

Public Accounts Committee

Oral evidence: Reducing NHS waiting times for elective care, HC 820

Thursday 11 September 2025

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Members present: Mr Clive Betts (Chair); Sarah Hall; Lloyd Hatton; Sarah Olney; Michael Payne; Oliver Ryan.

Health and Social Care Committee member also present: Josh Fenton-Glynn.

Gareth Davies, Comptroller and Auditor General, Head of the National Audit Office, Ashley McDougall, Director, NAO, and David Fairbrother, Treasury Officer of Accounts, were in attendance.

Questions 1 – 86

Witnesses

I: Samantha Jones, Permanent Secretary, Department of Health and Social Care; Matt Style, Director General, Secondary Care and Integration, Department of Health and Social Care; Sir Jim Mackey, CEO, NHS England; Professor Meghana Pandit, Co-Medical Director (Secondary Care), NHS England; Mark Cubbon, Elective Care, Cancer and Diagnostics Director, NHS England.

Report by the Comptroller and Auditor General
NHS England's management of elective care transformation
programmes (HC 766)

Examination of witnesses

Witnesses: Samantha Jones, Matt Style, Sir Jim Mackey, Professor Meghana Pandit and Mark Cubbon.

Q1 **Chair:** Welcome, everyone, to this morning's session of the Public Accounts Committee. Thank you for joining us. To begin with we have apologies from Sir Geoffrey Clifton-Brown, the chair of the Committee, who is not with us today. I am Clive Betts. I am chairing the Committee as the deputy chair this morning.

Members around the table are members of the Public Accounts Committee, with the exception of Josh Fenton-Glynn, who is a guest in our Committee from the Health and Social Care Committee. Josh, welcome and thank you for joining us. The Select Committees and the Public Accounts Committee try to work together on these important matters. Our job here is to look at how public money is spent and whether the public are getting value for that money. That is what we are going to do today with regard to waiting times and waiting lists in the NHS.

Data shows that, in June of this year, around 6 million people were waiting for elective care. We know from our experience as constituency MPs that constituents waiting to get appointments and care is a very big issue. It is a general issue, but also particular to the individuals who are waiting.

Three years ago, NHS England set out a recovery plan, particularly looking at programmes to do with surgery, diagnostics and out-patients, to get those waiting times reduced. There has been progress, I think, in getting the longest waiting times down but probably the overall waits and waiting lists have not reduced as much as was hoped for when the programme began. As we have seen, and will as we go through, some of the programmes have perhaps been less successful than others. There has been success in getting diagnostic centres up and running and getting more tests done, some success with new surgical hubs but a real struggle on out-patient appointments and getting the numbers of people waiting there down at all.

As always with the NHS, when one plan does not work we get a new plan. In January of this year there was £1.5 billion allocated for capital spending to try to get further progress on these matters. In today's session we have before us senior officials from the Department of Health and Social Care and NHS England. I am going to ask them to introduce



HOUSE OF COMMONS

themselves and say who they are and what role they have.

Samantha Jones: Good morning. My name is Samantha Jones. I am the Permanent Secretary here at the Department of Health and Social Care.

Matt Style: My name is Matthew Style. I am the director general for secondary care and integration in the Department of Health and Social Care.

Sir Jim Mackey: Good morning. I am Jim Mackey, the chief exec of NHS England.

Mark Cubbon: Good morning. My name is Mark Cubbon. I am the national director for electives, cancer and diagnostics.

Professor Pandit: Good morning. My name is Meghana Pandit and I am the national medical director.

Q2 **Chair:** Thank you all for coming. You have probably been advised in advance that the Committee wants to explore one or two other matters that are of particular relevance. Indeed, when the Committee met before, by chance on the same day, significant changes were announced about the eventual abolition of NHS England and the amalgamation of that function into the Department, but also the 50% reduction in the funding for integrated care boards, which it was going to have to manage. I suppose we want to ask a few questions about that from a financial point of view. How is it going, Sir Jim?

Sir Jim Mackey: That is a good question. We are at an interesting point with the change process. The change process of reduction in costs for NHS England, Department of Health and Social Care and that integration, but also with the integrated care board changes throughout the country, is a huge change. It was a very dramatic change for the service. As we explained on Tuesday in the Health and Social Care Select Committee, there was an awful lot of work done very quickly, working with ICB chief execs, chairs and other colleagues to develop the model ICB and start to reduce the variation in running costs and some of the key cost drivers such as CHC.

That was a pretty successful exercise, but difficult because we have to take a pretty significant cost reduction as part of all that. Every ICB has submitted a plan to deliver those changes. We have just published a model region as well this week, which is another important part of the jigsaw. We are now working through, with Treasury colleagues, how we can actually enact the change, hopefully by utilising the voluntary redundancy scheme. That will allow people to start to implement the structural changes.

In terms of how it has gone so far, there has been a really strong leadership response across the NHS to the financial reset generally, but also embracing this change. So far this year, the NHS has managed to hold to the financial plans that we agreed at the beginning of the year.



HOUSE OF COMMONS

Colleagues will remember that we were looking down the barrel at about a £6.6 billion deficit and £4.5 billion after deficit support. When the reset started, we ended up agreeing balanced plans quite quickly and so far the NHS is on track, but we have some really material pressures.

Resolving the redundancy cost conundrum is a big thing for us. I am sure we will cover this when we talk about elective progress, but there is also industrial action. The impact and cost of industrial action is another key pressure for us.

Q3 Chair: Let us put the industrial action to one side for a moment. You have mentioned the issue of redundancy costs. It seems pretty obvious that, if you are going to cut funding of an organisation by 50%, you are probably going to have to get rid of some staff. Therefore, there are probably going to be redundancy costs. It is not your personal responsibility. You were not there at the time. Is it not really quite amazing that that was not thought of as a key element when the process began?

Sir Jim Mackey: It was thought of and discussed right at the beginning and it is an issue that we have been working through with Treasury since then. We have had discussions this week as well. Hopefully we are getting closer to resolving the issue, but it is a pretty significant sum of money. You are right: people will not leave without some kind of redundancy compensation. At this stage, we are talking about voluntary redundancies. In NHS England alone, we have over 3,000 volunteers to take a voluntary redundancy settlement if we could fund it appropriately.

