent emergency care. That is across primary care and right through secondary care, community care and ambulance services.

There is, as you say, a focus on elective care and cancer. In particular, one of the things that Jim and colleagues are thinking about a lot is how to make sure that those two things, which can sometimes push against each other, are maintained in as much of a balance as we can get over winter, so that one does not squeeze out the other.

The third big priority is primary care. We talked about this at the last Committee, and that is not just general practice, of course, but primary care in it is widest sense. If we had a third, which is probably more Chris's area than mine, it is that relationship with social care to make sure that the relationships are working well, particularly around discharge.

Alongside that, Steve and I were a session today with our specialist services clinical directors and clinical leads from across the NHS. Each of them has a work programme that looks at specific areas of specialist attention, whether that is cardiovascular or paediatric intensive care, et cetera. There are some big priorities for the NHS that we are all collectively focused on, but then there are a huge number of other clinical programmes that exist to make sure that we do not drop the ball on other things.

Sir Chris Wormald: The list of 13 programmes that you are referring to, which is figure 4 on page 23 of the Report, are specifically all elective recovery. Those are the priorities within elective recovery. As you have rightly said, the NHS has enormous numbers of other things that it does that are not elective recovery.

Q22 **Anne Marie Morris:** That then leads me to a bit of a concern. We have our 13 elective work streams. Ms Pritchard has set out the other things that are also a focus. This morning, we have four new taskforces, as I understand it, to be launched—a bit like the vaccine taskforce. There is an awful lot, not just for you but the individual ICSs, to focus on. Are they not going to lose the plot? How are they going to ensure that they meet all of these different objectives and targets? You are asking a lot. Are you really going to be able to deliver on any—ideally all—given that number?

Amanda Pritchard: That is why we are trying to be clear about a hierarchy of priorities. The Government have been very clear about the ones that are the core priorities for Government, and they are as I have just described. Locally, you want to have that strength of clinical leadership in place to make sure that there is still an appropriate clinical focus on services like maternity, inpatient mental health services or whatever it happens to be.

The other thing that we are keen to make sure of is that local ICBs in particular are thinking about their populations and what the needs of their

populations are. A lot of that, inevitably, falls into a space that is more about prevention, so how do you balance all of that? That is partly a reflection of the scale of the leadership challenge in the NHS. It is complicated, but it is, I suspect, part of the thinking behind why Patricia Hewitt has been asked, as one of our current ICB chairs, to lead her review looking at how we can make sure that ICBs really are set up for success and that they are not overwhelmed with too many different priorities. That is a piece of work that we strongly welcome.

Q23 **Chair:** We will be producing our own report on that soon.

Sir Chris Wormald: The other point is what is a priority for who. The four national missions that you mentioned are the life sciences, so we are mainly talking about research and development, not things that ICSs or trusts would do. Those are national missions aimed at universities, researchers and pharma, et cetera.

Anne Marie Morris: But they will have a role in that.

Sir Chris Wormald: Yes, of course they will have a role and, of course, it is complicated, because we are talking about 10% of a G7 nation's economy, as it were. We need to be clear on what the priority should be for who. If you are a trust chief executive, your priority is not those four national missions. Those are R&D and life sciences. Those are elective and emergency care. If you run an ICS, your priority is different. You are completely right that, if you end up with everything being a priority and everything on a trust chief exec's desk—

Chair: What we are talking about today is the priority for trusts.

Sir Chris Wormald: Yes.

Q24 **Anne Marie Morris:** We have talked about the trusts. One of the things that you are looking at doing, Ms Pritchard, to try to ease the pressure is, effectively, to move some of the interventions from secondary to primary by asking GPs not to refer, and instead to ask for advice and guidance. What do you think the impact of that is going to be on GPs, who are already very stretched in terms of work?

Amanda Pritchard: We talked a little bit about this last time, did we not? I wonder if it is worth you, Jim, talking about this, because you are having these conversations right now.

Sir James Mackey: Yes. Again, no organisation should be simply changing the system and shunting work back into primary care. We have been very clear about that, and there has been no evidence that that is going on across the country. Where advice and guidance works well, it is an interactive conversation between clinicians and primary and secondary care. That can reduce the overall workload, if we are careful about it.

We have learned in the last year that there are some ways of executing advice and guidance that really helps overall, and there are some things that, if not done well, can cause problems in terms of bottlenecks and

hand-offs, so we are just making sure that that is spread appropriately across the country.

Q25 **Anne Marie Morris:** How are you effecting that? You talk about conversations. I do not imagine that people have time to be picking up the phone and hoping that somebody is going to be on the other end at the same time.

Sir James Mackey: It is usually a digital introduction, but it can be a phone call. Some organisations have clinicians in specialties on the end of a phone. If a GP is sitting in front of a patient and says, "I have this patient in front of me. I think they might need X. What do you think?" quite often, if done well, that could result in a reduction in referral for tests or to outpatients.

Q26 **Anne Marie Morris:** How are you monitoring this? It seems to me that it might work brilliantly, but, equally, it might double the workload. How are you monitoring, within each of the ICSs, how they are doing that to ensure that it does not add extra burden to a GP?

Sir James Mackey: It has to be monitored at every level. There is no easy way out of this. It is a very complicated system. We keep an eye on the aggregate numbers—the patterns and the rate of growth of advice and guidance in one system relative to another—and those sorts of things give you a bit of a pointer as to whether things are in kilter.

Q27 **Anne Marie Morris:** Are there any particular conditions that would normally be referred, where there is now some blanket guidance that says, "That should not be referred to secondary care. Sort it out yourself"?

Sir James Mackey: From next week, Tim Briggs, who is national director for clinical improvement, and now elective recovery, under the GIRFT programme, has organised some webinars with key clinical groups next week to share evidence and have a conversation about good practice and what might happen in certain specialties, et cetera, with some of the learning from advice and guidance, PIFU and some of the other changes that have been made in the last year. It is often very patient-specific and is very different specialty to specialty, so a lot of the ongoing interactions are often around people who have complex, long-term conditions and then just become a little bit unstable and need a bit of advice. That is quite different to cancer symptoms, where patients need to be referred into a specific pathway, so it is very hard to generalise.

Professor Powis: It is important to be clear that this has always happened. Secondary care doctors and primary care doctors have always talked. When I was a practising transplant physician, it was not unusual for a GP to contact me about a patient and ask for advice, and it was not unusual for me to talk to a GP about a patient of mine who they were looking after. That interaction is just part of clinical practice. What we need to do is to make sure that it occurs efficiently and effectively, and that, when you need to get through to somebody, you can get through to

somebody, and vice versa. It is just building on what doctors are trained to do, which is to talk to each other.

Q28 **Chair:** We would expect some of that to happen without a cross-charge. Are there any cross-charges? If you have a very popular transplant surgeon and every GP in the country wanting to ring them, how do you stop that happening and make sure that one trust is not overburdened?

Sir James Mackey: People are generally very respectful of it. There was anxiety at the beginning that clinicians would be on the end of a phone all day and would not get any work done. Everyone is very respectful. As Steve said, it has happened throughout time, to varying degrees, depending on the specialty, the place and those sorts of things. We have not seen any evidence yet that anybody is being absolutely swamped.

Chair: There is no cross-charging planned in this.

Sir James Mackey: Technically, there is a tariff for advice and guidance. In the financial regime that we have this year, it is less of an issue. It might be more of an issue next year. We did say that, when people are doing their outpatient plans, if they identify that they can make a change through reducing follow-ups or they need to create more primary care capacity to cope with advice and guidance, or PIFU, they should put it in the plan and we will help the resource move. It then just comes down to whether there is physical resource at the end of it and people in place to do it.

Q29 **Anne Marie Morris:** That all sounds wonderful and I absolutely understand, Professor Powis, that that is the way it has always been, but the numbers since you were in practice, as you described, when you were, as we were all, a lot younger, have grown exponentially. I am just a bit concerned, but I will not pursue it further now, as to how, given the volume we are talking about, this is going to work in practice, but let us see.

Let us move on, because one of the things that Ms Pritchard has also looked at is how we can reduce the outpatient work, such that, once you have been into secondary care, rather than, if you like, the usual check-ups and calls back for further conversations, et cetera, that should be reduced. How are you, Ms Prichard, managing that to make sure that there is not a risk to a patient because of the reduced intervention?

Amanda Pritchard: Again, it is probably best if Jim picks this up, but your point is spot on that part of this is very much a clinically led move—and Steve also might want to talk about this—to say that, for people who have long-term conditions, bringing them back on a three-month or six-month basis might be the exact point in their personal situation where they are fine. Having access when they need it, which might not be at that exact three or six-month interval, is much more important. It is based on some of the pioneering work that was done around cancer pathways and really asking whether we can apply that more widely.

Sir James Mackey: That is absolutely right. This is a difficult change, because it is changing the way that the system has worked forever. We set

out our ambition in the plan. That was based on an awful lot of modelling that has looked, specialty by specialty, and said, if everybody applied the best practice, what would be possible. We then modified it and we expected organisations and systems to work through what that might mean, accepting that it can be very different, specialty to specialty, clinician to clinician, and even patient to patient, and to try to make it as sensitive as possible while still trying to break out of the model in which everybody gets called back forever, even when they do not need to be called back.

A handful of organisations have really embraced it and are making quite significant progress on that. There is no evidence that there has been a negative impact on patients. This week, we hope to agree a commission on patient experience with patient advocates to construct a survey that will allow us to get beyond that and make sure that it does not just look good from our point of view though patients are unhappy.

Just to give a personal example, I have a longstanding gastro problem. My system would normally mean that I would get called back and scoped every three to five years. I would get follow-ups regularly and, most of the time, I am absolutely fine. I have an arrangement with the team that look after me that I will just get in touch if I need to get in touch.

Anne Marie Morris: With respect, Sir James, you are a very educated individual.

Sir James Mackey: That system is available for other patients.

Anne Marie Morris: Absolutely, but if you are somebody in a deprived area, without the level of education that you have—

Sir James Mackey: That is exactly the point. What we are trying to do is to systematise this, so that it works for everybody, and to make sure that the technology is available is support it. Again, if you are unable to access the technology, it is backed up with people who will talk to you on the telephone. You can ring a contact centre. Primary care colleagues know that they can identify people who they should worry about. There is no intention of reducing access for anybody. What we are trying to do is personalise it.

Anne Marie Morris: I look forward with interest to see how that works out, but it is important particularly for the vulnerable, the elderly and deprived.

Q30 **Chair:** Will you also be monitoring how many people you take out of the hell that is the outpatient queue? Are you monitoring how many you are reducing that by and then factoring that into your productivity ambitions?

Sir James Mackey: Yes.

Sir Chris Wormald: I was going to add one thing, because it comes up a lot. We sometimes see the technological solutions as either/or. There is a very important point that the more patients like Jim do it that way, the more it releases the pressure for patients who need the face-to-face,

sometimes for the reasons you say, or for other reasons. We should not see these routes as either/or options. If we get the route right for people like Jim, you make it better for everyone. That is the point.