Q4 Chair: People tend to only volunteer once they get some money to go with. Samantha Jones, it is slightly bewildering to some of us, looking from the outside, that a programme could begin like this without having had the conversations with the Treasury to begin with about who was going to fund this.

Samantha Jones: As Jim has just set out, discussions took place at the time. If we go back to what the Prime Minister and the Secretary of State announced in April, which was the abolition of NHS England and the creation of a new Department with a 50% reduction, at the moment we are working through what the new centre looks like and, importantly, who is going to lead it. We are already out to advert for a number of those senior posts. Really importantly, what is the shape and function of those individual areas within the new Department?

As Jim says, there are ongoing discussions with Treasury in terms of how we ensure, through the right approach, that we can fund and support people to exit the organisation. I am sure you are going to come back, as part of the Committee, about how we are going to make sure we deliver today, as well as focus on tomorrow and the elective recovery. At the moment we are working through the size and shape of each individual team across the Department as part of the discussions.



HOUSE OF COMMONS

Q5 **Chair:** That is the Department at national level. Some people might say, “Perhaps there is an overlap between people running the Department and people running NHS England”. Down at the ICB level, how on earth do they begin to plan for next year, or even the rest of this year, if they do not know, when they reduce staff, whether the cost of those redundancies is going to be covered by the Department or the Treasury, or whether they will have to include it in their budget calculations? That really is an unsatisfactory situation, is it not?

Sir Jim Mackey: It is unsatisfactory. As I discussed the other day, the thing that we are especially bothered about is how we are treating individual colleagues. Through no fault of their own they are in this position. There are different ways of approaching this change, though. The immediate plans were built on a very dramatic, speedy change process that would have incurred quite a lot of redundancy costs up front. If that cannot be agreed with Treasury, we have had some discussions with ICBs about doing it over a longer time period in a more managed way, which is possible, but we will not get the pace and scale of change that we need in order to deliver our operational imperatives.

Q6 **Chair:** You are absolutely right, Sir Jim, that the effect on individuals is important. We should all be concerned about the people who work in the NHS, but also the services to the public, who are our constituents. At some point, because I have still not had this properly explained to me, although probably other people have, could you set out for us the current roles and functions that ICBs perform and what, under the brave new world that you are shaping out to achieve, the ICBs will be doing? What functions that they are doing currently will not be done at all—there is a saving there presumably—and what functions will be passed on to some other part of the NHS or local government? I will just say that local government is concerned that, in the end, holes will appear and it will be asked to fill the holes with funding it does not have.

Sir Jim Mackey: We can get you that. That is largely covered in the model ICB and model region. I think we committed to this on Tuesday as well. We will get you a note to clarify how all that works.

Q7 **Chair:** Will the saving of 50% be made without any reduction in service?

Sir Jim Mackey: It should be, yes. All the plans we have from ICBs give us the assurance that they can deliver that change without a direct implication for service provision.

Q8 **Chair:** I have one more question, because it is important, about the interaction between the NHS and local government. It is absolutely key. Certainly in covid it proved a great strength where it worked properly. I speak from my personal perspective in Sheffield, where relationships with the NHS at local level and the council were brilliant and helped deliver better services. Now it looks as though the ICB’s reaction is to pull things to the centre of the ICB. The place arrangements, particularly local place with the director of public health, director of social care and the



HOUSE OF COMMONS

arrangements in local neighbourhoods, are going to be pulled into the centre and undermined. That is not satisfactory, is it?

Sir Jim Mackey: No. We have been clear that strong place arrangements are essential to an effective functioning of an ICB in those relationships with the local authority sector. This will be complicated in the new world, because every ICB will cover more than one local authority. They have bigger footprints. I would argue that that makes the place arrangements even more important. How that is done, though, varies place to place and we will make sure, through our oversight of ICBs, that there are strong and functional arrangements, but there will be a local nuance there.

Q9 **Chair:** If MPs, among others, have concerns that that is not happening at local level, do we come to you?

Sir Jim Mackey: Just get in touch, absolutely.

Chair: I will get your phone number.

Samantha Jones: To build on what Sir Jim said, the neighbourhood health approach that we are taking is fundamentally about keeping it as local as possible to individuals, involving local councils, making sure we have local authorities and the voluntary sector. Indeed, the Secretary of State announced the 43 earlier on this week. The reason I say that is that they are a practical example of what Jim was describing about it being as local as possible to individuals.

Q10 **Chair:** It is when the ICB says, "We have four councils. We can't afford to replicate what we do in four council areas separately", so that element goes. Quite frankly, the mayoral combined authorities are not the place where relationships on health get delivered. It is with the local councils and district councils.

Matt Style: This is partly why, in the 10-year plan, we were very clear that the building blocks for ICB future strategic plans had to be those local neighbourhood plans and we would hardwire that obligation to have regard to those neighbourhood plans into how ICBs were expected to work.

Chair: That is reassuring. We were going to raise some issues about the surcharges for people coming from abroad to access NHS care. I think we will probably write to you about those and get responses. That probably will help us move forward with the agenda today. We are coming back to the issue of reducing waiting lists.

Q11 **Lloyd Hatton:** I would like to start with community diagnostic centres, which in some ways have been a success story in the way that they have delivered tests and scans for patients closer to home rather than further up the road at an acute hospital. Could you set out, Sir Jim, where you feel there has been a success in building up the capacity of community diagnostic centres and the difference that that has made to ensuring that certainly some patients have a test or a scan much more quickly once



HOUSE OF COMMONS

they have been referred in by their GP?

Sir Jim Mackey: I will start and then bring Mark and maybe Meghana in as well, if that is okay. Going back to the CDC and surgical hub thing, the big part of that was about the separation of urgent elective care, which is a really key, important strategic move for us to protect both streams and give dedicated capacity, especially for diagnostics. That is to avoid the situation where patients might have a scan booked but an emergency patient comes in and they then get juggled, cancelled or whatever.

We have had a huge programme with massive investment and an awful lot of extra capacity created through CDCs and surgical hubs. As always, it is a big change, so the activity has grown since they were opened. The range of services is different in pretty much every CDC, but generally there has been an expansion of the range of services as well. Quite a lot of them are significantly more accessible and closer to the high street, with better access for the population.

In that regard, they have been a very successful development, have contributed towards the reductions in long waits that we have made so far, and are a big part of the next phase as we move more to the RTT standard. We are still struggling with waiting times because of growth and other dynamic factors there as well. Overall, it has been a really positive start. It is a really significant expansion of capacity and very welcomed by the NHS. Satisfaction rates are very high, so patient satisfaction rates are 93% or so, which is really fantastic, but there is still more to do.

Mark Cubbon: We are delighted that we have 170 CDCs now open, 100 of which are open seven days a week, 12 hours a day. That is a fantastic achievement by the teams that have set out to open them in a very short space of time. As Jim said, we are continually looking to see the range of tests that should be provided there and trying to reform the whole pathway for patients. That means that, when a patient first sees a GP, the GP can access the tests in the community without the patient having to go and have a consultation in hospital and then come back for another visit to have their tests.

We are putting out a number of what we call straight-to-test pathways. That means that, if a patient has a certain condition, they will be able to go, be directly booked in to have the test performed, have the diagnosis confirmed and then, if it is required, have a hospital consultation. If not, the treatment can be provided by the GP. That is much quicker for patients to access care, is much prompter decision making and prevents the patients being added to the waiting list unnecessarily.

Q12 **Lloyd Hatton:** Particularly in my constituency, I have a community diagnostic centre in Weymouth Community Hospital. I am pretty certain that it is one of the ones that is operating seven days a week. It is leading to certainly much higher patient satisfaction and I think GPs like the way it works as well.



Moving on, I suppose my concern is that, while the CDCs seem to be broadly a success story, the overall recovery target for diagnostics has been missed significantly. The chart in the NAO Report shows that it is still hovering at around twenty-something percent, where the recovery target is that it should be just 5% that are not on track. What I would like to know a bit more about, Sir Jim, is whether we are just shifting where these diagnostics takes place, rather than actually dealing with the real issue, which is driving down that figure from around twenty-something percent to 5%?

Sir Jim Mackey: Again, I will start and then Mark will come in. Overall, we were very concerned about this at the beginning. What we did not want was to just shift the location of the diagnostic and then have no overall growth or reduction in waiting times. There is a pretty significant growth in actual volume. Coming with that, there is a growth in demand and a material factor also, which is the growth in non-elective access to diagnostics.

The NHS is a very complex, dynamic thing. We have created this additional capacity and done a huge amount of extra work, but that is quickly backfilled by growth in demand. We are working all the time to control the non-elective, urgent demand as well, in order to protect as much of this as possible. You are right overall on the waiting time metrics. We have been a bit stuck and we will really have to focus on that in the next 12 months or so.

Q13 Lloyd Hatton: On that point quickly, Sir Jim, looking at the chart in the NAO Report, which looks at where we are in terms of meeting that 5% recovery target, do you see it as flatlining or do you think we will see a significant drop in the short to medium term? Is it going to keep stubbornly remaining around 20%?

Sir Jim Mackey: All our plans assume a significant drop over time. It cannot flatline, so we have to find ways of unlocking that, but it has been fairly flat over this last year or so.

Mark Cubbon: By the time we got to the end of March last year, about 82% of patients were seen and had their diagnostics within six weeks. We know that we missed the target that was set for last year. As Sir Jim mentioned, we were trying to compensate for a number of different things. One of them is the growth in diagnostic demand, which was far in excess of the modelling that was done to map out the delivery path for the end of March.

We have been working with the royal colleges to see how we can influence the range of tests that perhaps are undertaken for some patients that they may not necessarily need as a first part of their diagnostic path. We are making sure that we are using the diagnostic tests for the specific conditions that patients have all of the time and not doing duplicate tests where they are not necessary. The digital transformation we are seeing across diagnostics is making sure that,



whether it is a test result or an image from a diagnostic clinician in one hospital in one part of the country, you can see it in another part of the country as well, to prevent the need for undertaking repeat tests, which could be overinflating the demand. I do not know whether, Meghana, you want to say anything.

Professor Pandit: From a clinical perspective, because these centres are outside of the city and the hospital set-up, it is very convenient for patients to attend. As Jim said, their experience is very high attending these. Typically, a CDC will undertake CT scans, MRI scans, ultrasound, and echocardiograms and endoscopy if they are advanced. The clinical engagement in this project has shown that people are starting to develop pathways and one-stop clinics. For example, in Oxford there is a breathlessness pathway that the clinicians have developed, which means patients can see a multidisciplinary team and have the test. They have the test, see a physiotherapist, see a physician and get their diagnosis on the day. That has been very helpful and well received by the patients.

Q14 Lloyd Hatton: Building on what you have shared with us today, at the moment the vast majority of diagnostic tests do not happen in a CDC. They happen elsewhere, in an acute hospital. If we are to drive down and meet that 5% recovery target, do you see CDCs as playing a much larger role, not just over the next year or so but longer term? Will that be the shift? Certainly the 10-year plan is talking about how we shift from hospital to community setting. Do you see pushing more and more diagnostic tests into a CDC setting as one of the most critical ways that we can meet that 5% recovery target?

Sir Jim Mackey: It is a key part of the plan, absolutely. We want to protect the hospital sector for patients who really need to be there. As Sam and others have already said, the big part of the 10-year plan is neighbourhood care and trying to move care closer, but, at the same time, changing the pathways, digitising as much as we can, introducing new technologies et cetera. It is a really big, central part of our plan. In all my time in the NHS, we have really struggled to keep pace with demand for diagnostics. Things are moving all the time. There are new tests all the time. We have a bit of a job to do on all that, but it is absolutely central to everything we are trying to achieve.

Q15 Lloyd Hatton: I have one very final point on that. In terms of being able to do that from a cost point of view, delivering it close to the patient often will not be cheaper, particularly in rural and coastal areas such as mine, where there is a very sparsely populated community. A lot of people are a long way away from a larger hospital and public transport is nowhere near as good as we would like it to be. In some areas, you have maybe one in four people not owning a car, so there is a real need for it. Can we actually meet that need of having a CDC setting in more and more parts of the country, particularly in those rural and coastal areas where there is the need, but it would be more difficult and likely more expensive to set up and deliver?