Professor Powis: It is also worth remembering that this was an ambition in the long-term plan. This is work that started pre pandemic.

Chair: So many plans, Professor Powis, that we sometimes lose track, even on the Public Accounts Committee.

Q31 **Sarah Olney:** One of the things that I am very interested in throughout the Report is that we have talked about the number of people waiting for elective care, and it is broken down by length of time that people are waiting. I am just interested in whether you have a breakdown in the sorts of care that people are looking for, such as orthopaedic or ophthalmology. You have a grasp of how much of that is cancer, but I am just wondering what the breakdown of conditions is.

Chair: We had some good evidence on this, but it would be helpful to set it in context.

Sir James Mackey: The data is cut in lots of different ways. The big volumes are in specialties such as orthopaedics, ENT, general surgery and ophthalmology. They are all very predictable, big volume specialties. It is different organisation to organisation. The weight profile is different organisation to organisation. The way that the national numbers work is quite predictable, but then there is a very specific nuanced change that then can happen at an organisational level, with two organisations next door to each other having quite different profiles.

You have triggered a really important point, though, that we have to try to remember that there are people involved here as well, so it is not all about the stats and the maths behind it all. Getting back to the earlier points, we need everybody to really understand this. Clinicians need to understand what is on the waiting list. They do not always have the data to support that. GPs need to know who is on the waiting list, because they often just send in and do not get great data back to show who is there and who is waiting. The difference in load, specialty by specialty, and the weight variation, are really remarkable. A big part of what we have to try to do is to level that in a way that does not penalise people but allows them to accelerate access to care.

Q32 **Sarah Olney:** Are there particular types of treatment that are more represented in the longer waits? Are you seeing more people waiting longer for a hip replacement than for other forms of treatment?

Sir James Mackey: That is a very good point. On the two-year, 104-week programme, it was largely surgically orientated, so it was largely hips, knees, ENT procedures, cataract surgery and that sort of thing. As we are moving to 78 weeks, it is much more outpatient-orientated, so it is a much broader range of specialties, with quite a lot more physician and medical specialties there, where the access is broader. That is partly why we are a

little bit more confident than we were this time last year about getting through winter, because a lot of it is non-bed-orientated.

We constantly misunderstand what is on the waiting list. The 7 million people are not waiting for an operation. Only 3% of the waiting list will have an inpatient operative episode. 80% of the waiting list will have their experience completely ended in outpatients or in a diagnostic process. We are trying to turn that data into something that really means something operationally and clinically for people, but we need to avoid the trap of thinking that there are 7 million people waiting for surgery, because there are not.

Q33 **Sarah Olney:** That is good to know. What does the age profile look like? Is it weighted towards older people? How does that break down?

Sir James Mackey: It differs specialty to specialty, but the people who use healthcare are generally older. There is also some really powerful data to support the fact that very large volumes of our outpatient capacity is tied up with a smaller number of people. It is a bit like the frequent flyer thing in urgent care, where very high proportions of capacity are consumed by quite a small proportion of individuals. Also on the waiting list are roughly 7 million entries and 6 million people, so about a million people have multiple entries, waiting for multiple processes to happen.

Going back to an earlier point, we just need to understand this. This is not a long queue of 7 million people standing waiting at the hospital. It is very complicated. It is very different organisation to organisation and system to system, et cetera, but the people who need access to healthcare are generally old people.

Sir Chris Wormald: The other big moving part, Jim, is the level of clinical prioritisation that goes on within the list, is it not? That is the other thing that affects who waits what time, is it not?

Sir James Mackey: Absolutely, and making sure that you are working with good data. We talk a lot about validation, but clinical validation where clinical teams and management teams work through refreshing who is on the list—"Can we have a conversation? Do you still need this? Do you still want it? Is there something else you want to do with your life?" All that is happening, and we are trying to do more and more with technology.

Q34 **Chair:** What are examples of things that people might no longer want?

Sir James Mackey: There are a surprising number of people who, over the last year, have said that covid or other things have made them think again. They have decided that they might have needed a knee op, and now they are really not sure. There are still a reasonable number of people in the NHS who have decided that they are still afraid to access care for various reasons.

Chair: It is more a fear of having it.

Sir James Mackey: No, not necessarily. It is a range of things. They do not want to push somebody else out of the queue. There were some examples early on in covid. Stella Vig, one of our clinical directors, described where, during the first wave of covid, a lot of people lost weight; they were requiring things that corrected themselves as they lost weight. They took themselves out of the queue. A lot of people have put weight on again, as covid has progressed, so it is a very dynamic situation. I would just emphasise the need to have a really personal, granular understanding of what is required and what is going on with somebody.

Q35 **Chair:** You are not talking about big numbers coming off the list because they decide they do not want something, surely.

Sir James Mackey: It has reduced over time, but, at the beginning, although I cannot remember the numbers back into summer 2021, there were a very large number of patients who said they that were not prepared to access care at that point if we offered it.

Q36 **Chair:** They were not prepared to because of fears of covid.

Sir James Mackey: Yes, largely. It is changing day by day. As of today, we have roughly 1,400 people waiting two years, though most of those are patients who have refused options elsewhere. There is still a bit of that in the system and, as we go into a period where we are probably going to have flu within the next few weeks and there is still covid around, people are still a bit frightened to go into hospitals.

Q37 **Sarah Olney:** In previous times, there has also been a concentrated focus on reducing NHS waiting lists. What have you learned from those back in the past? I am thinking pre-covid, when there has been other work to reduce waiting lists. What have you learned from those previous attempts to address the same issue?

Sir James Mackey: I have just left another discussion about this earlier on. One of the things in the last couple of years is that it has made us all try to remember what we did in the early 2000s. Amanda is too young for this.

Amanda Pritchard: I am not, sadly.

Sir James Mackey: As we went through what seemed like a completely impossible task then, in the late 1990s and early 2000s, we tried lots of things. A lot of the things that we learned then were that good data is really important, validation is really important, clinical and management alignment is really important, and primary and secondary care interactions are really important. We have learned a lot of that. Some of the thinking at the same time was about the benefits of separating urgent and elective care, and we built that into the plan through the surgical hub expansion. There is a lot of dusting off of memories and textbooks and stuff, but we have technology now that we did not have then.

Q38 **Sarah Olney:** What particular technologies are you employing?

Sir James Mackey: The big benefit that we have now is the ability to offer remote access.

Sarah Olney: A Zoom consultation.

Sir James Mackey: Yes. Patient selection is important. It is possible, but it was not possible then. The market is developing artificial intelligence to help with validation and other things. We have robots that are now in wide use across the NHS. There are an awful lot of technological advances.

Chair: These have not advanced massively. There is still a lot to get this productivity rate up.

Sir James Mackey: Yes, absolutely. It is going to be hard. This is not going to be easy.

Chair: We do not suddenly have a lot of robots instead of staff.

Sir James Mackey: No.

Professor Powis: There are two things. The general point is that the lessons from previous challenges around long waiting lists have been baked into this programme from the start, so the need for clinical validation, and building on advice and guidance that we have talked about, have all been built in from the start, because that is what we have learned when, either in individual organisations or systematically, we have had to deal with long waiting lists before.

On the point about the use of technology, as I said, the shift in outpatients was a plan before the pandemic, but, because we had to do it at speed, there has been a cultural shift and a confidence around clinicians using it and learning how to use it at speed.

Clearly, we have to refine that, because we are now out of that emergency of the first wave of the pandemic, but it has moved that shift in the use of technology far more quickly than might have happened otherwise.

Q39 **Sarah Olney:** I am going to come back to the point about digital later on, but coming back to your dynamic waiting list, are there people who are on the list for inpatient treatment for whom, once they have received their diagnostic appointment, that will then materialise into the need for a surgical intervention or an operation of some kind? You say that it is only a small number of people waiting for an operation, but it could materialise into quite a few more.

Sir James Mackey: There are still quite consistent conversion metrics in certain specialties, and certainly at an organisational level, where you know that a certain proportion of people who are seen in outpatients will then move on to require surgery afterwards.

Sarah Olney: Is that consistent?

Sir James Mackey: It is pretty consistent. Everything got a bit lumpy during covid, but the patterns are starting to settle again now, where it is

starting to become more predictable, and local clinical teams understand this really well.

Q40 **Sarah Olney:** What you are saying is that you can predict reasonably well that, if you have X number of people waiting for that first appointment with a consultant, a consistent percentage of that will progress to needing something else.

Sir James Mackey: Usually, yes.

Q41 **Sir Geoffrey Clifton-Brown:** Ms Pritchard, paragraph 2.12 on page 31 shows us that there were 51 patients who had already waited for longer than 18 months, but, more worryingly still, 690,000 people who were due to fall within scope of the 18-month target by April 2023. Does this slipping of these targets mean that it is going to be very difficult to catch up and meet the all-critical target in 2025 of nobody waiting more than two years for elective surgery?

Amanda Pritchard: On the waiting times, Jim has just talked a little bit about where we are with the first of the big milestones, which was getting down to nobody except those who had chosen, or were highly clinically complex, waiting for more than two years. The next big milestone, of course, is the 78 weeks, or 18 months, by the end of this year. What we have seen over the last year is a 60% reduction in the number of people waiting over 78 weeks, so that is a huge improvement from where we were, but an even bigger reduction in, if you like, the cohort of people who would be waiting at the end of the year, where they are not treated, because that is a much bigger number to start with and, therefore, a much bigger reduction.

The point that Jim made is the important one on this. There is no doubt that it is going to be really challenging over the next few months, particularly because of some of the things that we talked about earlier on around known winter pressures and new winter pressures, but the fact that a higher proportion of that 78-week group is in the day case group rather than definitely needing inpatient surgery would make us feel that it is perhaps a more doable challenge than it would otherwise be.

Sir James Mackey: We were criticised in the Report for not watching all the right metrics and stuff, although it was said more elegantly than that. We are watching loads of metrics all the time. As Amanda said, the cohort for 78 weeks at the end of September last year was 5.5 million people. As of our weekly performance report last week, it was 260,000 people. They are people who, if nothing happened at that point, would wait 80 months.

What we are doing is watching the actuals and the cohort, and the NHS is reducing the aggregate of those two things really dramatically week on week. It is still going to be hard and there will be times when we stand still and it will be a struggle, but, by watching this range of metrics, learning from the past and the things that you have to watch, because they will catch you up later on, the NHS has done a fantastic job in really messy circumstances.

Q42 **Sir Geoffrey Clifton-Brown:** Amanda Pritchard or Sir James, do you know what percentage of outpatient appointments end up as inpatients? Given that you have said that a significant proportion of that 690,000 are outpatients, what we would need to be worried about is if they started translating into inpatients.

Sir James Mackey: I cannot do the maths in my head, but, roughly, of the people on the waiting list, 80% of the 7 million will end their episode completely in outpatients or in diagnostics. Only 3% of the aggregate waiting list will have an inpatient operative stay. A larger number of about 20% will have a day case episode. A very small proportion of the waiting list goes on to require an inpatient operative stay.

Q43 **Sir Geoffrey Clifton-Brown:** Sir James, your trust in Gloucestershire, on the following page's figure 7, is in the category of doing quite well, but this is a huge area of variation, from 2% in south-west London to 20% in Birmingham and Solihull, so it is clearly going to be a lot easier to meet the targets in some areas, in trusts like yours and mine in Gloucestershire, than it will be in others, such as Birmingham. What can be specifically done within the NHS to give those more difficult areas further guidance and help?

Sir James Mackey: We have a tiering process that identifies levels of risk and requirements for oversight. Tier 1 requires national oversight and, in tier 4, they are very free to do what they want. What we have been very keen to do is to try to give those that have capacity and have done well the ability to help others, and there is a really strong appetite for people to do that. Patients do not like getting moved around, and clinicians do not like moving patients around, so we have to see this in that context.

There is an awful lot of activity going on around the NHS where people are learning from and talking to each other, as they did during the pandemic, and trying things out that worked, et cetera. In this next phase, if we can find a way of hooking people with long waits for outpatients in one part of the country up with providers around the country who have virtual access, and get the selection right, we are in really serious business. It is very complicated and hard to do, but that will probably be the most beneficial thing for us to do in this next phase.

Q44 **Sir Geoffrey Clifton-Brown:** Can we move on to the cancer programme now and, in particular, figure 5, which gives the RAG ratings for recovery programmes? Of the recovery programmes, NHS England's own assessment showed the cancer programme as red-rated and delivery confidence rated as amber-red. Do you understand what is going wrong and how to improve it, Ms Pritchard?

Amanda Pritchard: Yes. That comes back to what I was talking about earlier in relation to referrals. The milestone that we had set out in the elective recovery plan was around the 62-day backlog, or the number of patients who are on a potential cancer pathway and who would then convert and are not treated within 62 days. That was the milestone that

we looked at, because that was the one that, pre covid, was the one that we were tracking.

As I say, because we have had such a significant increase in referrals, which is a good thing in terms of getting to what we really want, which is earlier diagnosis and all of the benefits that that brings, that is what is behind the assessment, because clearly we are off target and off trajectory around the 62-day standard as a specific milestone.

On a positive, we are in a position now where the number of patients who have waited for over 62 days has stabilised and is beginning to reduce. To be straightforward with this Committee, because of the referral position, we are not expecting to meet the March milestone on 62 days, but we are moving in the right direction on 62 days. Again, one of the things that has made a difference is seeing the cancer programme and the elective programme now as very much a combined programme around the delivery of 62 days. The tiering that Jim just talked about applies across cancer metrics as well as the waiting list metrics.

Q45 **Chair:** On the 62 days, you have just told us that, so you are not going to meet it on the assumptions that you made in March and that you have revised since. What about if you have further winter pressures that have not crystallised yet on cancer specifically? Is it likely to be delayed further, or are you factoring in the potential pressures?

Amanda Pritchard: The biggest variable on cancer at the moment is referrals. It is looking at the volumes coming in as well as the diagnostic capacity and the treatment capacity.

Q46 **Chair:** It is the GP referral that is slow.

Amanda Pritchard: Roughly one in four referrals from a GP is for suspected cancer. That is the volume that we are talking about at the moment. Our clear, supported view is that we do want to continue to encourage anyone who has suspicious symptoms to come forward, but this is a classic example where you could meet the target and miss the point, because you could try to suppress referrals in order to get the backlog down. That would be entirely the wrong thing to do, because what we want is to encourage people, if they are worried, to come forward and get diagnosed as quickly as possible, and then we will see those stage 1 and stage 2 diagnosis rates continue to go up.

Sir Chris Wormald: This is an area where increased demand is a good thing, not a bad thing. Secondly, I think I am right, Amanda, that this is one of the areas where you are already exceeding pre-pandemic activity.

Amanda Pritchard: Yes.

Sir Chris Wormald: If you have high demand and high levels of activity, those are both good things, even if we are not hitting the target.

Q47 **Sir Geoffrey Clifton-Brown:** There are two very illustrative tables in

figures 11 and 12 on pages 46 and 47. The one in figure 11 shows very clearly that you have not got back to the levels of cancer activity pre-pandemic. When do you expect to get back to the pre-pandemic level of cancer activity?

Amanda Pritchard: On activity for cancer, we have been just over 100% of pre-pandemic levels for most of this year, so that has been ahead of where we have been for the overall elective programme, which reflects the earlier conversation that we had about clinical prioritisation. Clearly, the decisions that are being made locally are the right ones, because people are prioritising the available capacity for treating cancer patients.

The gap is the problem, though, if you have referrals up 20% and activity back up to only 100% or just over. That is the thing that we are now working on. Going back to your point about what we have learned from the last time the NHS did this, some of the learning from last time was really about best practice pathways and how they can be best rolled out and supported. It builds on Jim's point about variation, but one of the things that we know makes a difference, for example, is the introduction of FIT testing as part of cancer pathways, so that you are only then scoping patients who really need to be scoped, rather than doing an unnecessary intervention. By supporting the tiering programme, that is one of the things that is supported.

Q48 **Chair:** Sorry, that was quite a lot of jargon. Do you or one of the clinicians want to just explain that in simple terms?

Professor Powis: FIT is a faecal immunochemical test. It is, essentially, where we are looking for blood in the poo for people who present with abdominal complaints. It is the same test that we use in the bowel screening service, but, if you use it for symptomatic testing as well, it is a good way of discriminating between those people who might need an endoscopy or a colonoscopy, and those who might not. We know that it is being used variably at the moment. The guidance on this came out a year or two ago, and so, again, this is back to Jim's point of ensuring that it is being implemented consistently across primary and secondary care.

Chair: You do the test at the GP surgery or at home.

Professor Powis: Yes. If you have a couple of negative tests, we know that that additional diagnostic test is likely not required.

Q49 **Sir Geoffrey Clifton-Brown:** More worrying still is the table on page 47 in figure 12. The extreme right-hand side of that table shows that the number of patients waiting after 104 days has gone up hugely from 2019. That must be really worrying because, if people are not being diagnosed or treated for 104 days, the cancer may well have got significantly more serious in that time.

Amanda Pritchard: I will let Steve and Jim pick this up as well, but part of the challenge with cancer is that not all of those patients will, in fact, have cancer.

Chair: But you do not know.

Amanda Pritchard: Exactly. It is the completion of the diagnostic process, but also the feedback to the patient. On a human level, it is clearly a deeply anxious time for people if they are on a potential pathway and they do not know. Just from a clinical perspective, it is about being clear that that definitely does not translate into that number of patients with cancer sooner.

Q50 **Sir Geoffrey Clifton-Brown:** I accept that, but, if you are one of those patients, as you say, that is deeply worrying. Therefore, the only way to eliminate that is to screen them more quickly. What can be done to screen those people waiting a long time for a diagnosis?

Professor Powis: Moving to earlier diagnosis is the key in cancer, as we said. Of course, in some of the people on that pathway, a diagnostic test has been performed and there will be a clinical conversation around exactly what the right treatment is. Prostate cancer is the one where there are a lot of different clinical options, including just waiting and watching. Beneath the headline figure, there is a fair amount of detail in different types of cancer for that conversation, but clearly the earlier the diagnosis, the better. That is why we have been focusing on building community diagnostic centres and why, in the last couple of weeks, we have moved straight to diagnostic tests from general practice rather than having to refer through a consultant.

The entire focus is on getting that diagnostic test done early, which, incidentally, is the same focus we are moving to in the non-cancer pathways. This is back to the question we heard earlier. The sooner you make the diagnosis, the sooner the discussion between the clinical team and the patient can go ahead and the sooner the treatment can occur.

We know that outcomes are dependent upon early diagnosis. The earlier we get that diagnostic test in place, the better the outcome is likely to be and the more amenable the cancer is likely to be to treatment.

Q51 **Sir Geoffrey Clifton-Brown:** Some of these tests are pretty straightforward. You have talked about cameras, blood tests, haemoglobin, and the stool tests and so on for bowel cancer. Why is it taking so long to do these relatively simple diagnostic tests?

Professor Powis: It may not just be the simple initial diagnostic test; it might be the interpretation of the pathology, the diagnosis of particular cancers and what treatment is required. As ever, between the headline figures there are individual patients with complex conditions, some of which is relatively straightforward and some of which is quite complicated.

Q52 **Sir Geoffrey Clifton-Brown:** Is it not possible to split out those who are complicated and those who are simple? Could you just blitz those who are simple, determine whether they who need to go for further tests or treatment and eliminate them? If I were on that 104-day waiting list, I would just want to know whether I had to go for further tests or even

treatment and whether I had got cancer. If I did not, that would be a huge relief.

Professor Powis: Absolutely, yes. Across all these pathways, the right diagnostic test early is the right thing to do. That is exactly why part of our strategy, as I said, is to ensure that diagnostic capacity increases and is more accessible.

Amanda Pritchard: It might be just worth saying that I was visiting a trust the other day, and I sat with them while they went through their cancer waiting list with the lead consultant in the team. It was really clear that they knew which of their patients they were actually worried about.

They were, quite rightly, looking at people with the longest wait first. One of the things that was really telling was that the ones in that group who they were worried about were often the patients who had had multiple different tests; it was the complex cases that were not straightforward and did not fit into those sorts of categories.

For the ones they were not worried about, you are absolutely right that the focus for us is on getting that answer more quickly. It is not that it changes the outcome clinically, but it massively changes it for the individual.

Sir Geoffrey Clifton-Brown: Thank you very much. Yes, I agree with that totally.

Q53 **Chair:** I want to come on to surgical hubs and community diagnostic centres. Before I do, Ms Pritchard, I just wanted to go back to an answer you gave earlier about the 78-week wait. I was wondering whether that was dependent on the assumptions you are making in March, just to push that point again, or whether it is likely to get delayed because of strikes or other workforce issues.

Amanda Pritchard: I will probably let Jim talk about his level of confidence in delivery, but I would just go back to the same risks that we talked about at the beginning of this conversation. At the moment we are supporting the NHS to try to do as much as possible to safeguard delivery of this next important milestone.

As Jim rightly says, it is talking about people, not numbers. That is why this really matters. Within that, there are risks. Clearly, there are risks around what happens with covid, flu—as we have said before, that is not just beds; it is staff—and the workforce.

Chair: It could slip back, being realistic.

Amanda Pritchard: Realistically, this is a very challenging milestone.

Q54 **Chair:** Thank you for the honesty. Do you want to give us an update on how surgical hubs and community diagnostic centres are going, Sir James?