HOUSE OF COMMONS

Sir Jim Mackey: You have rightly highlighted that we have a bunch of challenges here. We have the financial challenge, the workforce challenge, productivity, inequalities and making sure we have equity of access. In areas as you have described, we are very keen to make sure that people have local access, we are addressing those needs and people make those decisions in a sensitive fashion that takes all those factors into account.

I do not want to talk about the financial position all the way through this, but a big part of the constraint in diagnostics at the minute is our overall financial position. We could do more tests if we had more money. We are realistic, in that we have got what we have got, and the service is doing a very good job at managing within the overall resource. I hope that, as we get through this year, get a bit more stable financially and get on top of waiting times even further, we should be able to open up more capacity as time goes on.

Q16 Chair: Moving on to the surgical hubs, you have not delivered as many as you planned. Why?

Professor Pandit: Surgical hubs are of three different types. They could be independent and stand-alone, integrated or part of an existing theatre suite. Initially, the way that the activity was accounted for meant that every site had to have a specific code to make sure that elective procedures that are done in the hub are accounted for separately, particularly if it is in an existing theatre complex.

Consultants, doctors and nurses have focused on undertaking high-volume, low-complexity procedures in surgical hubs. This is where clinical engagement has shown that undertaking these procedures in a very standard way has meant that the productivity within the surgical hubs is increasing gradually. Theatre utilisation for those surgical hubs is in excess of 80%.

Q17 Chair: One problem with the figures around surgical hubs is that we have different sets of figures. The NAO found that, depending on which board the figures were being reported to, whether it was the board that looked over all of the transformation programme or that looking at the surgical hubs transformation programme, there were different figures about which hubs had been delivered and which were in progress. Mark Cubbon, why? How can you run an organisation that has two different sets of figures going to different boards?

Mark Cubbon: We have 122 hubs that are now operational and a few more hubs coming online later this autumn. We will be on track for the commitment that we set out for this year, for the number of hubs that will be open.

There were, as the report highlights, some issues in terms of separating out the amount of surgical work that had gone on in hubs, particularly for those that were adjacent to but embedded as part of an organisation in



HOUSE OF COMMONS

the way that Meghana described. Essentially, with all the hubs that have been expanded or developed as part of the transformation funding that was available, there is a separate code to accurately record all the activity that is undertaken in those sites.

Q18 **Chair:** I will come back to that in a second. You did not answer the question, I am afraid. Why do you have two lots of figures reported to two different boards?

Sir Jim Mackey: We have had correspondence this week about the numbers and stuff. Most of us were not around substantively in the organisation when a lot of this was enacted. I will commit to Sam and I, outside of this, reviewing again the numbers and different sources of information, because we share your frustration, and trying to clarify the matter once and for all.

Q19 **Chair:** This is an easier question. How many hubs are still to be started and how many are still to be completed? Do you have the capital to deliver these?

Mark Cubbon: With the investment that we have, we are progressing to open the hubs as part of the schedule we have for this year. Some of them are being expanded where we have added more theatres to existing hubs. For some, we are just waiting to have the full hub opened up. We have another 14 hubs that will be either expanded or developed and will be coming online to provide the capacity that we need and to provide patients with more timely access to the care that they want.

Q20 **Chair:** What time period are those 14 over?

Mark Cubbon: We will confirm the revised schedule with you happily after this meeting, because a few other schemes that were planned to open up, particularly for this year, have run into some delays with some of the estate's challenges, whether that is about the construction costs or the construction delays to some of those hubs being open. The ones we are expecting for 2025-26 are all going to be opened, as per the commitment, but we will give you the timeline for the remaining hubs after the meeting.

Q21 **Chair:** How many will be left at the end of this financial year?

Mark Cubbon: We have 122 and we will probably be at 125 open by the time we get to the end of September.

Q22 **Chair:** How many will be still to be opened by the end of this financial year?

Mark Cubbon: Can I provide the written update on the remaining hubs when we have confirmation of the timelines for those additional hubs to be operational?

Q23 **Chair:** Right. Is the intention still to complete them all?



HOUSE OF COMMONS

Mark Cubbon: Absolutely, with the amount of money that we have invested, we are keeping all the hubs on track and expect them to be opened as per the plan we set out.

Q24 **Chair:** We need a new schedule and the same numbers that everyone agrees on.

Mark Cubbon: Yes.

Chair: That is going to be provided to the Committee.

Mark Cubbon: It is.

Q25 **Chair:** Going back to the issue of identifying with particular codes the work being done in these hubs to make sure it is additional, one problem is that they have additional activity, and that is shown, but a lot of that activity has not actually reduced waiting lists. That is not what the money was spent for, was it? It was to reduce waiting lists, but it has not actually delivered. It seems that other activity has been done in these hubs additionally instead.

Sir Jim Mackey: The first plan was aimed at reducing long waits, so it set out how we would work through from two-year waits to 18 months et cetera and work through that plan. That has been achieved. You can see in the numbers a really dramatic reduction in long waits over that period. If you look at 52 weeks, for example, where we have not managed to hit the target set out in the first plan, they peaked at just over 400,000. We are under 200,000 now. We have had a big growth of activity and a really significant reduction in long waits. Now this new plan pivots more towards the RTT standard. On that also, the list has fallen year on year over the last year.

Q26 **Chair:** I was not saying that the list had not fallen. I was saying that the increase in activity in these hubs has not mirrored the reduction in waiting times. Some of the activity in the hubs has been used for other purposes, yet the money was allocated to reduce waiting times. Samantha Jones, that is what the Department allocated the money for. Is it not strange that you have allocated the money and then it has gone on to be spent in a different way?

Samantha Jones: We are very clear, from the coding that Mark and Jim have talked about, in terms of thinking about what activity is taking place in which centre. The other thing that I would like to highlight, and I am sure Mark will come in on, is the activity and the way that we are treating patients. We are constantly looking at how we are doing that, so through the use of digital and making it as convenient as possible. We are looking at when we bring people in for their treatment, how they are treated and the throughput within theatres. At the same time as opening the additional capacity, there is also work—and we have examples from across the country—where we are changing and becoming more efficient in the way that we are treating patients.