Sir James Mackey: A lot of the investments in surgical hubs are still to open. They were agreed about this time last year or earlier in the year. The

first one has just opened in Burnley, and then there is a range of them that will start opening over the next six to nine months.

The principles are really strong. There is a lot of evidence internationally that these things work. Tim Briggs is working on productivity benchmarks and an accreditation framework for the hubs to make sure we do not just build capacity and then not use it well.

Q55 **Chair:** I wanted to ask about using it well. You have a limited number of specialists to do this work. A lot of them will already be in NHS trusts. They will need a certain quota if they have an A&E. Do you have the people to staff these surgical hubs?

Sir James Mackey: All the organisations that were given money through the bid process have confirmed that they can solve the workforce issue to make sure they can staff them and deliver on the activity expectations outlined in the bid. There is a limited workforce so it is going to be challenging.

Q56 **Chair:** Will they be requiring doctors to do overtime? That is not popular because of the tax situation they find themselves in.

Sir James Mackey: In some cases, yes. A lot of doctors still work on waiting list initiatives and do additional hours here and there. The pension thing has not killed all of that. It has curtailed it, but it is happening. People are still finding that they can do waiting list initiatives, weekend sessions and evening sessions.

Q57 **Chair:** When will we see an effect? How quickly will you ramp up the effect of the surgical hubs?

Sir James Mackey: It is probably this time next year that we will see the surgical hub capacity really powering in. As I say, one is open. There are a handful opening in the next few months. It is really the spring into autumn that they start powering up.

Q58 **Chair:** I do not know whether Mr Style wants to come in here, but there is no problem at all in terms of capital funding. There is no uncertainty about the funding for any of these surgical hubs, just to be clear.

Matthew Style: Not at this stage, no. As Jim said, the key thing is that we are continuing not only to invest in this programme but to ensure we are getting the results as well. We are really rigorously monitoring the businesses cases that were put forward and the activity—

Q59 **Chair:** At the beginning, we talked about the 40 hospitals. Do any of these surgical hubs count as one of those 40 hospitals in addition to a hospital?

Matthew Style: Not as far as I know.

Q60 **Chair:** That is a very good Whitehall answer, but we have you on the record. We have heard many descriptions of what a new hospital is. How are the community diagnostic centres going?

Sir James Mackey: Again, they have just recently started opening and taking effect. It is a little bit early days to see a massive increase in activity, but, again, there is a lot of focus going into making sure people deliver what they said they were going to deliver in the bid process. Again, we are probably another six months away from seeing them genuinely add capacity overall.

Q61 **Chair:** You are confident that we will see results next year, which is great. How will you be reporting that to Parliament and to the public in the areas they are serving?

Sir James Mackey: We can have a conversation separately about that, but all of the business cases set out activity expectations and subsequent processes have set out activity expectations. Tim's accreditation process will set out productivity expectations, so we can report against them when they have been established for a reasonable time.

Just on your workforce point, it is very complicated to disaggregate rotas, but you can be seriously more productive when clinicians can just get on and do their elective work rather than being disturbed all the time.

Chair: Yes, as we have seen with the hip and knee replacements.

Sir James Mackey: Yes, absolutely. Hopefully we will see that kick in when things get established. We are just at a point where we do not have the evidence yet for that.

Q62 **Chair:** Ms Pritchard, as the NAO highlights, there was no proper evaluation of the elective accelerators programme. Will there be an evaluation built into the surgical hubs and community diagnostic centres?

Amanda Pritchard: As Jim and Matt have said, it has been different because there has been quite a significant investment made. There have had to be very robust business cases for each of those. The basis of a formal evaluation is clearly in place. We will certainly be tracking them.

Q63 **Chair:** There is an interesting model for care here. A previous Health Minister, Virginia Bottomley, talked about a community health centre in every neighbourhood. This is some of that, is it not?

Amanda Pritchard: Yes. Some of them are not being newly built; for some of them, the building was already there and it is about developing something on that footprint. Some of those are doing exactly that sort of range of local community activities: blood-taking, outpatient clinics as well as diagnostics and more. They are different in different places, and they have been largely based around the needs of that particular location.

Matthew Style: I was just going to say that these are investments that are not only helping to deliver the elective recovery programme; they are also investments that are driving the longer-term transformation and increase in productivity of the NHS as a whole. That is why they are exactly—

Q64 **Chair:** It still depends on having the right people. How many people doing this are GPs or staff from GP practices? Some big GP practices do quite a lot of diagnostics or they cluster together and do diagnostics across a group of surgeries. These are different from that, but how many staff working in them are being taken from primary care? Are they all being taken from secondary care?

Sir James Mackey: They are largely from secondary care. There is not a massive impact on primary care.

Q65 **Chair:** How many are not? There is going to be a limit on doctors and a challenge around balancing that with trusts' needs. It will be similar for nurses, and there are other health professionals involved. What is the range of health professionals that are involved?

Sir James Mackey: Diagnostics covers quite a broad range of things.

Chair: Yes, exactly. We have had some quite good evidence from some of them.

Sir James Mackey: It can cover endoscopy, MRI and those sorts of things. As part of the assessment process, people have had to demonstrate that they can staff them at all levels. There is no point having a radiologist—

Q66 **Chair:** I am puzzled how they can staff them, if hospitals are short of many of these professionals. I could list them all; I am sure they would all be happy if I were to name them. We know there are shortages of these people. How are some areas able to sponsor these new set-ups and not lose staff from the trusts they are also supporting?

Sir James Mackey: It is partly the productivity gain from being better organised and protected. There are quite long lead-in times for some of them, so they will be expecting some recruitment. For radiology you can get reporting done internationally. That is an established mechanism that works worldwide. There is a range of things in there.

It is a risk to the programme. It is a very tight workforce and it is a very tight market. From a programme perspective, organisations have been through very rigorous testing. The tyres have been kicked well. Just last week we asked for a call in on TIF investments to make sure, before people open, we are still on plan and they are still expecting to deliver what they were expecting to deliver. It is an ongoing process. We will just keep going, until they have established that they have delivered what they have said they are going to do.

Q67 **Sarah Olney:** I just want to ask quickly about the plans to use the independent sector to increase capacity. I am extremely privileged because I represent that part of the world that has the lowest waiting times, according to the chart in this Report, but I am still hearing lots of people opting for private treatment where they would previously have waited for the NHS. I have two concerns.

My main concern is whether the private sector is utilising resources that

would otherwise be used by the NHS. I can see that it is part of your goal to use private sector suppliers as part of NHS provision, but to what extent is that actual route in itself taking resources away from NHS delivery?

Also, is there a sense in which, when the patients opt for private sector treatment, it is the same surgeons and the same consultants? Is increasing that demand outside the NHS for private sector treatment also going to have a negative impact on the resources available to the NHS? That was slightly long-winded, but hopefully you can see where I am coming from. I wonder whether you would comment on that, Sir James.

Sir James Mackey: NHS activity in the independent sector is running at about 130% of 2019-20 volume. It is massively ahead of plan. It is really delivering very strongly. It is only about 8% of our overall capacity. That is very big growth in quite a small part of capacity, though it is all very important and meaningful.

Just last week we met the main independence sector providers. We meet them very regularly. We have had conversations about expansion in parts of the country where there is more need to augment NHS capacity. Whenever we have those conversations, it is all about additionality. They have to be supported from the NHS and demonstrate they are not just taking staff out of the local hospital. They have to show it is not a left-pocket, right-pocket problem; they have to demonstrate that the system is better off from a capacity point of view.

That is one of the areas that is a bit different from the early 2000s. It is a tighter international workforce market than it was then. Most of the private organisations we have talked to are still willing to make those commitments longer term; they just want a bit longer to run at it and they want more collaborative conversations with the NHS to make sure that it is developed in sync, that it is genuinely additional capacity and that nobody loses out.

There is a growth in self-pay in the UK, as there is across the world. It is a natural thing for people to choose to do, to take themselves out of the queue. Again, it is not massive in England. We are keeping an eye on it. It is something we keep a close watching brief on. It would be great if we could have a bit of an expansion in the independent sector in some of our more pressed areas in the country to help us with this recovery programme.

Q68 **Sarah Olney:** Are you confident that expanding independent sector provision is going to utilise resources and staff that otherwise would not be working in the NHS?

Sir James Mackey: We have to make sure we have safeguards to make sure it delivers an overall increase in capacity and is not just taking capacity from one place—

Q69 **Sarah Olney:** What sort of safeguards are you putting in place?

Sir James Mackey: We will have conversations about, first of all, understanding the specialties and what work is going to be done. You can anticipate a lot of these problems in advance. Is it going to distort rates? Is it going to create a different market for overtime rates in the hospital versus what people can get paid later on? You can try to specify that they will try not to recruit from the local system. Our independent sector is still largely staffed with people who are in the NHS and do additional work, which is different from other systems internationally.

It is very much about just understanding the specific nuances of what is needed and making sure that it helps overall and does not simply distort the picture and create a reduction in work in the NHS and an increase of more expensive work in the independent sector. It is very hard to generalise because the IS presence is very uneven across the country and our backlog is very uneven across the country. When you match these things up there, there are probably about three strategic areas where we need more capacity overall, and those conversations are being had.

Q70 **Sir Geoffrey Clifton-Brown:** Sir James, I want to come to you and talk about the difference in performance between the 42 different integrated care systems. On page 27, paragraph 2.5 of its Report, the NAO tells us, "Governance arrangements were examined in an internal audit report in June 2022. The report noted that the programme had made progress".

In paragraph 2.7, the NAO Report says, "However, by August, NHSE still could only report the current status of 40% of the indicators in its elective recovery programme dashboard (19 out of 47), making it difficult for senior leaders to see whether programmes were on track and identify actions to address problems". What are you doing to strengthen that data?

Sir James Mackey: I disagree with that. That was an unfair criticism by the NAO.

Chair: It is an agreed Report.

Sir James Mackey: It is not an agreed Report. It was not agreed by NHS England.

Chair: Would the Comptroller and Auditor General like to come in here?

***Gareth Davies*:** The accounting officer for the Department signed off the Report. The chief executive of NHS England agreed with the overall conclusion of the Report but had some reservations about some aspects of detail. I am not sure whether this is one of those, but we can check.

Sir James Mackey: It is one of those areas.

Q71 **Sir Geoffrey Clifton-Brown:** We can argue about whether it is agreed or not, but why, Sir James, do you disagree with that particular conclusion?

Sir James Mackey: This is our performance report. I have been getting this report pretty much every week since October 2021. It is the last report I get on a Friday evening. It is the last thing I read before I stop work on

a Friday evening. I look forward to it every week with excitement and trepidation.

There is a range of metrics in it that we keep developing all the time. A new problem might have appeared with something we have not foreseen before, and we have to develop a new metric to capture something else. That is scored all of the time. It said we did not have evidence to back all of the metrics up fully, but some of them had recently being created. It is a very agile system.

The key metrics of long waits, list size, activity levels and activity levels by point of delivery have been consistent throughout. We keep adding things in. As we have decided to develop more PIFU, for example. There is also the FIT thing. That is a very recent thing. The mechanism has been established for a couple of years, but it was really only in the summer that we decided we would mandate it. That is now being tracked in detail. This will continue to evolve. We will just keep adding in new metrics all the time, as we find important things to measure and track improvement on.

We cannot lose sight of the fact that in the end overall progress still settles back on six or seven indicators. They are the key ones, but that is not to say the other ones do not need tracking. One of them might be the main thing in an organisation, and if they can sort that thing out it will sort everything else out. We have developed a really comprehensive and agile approach. It would have been wrong to have picked six or seven indicators at the beginning and then not changed them. The thing is completely different from what it was this time last year, and it will be very different in January from what it was in August.

Q72 **Sir Geoffrey Clifton-Brown:** Your agile approach is good, and you are getting the data, which is good. What are you doing with that data? If one integrated care provider's performance is not up to even the average, let alone the best, what are you doing to bring the worst up towards the best?

Sir James Mackey: There is a range of interactions. We should remember as well that ICBs became legal entities in July. They are not things that have been very established for a long time. They need time to establish themselves.

When we get the data, the ICBs get the data and trusts get the data. Through the tiering approach, there are different escalated levels of conversations that happen. Tier 1 is national scrutiny, so there are weekly calls with those organisations. The ICBs are involved in different ways; the regional teams are involved. Tier 2 is a regional responsibility, so regional colleagues will be talking to their ICBs about whether organisations are on or off track.

That will then often trigger a conversation about having a problem with outpatients in ENT or whatever else. Other regional colleagues will know that has been solved somewhere else. We will pair organisations up in our

programme board, which has been established since November 2021. Again, this is an area we are criticised on in the Report.

In our next programme board we will have a presentation from Norfolk and Norwich and one other provider because they have made massive progress on outpatients and PIFU. That is the place where things are shared. We have webinars to share advice and support. We are developing mechanisms all the time to make sure people can access what is being dealt with somewhere else and learn from each other.

Amanda Pritchard: It is also worth saying, Jim, that it is not just performance management from a distance. Part of what Jim has done so effectively is deploy people out there, on the ground. There are clinicians to work with people—Tim Briggs is a good example—and help them improve pathways. There are colleagues to sit and help with things like how to manage their PTLs and waiting lists, et cetera. It is hands-on as well as some of the sharing and the performance management.

Chair: What does "PTL" stand for?

Amanda Pritchard: Patient tracking list—it is another way of describing the waiting list.

Q73 **Sir Geoffrey Clifton-Brown:** Sir James, you have collected all that data; you have analysed it and you must have worked out where the individual ICBs or even the individual underlying trust is simply way below performance. What are you doing to target those individual trusts or ICBs to bring them up? It might be weak management, for example. What would you do in that case? If there were a trust that was really weak and had weak management, what action would you take?

Sir James Mackey: At the end of the day, if there is a failure of management, it is at the end of a long process. We will support them. We will sometimes intervene, and sometimes the management will change. That has to be a last resort. We have to start off by assuming that everybody is trying very hard in complicated circumstances. We will go through various gears of interaction: sharing the data, understanding where people are, agreeing plans and agreeing whether people are on or off track.

On Friday this week I have two sessions with colleagues who are off track by a long way. We will have a very escalated level of interaction about why we are off track. We have had various conversations so far with various revised plans. As Amanda has said, some of those conversations have led us to implant teams into certain systems to help bring experience, support and challenge. That ranges from clinical validation challenge, clinical observations, buddying up with other providers to assistance with validation—you name it. We are trying everything we can think could help.

I have to say that in almost every instance everybody is trying really hard to deliver what they need to deliver. Everyone cares about this. Our enemy

in all this is the fact it is very complicated. People are under a lot of pressure in urgent care and other things.

Q74 **Sir Geoffrey Clifton-Brown:** I have one final question in this section. Ms Pritchard, I am sure what Sir James is doing, analysing data and then chasing up those trusts and integrated care boards that are not performing as they should, is fine. What would be really useful to me as a Member of Parliament—and to a vast number of the public, I suspect—would be to have some form of information.

When I talk to my trusts and my ICB, they tell me that everything is wonderful. It clearly cannot be wonderful, but they tell me it is. It would be really useful to have some published data in an intelligible form so one could see how my trust and my ICB are performing compared to others. Do you have any plans to publish that sort of data?

Amanda Pritchard: The NHS publishes more data than any other health system in the world.

Chair: It is about being able to understand it.

Amanda Pritchard: The key word is "intelligible", is it not? It is not a lack of data; there is a huge amount out there. We are working with ICBs and trusts at the moment—the Prime Minister has talked about this radical transparency agenda as well—on what our expectations should be for what they would be publishing for themselves as well as what we might supplement with clearer national reporting.

Matthew Style: There is patient-facing information available, which now, at individual trust level, sets out what an average waiting time will be for specific specialties in individual trusts.

Sir Geoffrey Clifton-Brown: Mr Style, with great respect, it is not about what my individual trust is getting up to. What I would like to know is how it compares with others—how it compares to its neighbours and to other trusts with similar demographics, et cetera.

Chair: It is about comparative data.

Sir Geoffrey Clifton-Brown: It is comparative data. That is what I am pressing you and Ms Pritchard to publish.

Amanda Pritchard: I have asked exactly the same question of the team just in the last couple of weeks. I have asked whether we could evolve—it is not quite the same purpose—the My Planned Care platform, which does what Matt has just said in terms of allowing you to look at different organisations and different specialties and see what the waiting times are.

From a patient perspective, that would assist with choice. If you could say, "My postcode is X", could you look at your neighbouring organisations for that speciality and see which had a shorter waiting time? Certainly, my sense is that this is the kind of thing we do have. We have many of the bits of the jigsaw, but having the ability to stick them all together so the public

can see that transparent information is absolutely where we need to go next. That is something we are working on at the moment.

Sir Geoffrey Clifton-Brown: Apart from anything else, if I knew that my neighbouring hospital could deliver my operation in a time that was X number of weeks shorter, I might say to the specialist, "Please could I go there?"

Amanda Pritchard: Yes, absolutely. It is all about giving patients the information so they can make an informed choice. If people did choose to go to a place with a shorter wait, it would be a good thing.

Q75 **Anne Marie Morris:** Ms Pritchard, taking it down to the very local level, it is a huge challenge for any ICS to look at all the different things they are being asked to do, is it not? If we simply take the electives, we effectively have these 13 things they need to look at. Only one of them, for example, is surgical transformation, yet there is not just one bunch of people who just do surgery. You have heart surgeons, cancer surgeons, skin surgeons, et cetera. That is a hugely complex field. How much flexibility does each individual ICS have to try to get that mix right?

Amanda Pritchard: That is a really important point. Ultimately, the top level of the things we are measuring is around whether we have delivered the reduction in long waits, whether we have delivered the activity that sits behind that and whether we have delivered the right access for patients on cancer pathways.

What is described here is what the best evidence is nationally about those things that will help people to deliver those outcomes. The local mix of what the most important thing is will be different in different places, exactly as Jim has said.

Programmes like surgical transformation are supported by the GIRFT team, the Getting It Right First Time team. That is a clinical programme focusing on variation. Part of what they do is to ensure people have the local data so they can see for themselves where they might be out of kilter and where it looks like they have an opportunity. They either want to get into that locally and do it themselves or—we have seen this in some of the tier one trusts, for example—they actively ask for support, and the national team have been able to go in and really help them look, clinician to clinician, at the design of those services.

The surgical transformation programme is definitely not a lift-and-shift. It is about transparent data that allows you to compare where you are as an individual organisation or ICB and practical support that sits behind that. That can be mandated, if you are very obviously in need of support, but it is more likely to be pulled on if you want it.

Q76 **Anne Marie Morris:** If we look at figure 7 again—we have looked at this before—it is the percentage of waiting lists in scope of your 78-week target because they have already waited 43 weeks. My own authority, Devon, is the third-worst performing with 17% having waited over 43 weeks. Taking

it by way of example, because it is the third-worst, I would assume that your team will absolutely have engaged with Devon to look at what they have got right and what they have got wrong.

Can you explain to me what you have done to improve performance? This is by way of example because the same would be true of other trusts. To what extent have the figures I see been considerably improved? To what extent has the learning you talk about from the data you have collected made a real difference in how we have improved performance?

Amanda Pritchard: Devon is Jim's specialist subject. He has spent some considerable time working with colleagues in Devon over the past few months.

Chair: Sir James, perhaps you can come in. I should say that your trust—we should give you the credit—is at the other end of the scale.

Sir James Mackey: Devon really deteriorated in the spring as covid and absence hit. It was just at the wrong time from the point of view of coming out of winter. As activity should have been stepping up, they got hit really quite hard and they have struggled since.

We have had Tim Briggs and the GIRFT team there; Pauline Philip has spent time there; Bernie Bluhm, who works for us in the national programme, is moving part of her time into the south-west to support them; there is a retired chief exec, Michael Wilson, who is working in Devon and Plymouth at the moment to try to accelerate support there.

There are signs that it is starting to improve and move in the right direction, but it is a very difficult position. We have also had periods where we have tried to hook the system up with other providers for mutual aid. It is a long way from everywhere. The cohort of patients in the first round was very surgically oriented. The level of patient movement is quite limited for understandable reasons, but we have tried that. We have tried buddying them up with other trusts and other regions at different points. We have loads of activities going on to try to support Devon.

Q77 **Anne Marie Morris:** Forgive me, then, Sir James. Are things getting better? Are you suggesting that the main cause was covid as opposed to anything systemic?

Sir James Mackey: All these things are a combination of things. It is a part of the country that has had very little separation in urgent and elective care. There is very little protected elective capacity. The geography is a bit of an issue. Urgent care is very pressured. They have lots of delayed transfers of care in social care, which has squeezed their inpatient capacity. There are not large providers on the doorstep who can help when they get into a little bit of trouble. When you add all this stuff together, it creates a bit of a messy picture.

It would be really lovely if every organisation that is off plan or has a problem could think the problem was just one thing and that they could

just fix one thing. It is just never really that straightforward. There are signs of progress, and it looks like it is starting to move in the right direction, but it has been a pretty hard six months.

Q78 **Anne Marie Morris:** That is very good to hear. Is there anything particular about the particular attributes of Devon—the same will be true of other rural deprived areas—that causes this messy picture that you describe? Is it typical? Is it partly caused by the challenges you have in rural areas? In these areas, you have sparsity and usually a greater ageing population than other areas. Are there particular steps or adjustments you can put in place, therefore, to ensure health authorities like that are better placed going forwards?

Sir James Mackey: There is evidence over the years that more rural areas, coastal and isolated areas, and places that do not have a 360-degree provision around them have problems with workforce. There are often patient access problems, et cetera. There is a range of factors there that cause longer-term structural problems.