HOUSE OF COMMONS

Q27 **Chair:** The hubs may be opening, but the hubs are only delivering half of the planned additional capacity that they were meant to deliver. Why?

Mark Cubbon: When the hubs opened up, we identified a problem where some of the work had been displaced from very busy sites. This is particularly for hubs that have been adjacent to hospitals. We have seen a significant change since we have been able to capture the data more accurately, where we are seeing much greater levels of productivity through the lists in surgical hubs and much greater productivity in the use of the beds within the hubs. We are seeing much greater patient satisfaction as a result. All in all, the surgical hubs are contributing to the lower waiting list size and the reduction in patients waiting longer.

Q28 **Chair:** It is only half the amount that was planned in terms of the effect on waiting lists, because they are being used for other things. You are right. These hubs tend to be new. The equipment is nice and shiny. The waiting areas are nice. They are easy for patients to access and go through in a short period of time, so surgeons use them. They put others of their operations through there, rather than reducing the elective waiting times. How do you stop that?

Mark Cubbon: With the data that we have, we have much greater scrutiny of the use of the surgical hubs. We have a review that goes on at organisational level. We have a review that goes on across each region with the GIRFT—getting it right first time—team, where we have peer-to-peer challenge to make sure that all the assets are being used optimally and try to get as many patients through the hubs as possible.

Matt Style: I will add two things. It is critically important that the decisions about how capacity is used in the NHS are clinical decisions made locally. The most appropriate use of the new facilities will, at the end of the day, be determined by clinical teams locally. That is very important.

It is also worth saying that we have had in place, across all of the programme, robust financial arrangements to make sure that we pay for activity that is undertaken across the NHS. We do not have block payments any more. We have payment by results, which we reintroduced as part of this programme. That has ensured that we have maximised the amount of activity we can deliver, but also protected taxpayers, so we are only paying for activity that is actually delivered.

Q29 **Chair:** I take the point that clinical decisions are absolutely important. Of course they are and clinicians will decide on priorities and what patients need. Equally, Parliament decides on spending money for particular purposes. If that money is then used for a different purpose, we have to ask questions about it.

Sir Jim Mackey: I will just clarify. I think you are implying, Chair, that we have opened surgical hubs for elective patients but they are being used for a completely different range of patients. That is really not happening. They are largely dedicated elective capacity.



HOUSE OF COMMONS

Over the period of the report, activity was materially impacted by industrial action and the overall financial position largely related to industrial action. Volume could have been higher through that period, and was not because of trying to manage within the overall resource limit. We will go back and double check, but, in my experience and from the data I have seen, elective surgical hubs are being used for elective care, not for urgent care or other services.

Q30 Chair: That is not quite what the NAO Report says, and it has been signed off, has it not?

Samantha Jones: We will absolutely double-check, in terms of the point that you are making, and come back.

Q31 Chair: It is quite important. I have one final question and then we will come on to the issue of out-patients. These are NHS facilities, but we know now, in the current world, many private-provider facilities are used by the NHS for patients who do not pay for those services, because they are additional capacity. How is that capacity modelled into this?

I will raise two questions from a personal perspective, if I might. I have a company called Optegra that provides cataract surgery in my constituency. It has got waiting times down to two weeks. People think that it is a brilliant service. I have talked to friends and councillors who have been there. It is wonderful. It has just been told, "Reduce your activity. You are too successful. You are getting people through too quickly".

I went to the Canon centre the other day, where LivingCare provides diagnostic services and modern equipment. Canon provides it. It is state of the art. Professional footballers go there. It is that good. It is top quality. It is sat there unused; the NHS hardly uses it. Is that not something that needs factoring in when you are looking at these programmes in future?

Sir Jim Mackey: It is factored in and we are very dependent on and value our relationship with independent sector providers. They have been a really important partner in delivering what we have delivered so far and will be in the future. What you are describing, especially the ophthalmology thing, is a very good example. There has been huge expansion of independent sector provision in this area over the last few years, which has materially contributed towards a reduction in waiting times, as well as NHS-delivered care.

I will come back to it again: money is very tight this year. We nearly started this year with a £5 billion or £6 billion problem during the planning round. We had patients being offered treatment within a few days in some places for cataract operations. When local ICBs and providers are working through the plans and they have long waits in orthopaedics, general surgery, neurology or other specialties, there has been a correction of that where there have been decisions made to slightly increase waiting times for ophthalmology in order to free up the



resource to provide access for those other patients who are waiting too long.

Chair: Sometimes it looks as though it is so successful that we have to make sure it is not as successful in future, but that is probably an unfair comment. I get the point you are making. We have to move on now to out-patients, which has probably been the least successful part of the transformation programme. I think that that is fair to say.

Q32 Josh Fenton-Glynn: Out-patients represent 80% of the elective waiting lists, so the key to solving elective waiting lists is solving out-patients. You had a 25% target of reduction. After 13 months, you had reduced the use by 0.1% and then, more or less, you stopped measuring it in the same way. When you miss something such as that, it is either that the target is wrong or what you have done is wrong. Which did you get wrong?

Sir Jim Mackey: That is a really good question and you are right that out-patients is the key to how this all works in the future. We are all still convinced of that and committed to it. Right at the beginning of this programme in 2021, 2022 or whatever it was when I started it in a previous role, we identified out-patients as a big thing. There was a huge variation. There were some examples where follow-up rates were materially different where clinicians had adopted different practices. Surgical specialties are generally quite advanced now in this, but there was still a big volume to go at to allow more new patients to be seen.

There were mixed clinical views in the clinical community about that. There was a lot of concern about what would happen to patients who might need a follow-up but did not get access to one, so trying PIFU and using technology were ways to support that. As I remember it, we got very close to some big changes during that long period of industrial action. We had a really good summit in London at one point with all the colleges. All the colleges committed to help.

Then we went into a long period of industrial action. We then spent a long period—it felt like over a year—of basically the people who were involved in this having to spend all their time cancelling and rebooking. We have regrouped. I will bring Mark in. It is still central. We are having to regroup and work out how we get better clinical engagement and get a new plan together.

Q33 Josh Fenton-Glynn: It feels like you are not measuring the target any more, though. Is that because you have got the target wrong?