We have not yet had a conversation in terms of the specifics about learning from the elective programme and what that might mean in terms of the broader system, but I am sure we will in the next couple of months. There is a bit of that. It is also not absolutely the case that, if you are in a rural area, you are definitely going to struggle.

My patch is a rural area; we cover 2,500 square miles. It is different to Devon; we have better infrastructure around us. You could look at that and think that Northumberland and Devon were quite similar from a geographical perspective, but when you get beyond that, it is much more complicated than that.

Anne Marie Morris: I am glad there is going to be improvement. I look forward to seeing it. I am also pleased that you reinforced that reports have already been published about the particular challenges of coastal and rural areas. It is nice to have that recognised.

Q79 **Mrs Drummond:** I have a very quick question. It follows on from that question and Sarah's earlier one about "did not attends" and the impact that is having on waiting lists. Particularly geographically, have you noticed that, for instance, Devon has more "did not attends"? How does that impact on waiting times and outcomes?

Sir James Mackey: We are not seeing a big geographical difference in "did not attends". We do see occasionally differences in parts of the population that we should worry more about, which is a cause for concern. On the inequalities point, that is being tracked in various parts of the country. People have identified that people of certain backgrounds are less likely to attend than otherwise. There is a big thing in children's services, for example, where children are not brought in for their appointments.

There are lots of examples of people from different demographic backgrounds, and people in poverty and stuff. There is lots of evidence of

people not turning up in the way you would expect them to. It is completely understandable and predictable. It is then about what we do about that at ICB and trust level. It is about understanding the differences and then trying to create access that is possible for people. It can be about taking the service to them rather than waiting and sitting back for it.

There is not a uniform trend on DNAs. It is not uniformly getting better or worse. It is very nuanced behind that.

Q80 **Mrs Drummond:** Is it impacting on waiting times? What is your analysis of that?

Sir James Mackey: A DNA ties up capacity that could have been used to see somebody else. There is not evidence that it has massively deteriorated or that it is a bigger problem than it was pre covid.

There was a bit of controversy in the summer, when we were trying to get back to pre-covid policies, about offering somebody two choices. We should really be sending the patient back and having a conversation with the GP about what is going to happen next. You cannot stay on the list forever and keep refusing choices. I have to say the service has been very nervous about that because we do not want to lose people, and we do not want to prevent access when people have a good, justifiable concern.

Going back to the earlier points of conversation, it is all about the patient-clinician interaction, the primary care-secondary care interaction and understanding whether there is something else going on that is preventing them from accessing care.

Q81 **Chair:** You talk about this as though some of them are repeat offenders for this.

Sir James Mackey: Yes.

Q82 **Chair:** That is when you worry that there is something else going on.

Sir James Mackey: Yes, we all have examples of patients who have refused 10 or 15 slots. That has not been uncommon. I can think of patients in my system who we have tried lots of times to get in to have an appointment, and for various reasons they keep refusing. We became very paternalistic about all that, for obvious reasons, during covid. We are all trying to get back to normal and make sure that, in that transition, patients do not lose access. Sometimes we should be providing access for the most vulnerable in society.

Q83 **Sir Geoffrey Clifton-Brown:** Can we go to paragraph 2.8 on page 29? Ms Pritchard, I want to talk about the withdrawal of treatments. The Report says that NHSE is "withdrawing certain treatments where NHSE and the Academy of Medical Royal Colleges (AoMRC) agree there is too little clinical value. NHSE expects some 1.8 million treatments to be avoided in 2022-23 as a result".

Could you tell us a little bit more about those treatments? Are they things

like tonsillectomy? When I was a child, specialists used to whip out tonsils as quick as anything. Yet it is still, I believe, being done today. Why has it taken the NHS so long to react to these unnecessary treatments?

Amanda Pritchard: Helpfully, the lead for that programme within NHS England is Professor Powis.

Chair: We are going to get a masterclass in tonsillectomies.

Professor Powis: Indeed, tonsillectomy was on a previous list of procedures that we recommended were not undertaken. That was pre pandemic. Again, this is not a new programme. There was an initial list of 13 procedures that we recommended were not continued except under very specific circumstances. It is very rarely all or nothing. There are always some indications where some of these procedures, including tonsillectomy, are still appropriate. That was in 2018 or 2019.

Again, the work that is highlighted here is work that the Academy of Medical Royal Colleges is now doing on our behalf. The initial list was generated within NHS England. We then asked the academy, because of the need for professional clinical involvement, to undertake this work. The work was led by Professor Martin Marshall, who was until recently the chair of the Royal College of General Practitioners, and Sir Terence Stephenson, former chair of the General Medical Council.

Throughout the pandemic, this work has been going on to identify the next list of procedures where the evidence base for their use is not there. A lot of it is based on NICE guidance and other professional societies that have undertaken this work. It really is taking the evidence base from the work of clinicians and fellow professionals.

I had a tonsillectomy when I was a young child; I was probably in for two weeks at the time, but whether it was necessary or not I do not know. As you rightly hinted, over time clinical evidence moves on and clinical practice moves on. It is quite right that, as well as introducing new procedures, we should stop doing procedures where it has become apparent that they are of very little benefit.

There is a range of levers we can use and have used to ensure these procedures are not undertaken. Some of them are contractual; they are in our commissioning arrangements. There are some procedures where we simply can say, "Unless you have a very specific patient with a specific case that has gone through an approval process, we will not pay for it".

Some of it is in guidance, particularly in areas where we do not specifically commission for a particular item. This is a programme that we will continue.

Chair: It is an old programme.

Professor Powis: We have done something similar in medicines as well. We have moved some things to over the counter where there is very little evidence that having them through prescriptions is the right thing to do.

Q84 **Sir Geoffrey Clifton-Brown:** Are these 13 procedures in the public domain?

Professor Powis: The 13 were. There is a new list that we are hoping to publish soon. That is the recent work of the academy. There is new work ongoing at the moment, and we are on the third list. The 13 were the very first list, which from memory was in 2018 but could have been 2019 because the pandemic has warped my memory of all those pre-pandemic years at the moment.

Q85 **Sir Geoffrey Clifton-Brown:** That paragraph tells us that NHSE expects some 1.8 million treatments to be avoided in 2022-23 as a result. To a layman, that seems a very large figure. Is it a realistic figure?

Professor Powis: Yes. Again, this is based on analysis around the various procedures on the list and the volumes of work that are undertaken. There are usually trajectories underlying the work. They do not all suddenly stop. There is usually a period of time when we see them reduce. I am sure we can get you the data. During the pandemic, as Jim has said, there was a mix of things going on that meant there was less activity, but we have been tracking these through the pandemic.

Q86 **Chair:** Right at the start, Ms Pritchard, we talked about the risks facing the NHS. In the current context, from your position, how is the NHS doing compared with this time last year? These risks are yet to materialise, are they not? We went through them all: strikes, sickness, recruitment shortfall, flu, covid and vacancies generally in the NHS workforce.

Amanda Pritchard: Like Steve, my sense of exact timing has probably faded slightly, but at this time last year we were at the point of being very worried about omicron. The risk profile was different then compared to where it is now. My memory is that we had seen it going up so we knew that—

Chair: We had a lockdown, of course. It feels like a million years ago, but it was only a year ago.

Amanda Pritchard: You are right. It does feel like a million years ago, but with omicron, without knowing much about the severity, we were looking at a rate of growth that meant it could have been not just the volume it was but also a much more worrying variant than we thought at the time. At that point we were trying—it was not dissimilar to what we are trying to do now—to say, "Let us try to hold on to as much as possible of the activity that is going on within the NHS that is not emergency-focused".

Our story of the pandemic was that we went to about 40% of elective activity in that very first lockdown, which really did represent only the most urgent work. It was then about 70% in the second big wave, and we held

on to about 90% in the third wave, which was the omicron wave. At that time the focus was very much more on our response to omicron.

Q87 **Chair:** Sir Jim, how much might get cancelled this winter? There are a lot of known unknowns, but you must have done some projections. What is the worst-case scenario?

Sir James Mackey: I would love to say none.

Chair: We are all realists so we would not believe you.

Sir James Mackey: Probably the biggest risk is the industrial action. As Amanda said, the NHS has got better at managing to keep things going as we have had different waves of covid. We have learned from a bit of that with flu and stuff over this winter. There is still pressure on urgent care. We are going to have lumpy periods. There will be times when things get cancelled and we will have to get back on our feet as quickly as we can.

Q88 **Chair:** Bearing that in mind, you have already said you will be behind and you are not going to beat the 62-week target. The 78-week target is at risk. Are you confident that, if you do get behind, you will still be able to meet that 2025 target? Is there a point beyond which you will not be able to ramp up the productivity again, if you have slipped behind in the next couple of months?

Amanda Pritchard: We would need to take stock as we went on. We are certainly nowhere near saying that it is not a doable thing.

Q89 **Chair:** If some of these risks crystallise, that must put it at risk. We are realists. You went out boldly in March. You did not know you had the money then. You have money, but overnight that does not solve the strikes, the sickness and all of those staffing challenges. With all of these pressures, if you had challenges this Christmas, what would it mean for that longer-term target?

Amanda Pritchard: The first thing is that we will continue to go at this, no matter how challenging this winter is.

Chair: I would hope so.

Amanda Pritchard: As you know, there are no easy options now. I remember something that Steve said, very powerfully, when we were talking about Omicron this time last year. As a result of where we are with the elective position, nobody wants to cancel a patient who has been waiting 18 months. That is not the same as it was pre pandemic. Some of those judgments were different.

Clinically, everybody will want, as they always have done, to do absolutely everything they can to continue the programme.

Q90 **Chair:** How far would you have to fall behind now before you—

Amanda Pritchard: We talked about this earlier. It is back to the profile of the waiting list. The bit that is hardest for us to mitigate is the more complex inpatient cases. Those are a very small percentage of what is on the current waiting list. Nonetheless, if we look at the 104-week position, we can see that those patients tend to have waited the longest because they are the most complex to arrange care for. That is the thing we need to watch most carefully over winter. That is where the mitigation is going to be most challenging.

Q91 **Chair:** Will there be any rationing or reducing of NHS services if these pressures kick in?

Amanda Pritchard: What we did during covid—we would take the same approach this winter, if we were under similar sorts of pressure—was we had national co-ordination but local decision making. We want to make sure clinicians are in the driving seat. They will make the best decisions about what judgments to make between different priorities locally. We will support them through things like the regional work on mutual aid through ICBs to try to make best use of local resources and then nationally, if we have to, get into offering patients the opportunity to move around.

Q92 **Chair:** Rather than reducing services, the more likely thing is that people will have to travel further or have online consultations from someone outside their area. Is that what you are saying?

Amanda Pritchard: Every winter we have a certain number of planned appointments that end up being postponed for one reason or another. I am definitely not into crystal ball gazing about this winter, but it would be surprising if no hospital ended up having to do that.