Sir Jim Mackey: We have tried to look at it in different ways over the time to find the best way to measure what we are trying to achieve, but also incentivise it financially. We have some ideas about how we use different financial mechanisms next year.

Mark Cubbon: First and foremost, we recognise, and the report highlights this, that, outside of the central elective care programme, we



had another team in another part of the organisation that was delivering this transformation programme for out-patients. We have put them together to make sure that we can all drive against the same aim. We are looking at how we use digital transformation and clinical engagement, bringing them together, to transform pathways for out-patients.

The model that we have for out-patients is very traditional. We have had the same model for decades. Many of us will have had out-patient appointments at some time and been to see a GP. The GP will refer us to a hospital. We will be seen by a hospital consultant, might come back another time to have a test, might need to have a procedure, and then we will come back in a traditional way often for what we call a follow-up appointment. We need to change the whole model. There are a number of examples in different parts of the country where that model is already being transformed.

- Q34 **Josh Fenton-Glynn:** I am going to come to the shift in the model in a little bit. I want to think a bit about resources though, because 80% of programmes are out-patient. Should that have been more of a focus of where we put resources into reducing elective recovery times, do you think, Sir Jim?

Sir Jim Mackey: Yes, it should have been. The programme probably was under-resourced at the time, but the material issue throughout has been clinical engagement. We have struggled throughout to get the clinical community uniformly behind it. Once we achieve that, the thing will get resolved.

- Q35 **Josh Fenton-Glynn:** It feels like we can make a change when we spend a load of money on a diagnostic centre or a new surgical hub, because it is a new building for people to work in, but, when it comes to getting clinicians on board and getting buy-in, it is more tricky.

Sir Jim Mackey: It is more complicated than that, to be fair. I will bring in Meghana in a second. The big concern that has prevented us from going really hard at it is the concern about missing clinical risk. If we do sweeping changes without really strong clinical engagement, that means a patient who should have been seen in a follow-up setting was not and comes to harm. None of us wants that. It is really variable from specialty to specialty. I accept the challenge that it looks like, if we can get big investment, things can work. We all agree that out-patients is the big untapped thing for us to go at that can be dealt with without a lot of resource, but it is very complicated.

- Q36 **Josh Fenton-Glynn:** If it is untapped, why did we focus the £1.5 billion bid at the start of the year on surgical hubs rather than more money on out-patients?

Sir Jim Mackey: I do not think that they are either/or. At the time we definitely needed to separate urgent elective care. We needed more theatre capacity. From a diagnostic point of view—you will have seen stats over the years—we have been massively behind other developed



HOUSE OF COMMONS

countries in terms of diagnostic capacity. We will have to deal with all these things in the round.

Q37 Josh Fenton-Glynn: Going back to the clinician buy-in, is the barrier the royal colleges? Is it the BMA? Is it some mixture of all of those groups?

Professor Pandit: In my experience as a consultant, chief medical officer in an acute trust, CEO and now national medical director, I have learned that any reform or change management programme cannot work without clinical engagement. Particularly, sustaining the benefit of that is also down to clinical engagement. We have learned from what has happened previously.

If I may describe the clinical engagement now in the elective reform plan, at out-patient level or at theatre level, it is at local, regional and national level. There is a lot of activity going on. At a local level, clinicians now have access to their own datasets. They can understand their performance, which was not the case before. As a clinician, when you can see your data and have peer comparison, you understand what needs to change. They undertake quality improvement activity.

In terms of regional level, there are clinicians embedded within regions and their role is more as an oversight and peer group. They enable learning networks and improvement guides to make the changes. Finally, at national level, the getting it right first time programme, which is in virtually every clinical specialty now, allows clinicians to see the variation among different organisations at specialty levels, such that they can reduce that unwarranted variation by adopting best practice from other centres.

That is replicated also at national level by Mark having in his team two national clinical directors who work for him. I am also a member of the elective programme board. That increases the clinical engagement. An example of local activity enabling out-patient programme productivity is the integrated GP and cardiology clinic, which has shifted work to the community and improved access for patients.

Q38 Josh Fenton-Glynn: You are telling me lots of things that you think are going right, which is good and I look forward to seeing the results. I am not hearing where the blockage is. It is three years on now and we have not really seen much of a change. You have said industrial action. Beyond that, is it royal colleges not wanting to change? Is it BMA not wanting to change?

Professor Pandit: The royal colleges are very engaged and we meet with them regularly. There are webinars and roundtables. The Royal College of Physicians put out a publication called *Prescription for out-patients* that very much says what the next steps should be. There is a lot of engagement. I have not come across any opposition.

Q39 Josh Fenton-Glynn: It does not seem to be moving quickly enough.



HOUSE OF COMMONS

Mark Cubbon: We did not get some of this right in terms of how we were applying all the skills that we have in NHS England, the clinical expertise across the colleges and within our own organisation, and the clinical expertise that sits across the service, to make sure that we were as joined up as possible about the scale of opportunity and the ideas and examples of where we are getting some of this right and it needs to be shared and scaled up across the whole service. That is something that we have set about to correct.

We have had some really positive engagement with the colleges around our five key problem specialties—these are specialties with the highest proportion of waits on the waiting list—to look at the right pathways and how we can transform those pathways so they are delivering prompter care for patients with fewer visits to hospital, where they can be avoided. We were instrumental in working with the Royal College of Physicians in the publication that Meghana set out. We are at the final stages of completing a whole new approach for how we want to deliver out-patients provision across the NHS in the next year.

Q40 **Josh Fenton-Glynn:** You have learned lessons and you are now trying to work differently.

Mark Cubbon: We have.

Q41 **Josh Fenton-Glynn:** I hope that you can come in on this, Samantha. In the broader way that there have been things that have not worked there and you have had to change the way that you approach it, how is that going to work for the three shifts? If we do not get clinicians on board with the three shifts, they ain't happening. The Secretary of State said that it is the most revolutionary change in NHS history. If we need a new building to change things, that ain't working unless we do it properly. How are we going to get clinicians involved in the three shifts?

Samantha Jones: I am going to ask Matthew to pick up our governance and accountability arrangements at a national level. I do not think it is right that the Committee believes that we need a new building to incentivise people to change things. We should recognise that it is difficult change involving people, so patients who are using the services. I think we underestimated that collectively.

In practice, as you will see through the 10-year plan set out by the Secretary of State, that means putting as much as possible in the hands of the people who use the services. That can be through the NHS app and the use of digital, so that we say to people, "If you do not need to come in for out-patients, please do not come in. This is how you can access", et cetera.

Q42 **Josh Fenton-Glynn:** I am going to stop you there for a second, because what you say about people not needing to come in and changing patient behaviour is really interesting. There was a target of 25% of out-patient follow-up appointments being remote. Not only have you missed that



target, but you have gone down from 22% of people having remote appointments to 19%. It is not a great start, is it?

Samantha Jones: I will finish your other question and then hand back to Mark in terms of the detail of the individual out-patients. You asked about the shift that was set out in the 10-year plan. As part of the creation of the new Department of Health and Social Care and the work that we talked about at the beginning, Jim and I have agreed single responsible officers for every single area across the 10-year plan. In practice, that means that we are working across the Department of Health and Social Care, NHS England and, really importantly, with local leaders, local clinicians and people who actually use our services, which did not happen before. There is a governance structure being set out so that we are very clear about who is responsible and how that is working in practice.

On top of that, we are testing and using individual areas across the country where things work. The Secretary of State earlier on this week talked about taking the best to the rest of the NHS. That is a very practical example about how we are using examples from up and down the country to change the way that we deliver services.

Q43 **Josh Fenton-Glynn:** Where can you point to as a good example?

Samantha Jones: Bear with me one second.

Josh Fenton-Glynn: Sorry, that was an unfair one to drop on you just there.

Samantha Jones: No, we have a number of examples. I am just trying to find them in my pack. We have the Queen Victoria hospital. Rather than coming in, having your out-patient appointment and then going to diagnostics, it is going straight to test. Mark, you can talk about Manchester, because it is your trust, where we have collectively reduced the time waiting for an ECG diagnosis. It is really important that we break this down to individual specialties and services, rather than look at it from a national perspective, because that is where the change happens. There are also other examples across south-west London about a 12-month hearing health pilot working locally with people. In terms of the actual target itself, I will pass over to Mark.

Mark Cubbon: There has been a shift. We saw a dramatic change through the covid pandemic, where it was sheer necessity that drove the use of virtual tests and the adoption of the technology. There has been some move away from that for actual consultations that would have replaced face-to-face consultations. There has been a significant change at the front end of the pathway using technology with what we call advice and guidance.

Q44 **Josh Fenton-Glynn:** I am going to need "front end of the pathway using technology" translated into English.



HOUSE OF COMMONS

Mark Cubbon: I am happy to do that, apologies. If you were going to see a GP, normally a GP might try to treat the condition themselves, but then may refer you to have specialist opinion through the hospital team that may want to see you. That would normally be through a referral that is sent, which is a process where a document goes for the referral, referral gets assessed and you get added to the waiting list and wait to be seen.

We have introduced this thing called advice and guidance. It is a process where a GP would initiate a request and it might not necessarily need a full referral to hospital, but they may ask a question about a type of medication or type of condition, to ask the hospital specialist for their opinion before a referral is sent. They do that. That allows a GP, in front of a patient, to treat that patient themselves, with that specialist advice. The patient does not have to sit on a waiting list. The patient gets the treatment as quickly as possible.

Q45 **Josh Fenton-Glynn:** Fewer people are going through to those appointments than might have been.

Mark Cubbon: Exactly, yes. We are seeing a really significant shift. Over the past four years, we have seen continued growth with the use of advice and guidance. This year alone, we are expecting 1.1 million more requests to come through this advice and guidance route. For this year, we have made a payment to GPs to support the increased adoption of these requests and referrals to come through this route as well. The whole transformation we want to see for out-patients across the country will be a further strengthening and broadening of the adoption of an advice and guidance model, so that patients can get much more timely access to treatment without waiting for long periods of time on waiting lists.

Matt Style: I want to briefly add one thing. Colleagues have talked a lot about the importance of clinical engagement with the royal colleges and the sort of national policymaking. I wanted to add that the out-patient transformation involves quite a fundamental change to the way an acute hospital works at every single level. You are talking about changing the way people do their jobs, not just the clinicians, but also the admin staff, and it is nurses as well as doctors. It is a really quite fundamental reorganisation. That is why industrial action was so disruptive to the ability of the programme to make progress, because it is a really thoroughgoing operational change, as well as a big national clinical change.

Q46 **Josh Fenton-Glynn:** From a Health and Social Care Committee perspective, this is my concern. Sir Jim has been tasked with managing the change to NHS England. We have been tasked with the three shifts and the key part of this change has been missed on a previous strategy. I am very keen that, if we are going to have these shifts and have them work, we get that right.



HOUSE OF COMMONS

Mark Cubbon: I completely agree.

Samantha Jones: I agree.

Q47 **Michael Payne:** Thank you, colleagues, for appearing before the Committee today. I have a question about deprivation and inequalities, following up from my colleague Josh Fenton-Glynn's questions. There is national evidence that residents in more deprived areas wait longer for treatment. Healthwatch, the King's Fund and other organisations have put national evidence out there that points very clearly to that point. This is maybe for you, Sir Jim, or Mr Cubbon. Is there reliable published data breaking down waiting times by the indices of multiple deprivation deciles? I think that MPs would be interested in that and, more broadly, it is an important point. I wondered what is being done specifically to target improvements in the areas with highest deprivation.

Mark Cubbon: That is a brilliant question, thank you. We have now published—today, actually—data, which is what we call health inequalities data, which covers the points that you have raised, whether that is about age, sex, the deprivation indices, ethnicity and so on and so forth. The data shows that there are some differences. We ask all the local systems, whether that is our ICBs that are commissioning services for their local populations, or organisations that are providing services for their patients, to make sure that they thoroughly go through the data to understand what might be driving the difference.

I will give you an example from my own organisation of the work that we have been doing. We have been looking to see why certain groups of patients, whether that is by ethnicity or age group, may have a higher do-not-attend rate. They may not turn up to clinic appointments, to surgery, or for some diagnostic test that has been booked. We found that, for some groups of patients, they are having to take children to school and they have been offered appointments for 9 am.