Q93 **Chair:** Just to pin you down on the 2025 target, is there a risk that you will get to a point where you will not be able to catch up enough to hit the 2025 target? You have danced around that. I know it is complicated. It is not a simple yes-or-no answer. Would you still hit the target if all of these risks came together?

Amanda Pritchard: No, I understand where you are going with this. The answer is that theoretically, yes, that must be correct, but at the moment we are a very long way away from that. We will be doing absolutely everything we can to support the NHS to deliver.

Q94 **Chair:** Sir Jim, earlier you talked about the backlog being uneven across the country. Are there so many areas that are off track that you do not know where to devote your time? Figure 7 highlights quite a lot of challenging areas. We talked about Devon, but you can see all of the areas on page 32, for example. That are quite a lot of areas to focus your attention on. Is it difficult to decide where to go?

Sir James Mackey: All these things are difficult, but, no, not really. When we started last year, you could see quite quickly that the really big numbers were concentrated in a small number of places. As we look to really raise activity, it looks like there are probably about 15 very large organisations

we need to focus on. If we can materially impact activity levels in those organisations, that will really help the aggregate position. We are constantly looking at that all the time.

It generally settles around a level of 15 to 20 that need a lot of attention at a particular point. The tiering process has really helped with that.

Q95 **Chair:** Are you seeing any patterns there? All of this was predicated on an 8% reduction in staffing. That is now 9.7%. That is right, according to the figures I have seen. That is an increase of 1.7% in the vacancy rate. That is a reduction in full-time equivalent staff of around 21,000. Presumably that is not necessarily even. Is that having an impact on performance? If so, how on earth do you backfill those jobs?

Sir James Mackey: We have this really odd thing going on whereby the NHS has more people and more vacancies as well. We are trying to expand and change how the model works. It is not massively out of sync across the country, but some parts of the country struggle harder to recruit.

Some of those have recovered really well. Again, going back to the earlier point, it is not necessarily that, de facto, if you are in a certain kind of area, you are not going to get back on your feet; some of them have. It is a bit more complicated and nuanced than that.

Chair: It is ever complicated.

Q96 **Anne Marie Morris:** Sir James, that leads us quite neatly on to the real challenge of productivity. We had hoped productivity would get better; in fact, it has got worse. I appreciate that things are very difficult. How are we going to get back on track? How are you going to improve productivity from where we are now?

Sir James Mackey: First of all, we all need to understand what that means for all of us at a system level, institution level, regional level, et cetera. In my trust life, my finance and performance committee is going to have a specific session on productivity in December to understand the growth in the workforce, whether we are delivering the right kinds of volumes and what is actually happening.

We will be expecting that to be happening all over the country during the planning round and for people to come out of it with a bit of a plan as to how they gradually go about restoring productivity levels. We should also not just think about the NHS in isolation. The whole of the world has had a productivity hit in every sector, some harder than others.

If we are honest, our version of the productivity hit now would have been very different six months ago. It would have been very different 12 months ago. As we have gone through the blurry last couple of years, sometimes it has been about IPC rules; sometimes it has been about testing; sometimes it has been about absence or fatigue. We are working through all these things all the time.

You start with the data and you start asking questions. You have conversations between clinical and management colleagues and you try to agree and settle on a plan as to how things can be normalised again.

Q97 **Anne Marie Morris:** Is this going to impact the recovery programme?

Sir James Mackey: As Amanda has said, we are not ready to put a flag out. We are going to keep going. The NHS wants to deliver this; we want to deliver everything. There is no evidence yet that we cannot achieve this so we are just going to keep taking it step by step and stage by stage, accepting that we are surrounded by risk. In healthcare, it is all about managing risk. We have to keep reviewing progress, regrouping at different points and having a go.

Q98 **Anne Marie Morris:** Sir James, unless something changes, nothing will change. This takes us to the issue of innovation. What is it you are looking at doing differently? If you carry on trying to do what you are doing in the same way but recognising the challenges, nothing will change.

Sir James Mackey: Yes, it is a combination of all the things we have been talking about over the last two hours. It is surgical productivity, workforce variation and all those other things that have been highlighted. It is about the separation of urgent elective care. From my point of view, in the way I look at the plan, the thing that has the potential to free up most clinical time and see more new patients is the transformation in outpatients because 80% of the waiting list is tied up by outpatients.

Q99 **Anne Marie Morris:** Let me then ask you this. Is there more scope to use those outside the most obvious part of the NHS? Let us take ophthalmology. You said that was one of the worst in terms of delays. At the moment primary ophthalmology care and secondary ophthalmology care are commissioned in different ways. The secondary care is commissioned locally by the ICSs, but there is no mandate that requires them to do that. In Devon, it is 50-50. Half my area in Devon has it commissioned and half does not.

You have the common names like Boots and Specsavers that can deliver secondary care, but it is not used. Will you try to use those sorts of providers? It seems to me that not to use them when you have long waiting lists within the traditional secondary setting is a mistake.

Chair: We have had some good evidence on this.

Sir James Mackey: Most of the growth in the independent sector provision is new-entrant providers in ophthalmology. That is where most of the growth is: where people have come into the system, established themselves and are seeing NHS patients.

Q100 **Anne Marie Morris:** Will you encourage the ICSs to use them? Not all are, frankly, willing to do that.

Sir James Mackey: We will do and we are, where there is a problem. That is happening. On the discussion earlier on about choice, we want to really

accelerate choice at the point of referral. If the patients had that choice at the time they were seeing their GP and they could use an independent sector provider, it would help overall as well. That is coming. We are working through plans to try to do that next year.

Q101 **Anne Marie Morris:** Hopefully there are many other workstreams of a similar nature that are not as you would expect. On that note, I am going to turn to Sir Chris. One of the challenges is the shortage of professional medics. One of the reasons we have a shortage is because there is a Government limit on the number of medical students that go on to F1. As I understand it, that is because there is a limit on the number of training places.

Is that about a lack of money or is it about a lack of supervision? If we take the qualifiers in August this year, we find that there are 800 qualified individuals who have got through a medical degree, but they cannot become F1s. They have been told to apply again for 2023. That just seems an incredible waste when we absolutely need more clinicians.

Sir Chris Wormald: Yes, it is one of the reasons we are doing a workforce strategy, which was reconfirmed by the Chancellor on 17 November. The limits are about the overall capacity of the system. It is both none and all the things you have mentioned. If you take somebody on a medical course, there has to be a route all the way through for them to be practising before you can start. To change the system, you have to look at all of it. That is some of the point of the workforce strategy.

Anne Marie Morris: That is excellent. It seems like innovation is on its way across the board from the Department and NHS England.

Q102 **Sarah Olney:** You mentioned earlier the central importance of data in terms of bringing down the waiting list, the role of digital technology in delivering more services and that this is a big change from when you were last tackling waiting lists in the early 2000s. I wonder whether you could tell me how much progress the NHS has made on implementing digital technology, what more can or needs to be done, and how much progress is being made there.

Amanda Pritchard: I can start. One of the things that has been critical for the NHS is having the right building blocks. The presence of electronic systems in hospitals, for example, is one of the obvious building blocks of our ability to join up data around patients for planning and reporting purposes, et cetera.

When we started this time last year, about a fifth of organisations in the NHS still did not have electronic health records and there were varying degrees of maturity in place for others. This year more new electronic health records have been put in than any year we have had so far. To be honest, that brings with it its own disruption. We have real challenges in some organisations around their own ability to get clean data. It will be worth it in the long run. There is an inevitable hiatus, but it is the right thing to do.

Completing the programme to implement electronic health records is crucial. Building on that, there are various things that we need to do to join up data. The federated data platform is one of the projects that is going on around that. It is not the only one. It is things like the work more locally to create single versions of the truth so that ICBs can use them for things like population health management purposes. That is the analytics as much as anything else.

There is a layering in place, and then you can put some of the whizzier tech on top of that. This involves some of the things we talked about already such as being able to send reports off so they can be viewed, read and reported elsewhere. That is live in radiology in some places and has been for a long time; it is increasingly true in pathology services as well due to the digital link-up there.

Increasingly, we also have the ability to use AI for real. We can use it for the things like the second read of a scan. That is emerging technology rather than something that is universally available, but, having put the investment in place to get some of the basics right, that allows us to start building from there.

Some of the technology that has made the biggest difference, though, is the really simple stuff like the ability to use Teams, Zoom or other video conferencing facilities so you can do some of the things Jim was talking about around remote monitoring and consultation.

Professor Powis: One of the biggest changes that occurred through the pandemic—it was almost unnoticed—was the use of the NHS app. The requirement to have your vaccine details on the app has driven a huge usage of the NHS app. At one point it was the most downloaded app. Do not quote me on that, but it was one of the most downloaded apps.

People have just got used to using it. Of course, what we are doing is building on that to ensure that your GP health record is increasingly available directly to the citizen on the app. My own practice has worked on this. I can see my blood results almost immediately. I can order my prescriptions online. I can see letters sent from secondary care into primary care. That has almost gone on by stealth, but people are much more comfortable using this and using it as an access point into health systems.

Q103 **Sarah Olney:** You are saying that one of the upsides, not that there were many, of the pandemic has been a bit of a change in patient behaviour and patients' readiness to use tech.

Professor Powis: Yes, and in clinicians too. I would not underestimate the cultural change that has come with being familiar to doing things on Zoom, Teams and all the different platforms. Part of this is people becoming comfortable with the technology as much as having the technology. That has really changed dramatically during the pandemic. There is no going back on it. Everybody is much more comfortable at doing it.

Q104 **Sir Geoffrey Clifton-Brown:** If I could turn to you, Ms Pritchard, the Chancellor, in his autumn statement, gave a £3.3 billion for the NHS and £4.7 billion for social care—a record £8 billion package. You are on record as saying that this should provide sufficient funding to the NHS to fulfil its key priorities. Does that remain your view?

Amanda Pritchard: Yes, it does.

Q105 **Sir Geoffrey Clifton-Brown:** If we do not meet the targets we have been talking about today, it will not be because there is a lack of funding.

Amanda Pritchard: As I said, it should be sufficient funding for the NHS to fulfil its key priorities. There are probably two important things to say, if I was going to expand on the answer. First, what are the key priorities? We have discussed that earlier in this session. Again, it would be wrong of me not also to acknowledge that our priorities include mental health, maintaining the long-term investment plan in mental health and maintaining earlier cancer diagnosis. The funding package allows us to maintain spending in those areas as well.

As we have said, the NHS is not in a vacuum. There are risks that are not associated with the current funding but are associated with the unknowns we have discussed. We have talked about industrial action, covid, flu and social care. It is great that funding is coming to social care, but there is clearly a significant challenge to overcome there. We have talked about the assumption that has been made about the ongoing level of inflation. Again, should that not prove to be the case, that will clearly play into this.

Within that framework, I am happy to say that it should provide sufficient funding for the NHS to fulfil its key priorities. It does enable us, in this context, to maintain our planned spending in those key priorities, as set out—

Q106 **Sir Geoffrey Clifton-Brown:** I was anticipating that you would want to give us some caveats on that statement. Can I go on to the workforce? In that same statement, the Chancellor said that there will be an independently verified forecast for the number of doctors, nurses and other professionals that will be needed in five, 10 and 15 years' time, taking full account of the improvements in retention and productivity. That is quite a big bit of work. When are we likely to see that?

Amanda Pritchard: Chris might want to comment on this because this is the work that we have been doing, to which we just referred, around the workforce plan.

Sir Chris Wormald: Yes, there are two parts to this. There is the work that NHSE was already doing on the workforce plan. We are not, as it were, stopping and starting again. The idea is that work will be completed this calendar year, and then we will have the independent verification process that the Chancellor described. Matt, is there anything you want to add?

Matthew Style: The innovations that Ms Morris was talking about earlier and the productivity agenda that we have also discussed will be absolutely at the heart of the work that has been commissioned. This is not just about raw numbers of clinicians that we think we might need in the future on a standstill basis. It is actually getting into the heart of the creativity and innovation, different workforce models and different training models that will be necessary in order to deliver that. It will be a comprehensive piece of work.

Q107 **Sir Geoffrey Clifton-Brown:** I get that, and I am delighted to hear about the positivity of new technology, increased productivity and all that. Paragraph 3.18 on page 49 gives three here and now problems with NHS staff. I would like to get your reaction to how you are dealing with these: the high rate of leavers, the need to recruit key staff groups, and that staff sickness absence will remain high as a result of stress and covid-19 infections. What are you doing to address all three of those?

Sir Chris Wormald: That is mainly for Amanda.

Amanda Pritchard: We might bring Steve in on the specifics around recruitment, because part of the challenge for recruitment is that it is not just any staff; it is the right staff and the right skills.

On sickness, we would absolutely recognise those figures. That has been one of the slightly hidden impacts of the high levels of covid we have had this year, but also, as this Report rightly says, we are seeing it around the world, but it is a known consequence of having gone through something like the NHS has done for the last two years.

Part of the challenge for us remains making sure that, while we are pulling out all the stops to support people to do the work on elective and to support patients on the urgent emergency care pathway, we are also doing everything we can to look after our staff. That does not necessarily go to dramatic national changes in those figures, but locally we know we can encourage people to take up the flu and covid vaccines. We can ensure the national offers that were put in place around covid-time to support workforce; that is as much about mental health support as it is about physical health support.

We can continue to encourage local employers to learn from best practice, to support flexibility in rosters and to support some of the innovation we have seen in different parts of the NHS around things that matter to those staff groups. Different staff groups will give slightly different answers to that, but we see all around the NHS that there are definitely things you can do that will make what is a very difficult job a bit easier.

The second point, having said all of that, is that we clearly want to hold on to as many staff as we possibly can and we want to support them particularly through this difficult period with potential industrial action, but we also need to be training and recruiting the staff we will need now and for the future.

Professor Powis: Across all staff groups it is ensuring that we do as much as possible to make staff feel they are working in a good environment. With all the health and wellbeing we have been talking about in specific groups such as nursing, the chief nursing officer is continuing to work with the Department on appropriate international recruitment. In doctors it is around ensuring we are increasing training numbers, which we are doing in particular specialities that are particularly important. For instance, for cancer we have done that recently.

In the longer term it is around getting more staff in. There needs to be an increase in the number of medical students. The Chancellor in his previous role as chair of the Health Committee asked me that very directly at the previous Health Committee. I believe we need to expand our number of medical students. We need to expand that in medical schools, perhaps with new medical schools in areas of the country such as rural and coastal areas, where we know that people put down roots and then help solve the workforce problems in those areas in the future. It is all of those things together.

Of course, for senior doctors there is the pensions issue. We have talked about that earlier.

Chair: That was first raised here in 2012. Sir Chris's predecessor dismissed it as not an issue.

Professor Powis: Some moves have been made to improve that but it is clearly a worry for a lot of senior doctors. It is meaning that some of them are leaving. It is predominantly, of course, the tax bill, but it is also the complexity that underlies it.

Sir Chris Wormald: The only thing I would add to that list is that return is the other dynamic.

Chair: Do you mean in terms of people coming back?

Sir Chris Wormald: Yes. I have said to the Committee before there is a long-term change in the economy driven by the very long length of our working lives now; people do not tend to stay in the same thing. In 2012, when I was doing education, we had the highest rate of return as well as the highest rate of leaving from the education system. That is happening across the economy. It is really difficult in health, because of course there is a very high bar for professional practice, so it is much more difficult to return. This would be another thing that is on this list of things we learned about in the pandemic that want to keep. We of course did very well on return, and that will be the other aspect we want to look at.

Q108 **Sir Geoffrey Clifton-Brown:** Can I see if I can get an agreement from you to this question? The only sustainable way to make sure we are going to consistently have enough staff in the NHS is not pinching them from countries around the world like Thailand, because that is going to become less and less sustainable. The only sustainable way is to considerably up

the number of young people we train for those posts and make the profession more attractive to come into. Putting student loan fees on, making them pay car parking charges and, of course, salaries are all things that make the profession not as attractive as it should be. Surely the absolute thrust of the NHS ought to be training and attracting more youngsters into it.

Sir Chris Wormald: That is a component of it, but not the only thing. The other big thing we have to do—this is a point my dear friend the Chief Medical Officer repeatedly makes—is make sure everyone is working at the top of their profession. When we have very expensively trained doctors, they should be doing only the things that doctors can. That works down for every other profession as well. There is a big element that goes to some of the technology points we were talking to as well, which is about making sure that we get the most out of everyone we do have.

That has two effects: first, you have a more fulfilling job because you are using your professional skills; and, secondly, you are maximising our shortage things. That is another very big component. As I say, the point of having a workforce plan is exactly to get into these questions.

Q109 **Sir Geoffrey Clifton-Brown:** Ms Pritchard, my health trusts tell me there is a real morale problem at the moment. What are you doing to make sure that all of your staff across the NHS are getting more wellbeing advice from people like ARRS?

Amanda Pritchard: It goes back to what I was just talking about before, in terms of making sure that not only do we maintain the national offer around health and wellbeing but we are promoting things that we know make a difference. I have talked about things like flexibility, childcare, time off for carers and leave. Those are the sorts of things we know really matter.

The morale point is a really important one. It is also people's desire to know they are really doing a good job. When the NHS is under the level of pressure it is at the moment, that makes it much harder for colleagues. They feel it very personally, and that is one of the reasons why it is really important that we keep going with some of our recovery plans. The right answer for our staff as well as our patients is to get to the place where we can really celebrate the success of having met some of these milestones, as well as seeing some of these improvements in other areas that we are striving for.

Q110 **Sir Geoffrey Clifton-Brown:** Sometimes a word of thanks both from within the trusts but also from members of the public can help. My wife had superb treatment for a dislocated hip recently. I took the trouble to write to the chief executive and say, "Will you please thank those staff on duty on that shift?" Staff must get an awful lot of criticism—I know they do—but where things go well, we should encourage people to say thank you.

Amanda Pritchard: Thank you for saying that. I have to say, as a former trust chief exec, it means such a lot to individual members of staff, and to everybody, just to have recognition. We all know when it does not work, but it really means a lot when people take the time to say thank you, so thank you.

Q111 **Sir Geoffrey Clifton-Brown:** Can I move us on to the vexed subject of social care? In that autumn statement, the Chancellor said that he would give £2.8 billion for social care in 2023-24 and £4.7 billion in 2024-25. I know we are facing severe financial difficulties, but it seems to me that we need to get social care sorted our rapidly. My example in Gloucestershire is that we have got 200 patients, which is twice the national average for the percentage, not able to be discharged from hospital when they are clinically fit to be discharged, because there are not enough social care workers to provide care packages. Unless we get this sorted out rapidly, we are not going to meet all these targets we have been talking about today in the NHS.

What can be done to sort out the social care sector? In the social care sector I am convinced that a lot of it is actually wages, because they can go and earn more in Tesco than they can working in the social care sector.

Sir Chris Wormald: Obviously the money is very important. As you say, in a very tight fiscal situation the Chancellor chose to put quite a lot of money into social care. In percentage terms, it was a lot more than went to the NHS, and for exactly the reason you were saying. The flow through from hospital to care is clearly the key bit.

Chair: The reasons are well rehearsed.

Sir Chris Wormald: The money is necessary but not sufficient. We need better integration between health and care. That is of course part of the purpose of ICSs, to look much more across the system and how the NHS and the social care system can work better together. That bit is absolutely essential for all this money to be spent well, assisting both the social care system and the NHS to achieve their objectives.

As you say, there is a big workforce component to that, which we discussed at previous hearings. Everything I have said still maintains. Those are largely the three things we need to get right to get the most out of this money. It is the investment, the working together and the workforce.

Chair: We have talked about this quite a lot before.

Q112 **Sir Geoffrey Clifton-Brown:** As a point of information, Sir Chris, is the £2.8 billion I mentioned plus the £600 million from the better care fund, or is that included in the £2.8 billion?

Sir Chris Wormald: The £2.8 billion is all-in, so it includes the extra money, the £600 million for the better care fund.

Q113 **Sir Geoffrey Clifton-Brown:** What assurances can be given that the

planned additional funding, for example raised through increases in council tax, will be ringfenced to adult social care?

Sir Chris Wormald: It is a matter for local government and its own audit system to do that. You may know better than me, but the money that is raised from council tax specifically for social care as part of the precept is ringfenced and that is audited locally.

There are two other key parts. One is the ICS system, of which both local government and the NHS are a part. It needs both sides to do their bit. The other is the new powers that we took in the last Act for CQC to be able to look at commissioning at local authorities as well as looking at ICS working. We will get much more of an oversight of how the system is working and much more data about the social care system through our new powers.

Q114 **Sir Geoffrey Clifton-Brown:** What do the Government mean when they say that 200,000 more care packages will be delivered in the next two years? For example, what is the size and nature of these care packages?

Sir Chris Wormald: You are going out beyond the level that I briefed myself. Could I write to you specifically on that?

Sir Geoffrey Clifton-Brown: Yes, of course.

Chair: Care packages are often about prevention.

Sir Chris Wormald: There will be a definition of exactly what we mean by "care package". Rather than guess, I will write to you.

Sir Geoffrey Clifton-Brown: No, that is really helpful. I am perfectly happy with that.

Chair: Can I thank our witnesses very much indeed for a marathon session, and wish you all the best? We all want to see backlogs and waiting times reduced. We are all united in that, but obviously our job is to hold you to account for what you have told us today and what you have promised to do. We hope that goes well for you all.

The transcript of this session will go up on the website uncorrected in the next couple of days—thank you to our colleagues at *Hansard*—and our report will be published in the new year. Thank you very much.