With the engagement we have done with our patient forum, we have been looking at ways that we can modify the booking principles, so that their booking times allow working mums and dads to go to work. They will still need to drop children off at school, but they will also have a bit more flexibility in terms of when the out-patient appointment will be provided. There are things such as that that we need to get into. You can only do that by a thorough review of the data that is now available publicly.

Q48 **Michael Payne:** If I may press on a wider point, is there also specific data in relation to harm or clinical deterioration caused by long waits? This Committee is concerned with value for money for the taxpayer. Clearly, harm or clinical deterioration for somebody from a long wait is potentially a value-for-money challenge for the taxpayer, but also, and perhaps more importantly, a risk for that individual and their loved ones, who are potentially caring for them. Is there data in relation to long waits and harm and clinical deterioration as well?



HOUSE OF COMMONS

Mark Cubbon: Shall I pick up the long wait point? Then I will hand over to Meghana to give a view from a clinical perspective. As has already been highlighted, we have made massive progress on the long wait position, thankfully, because we have had some patients waiting far longer than any of us would like. We know that organisations that have long waits are working really hard to reduce them as quickly as possible. This year, we want to make further progress to reduce the waiting list even further from a long wait perspective.

When a patient is on the waiting list, they get contacted periodically to pick up whether a patient still needs to have the consultation, test or procedure that they are booked for. We also try to pick up any change in the health condition. If there is a significant change that may indicate that there has been a worsening of the condition, the patient can be brought forward in the list and have their treatment provided as quickly as possible. Meghana, do you want to talk through the clinical process behind that?

Professor Pandit: Particularly over the post-pandemic period, where there were several people waiting long periods for their surgery, clinicians undertook regular harm reviews. The number of those harm reviews was initially very high, but has gradually come down. Where harm was identified, not only was that individual's treatment expedited, but also a thorough analysis was undertaken of that as an incident to achieve learning from that and prevent further harm. That has been done regularly.

There is also an increasing collaboration between primary care and secondary care, so GPs and consultants, for being able to get to the consultant quite quickly without having to wait. Most teams, certainly in my organisation, have set up contact points for GPs where they can come through to say, "I have seen this patient in my clinic today who has been waiting long and I think they need to be seen immediately". That works very well. Now that the numbers of people waiting over 65 weeks and 78 weeks have reduced considerably, that is done, again, at a regular three-monthly interval.

Samantha Jones: I was going to build on the publication of the data on a monthly basis now from a transparency perspective, but also from a local perspective, on the point that you are making. The reason that there is so much focus in the 10-year plan on neighbourhood health is precisely this: it happens locally, it is understood locally and clinical teams understand it locally in terms of the services that are best provided because it is them that are collectively working together to deliver that care. It is the publication of the data from a national perspective, but, importantly, it being used locally through the neighbourhood health service.

Matt Style: I would very briefly highlight two national programmes, in addition to what colleagues have said, that have been seeking to address



HOUSE OF COMMONS

the issue you raise. The first is the Further Faster 20 programme, which has specifically targeted national support to reduce waiting times in those communities where economic inactivity is a particular problem. There is also the targeted lung health check programme, which has specifically targeted investment in expanding diagnostic capacity into those areas of the country where there have been the biggest problems with late diagnosis of lung cancer. That programme has made great strides in eliminating the deprivation factor in early diagnosis. Both those programmes are being evaluated and that will be important evidence to determine where we go next on the agenda that you raise.

Michael Payne: I have seen some of the impact of the lung cancer and lung disease work in my own constituency.

Mark Cubbon: Would it be helpful to give you an example of this Further Faster 20 work and how that is applied? This programme is trying to address this economic inactivity issue for patients who have what is deemed to be a long-term condition. I was at an organisation just recently where, in its orthopaedic service, it has introduced health coaches for patients who have been off on long-term sick for some time, either with back pain or with joint pain, where they have been getting weight loss advice, while also looking at how we can reintroduce them into the job market, with refinement of skills, access to skills and getting their health back on track as well. As Matthew said, it is too early to roll this out across the whole country. We are going to do a thorough evaluation, but there are already starting to be some really interesting opportunities highlighted that we could perhaps scale up across the country.

Q49 **Chair:** Finally in this session, this is something that our colleague Anna Dixon would have asked if she was here, but she has been under the tender care of the NHS recently for a hip replacement, which I understand is going well. It is about the very simple things that can be done but are not always done in the NHS to reduce waiting times. One is the shared care arrangements with GPs. Why are more blood tests and things like that not just done at the GP surgery, rather than people queuing in hospital corridors waiting for them? In terms of follow-up appointments, why is there often a rigidity about, "The computer says you have to come back in three months. You come back in three months", with no real flexibility for patients to say what they feel is appropriate?

Sir Jim Mackey: Those are really good points. On the first point on the blood test example, it is a big part of what we are trying to do with the neighbourhood care thing, shift as much of this into primary or community care wherever possible, so people are not having to wait for the hospital system.

On the second point, we do have a lot of technology now in the NHS, such as patient portals and through the app, where patients can choose. You get a follow-up reminder that says, "We need to see you" or



HOUSE OF COMMONS

whatever “in two months’ time”. You have the ability to change that or cancel it, or have an interaction with the clinical team to hold it until you are ready. Going back to the earlier points, it is not everywhere. It is not systematic in every specialty, but that is a big part of what we will be trying to do in the next couple of years.

Q50 Chair: We should see some reductions in follow-up appointments, should we?

Sir Jim Mackey: We are going to have to at some point, absolutely.

Chair: I am sure that we will want to monitor those.

Q51 Lloyd Hatton: To press that point again that the Chair rightly made, with things as routine as a blood test, when you are looking at rural and coastal areas where public transport is not great, the journeys that patients are making are often ridiculous, particularly in my part of the world, where someone might be travelling in excess of an hour each way for a blood test. We are not talking about day surgery or a long-term admission to hospital. We are talking about a routine blood test. They will drive past not one, not two, but three community hospitals to get there, which seems absolutely bonkers. I have had this conversation with my ICB and the trust, but to see that shift for the most routine care is absolutely essential for patients in coastal and rural areas. It cannot come too soon.

Sir Jim Mackey: I could not agree more. It is a key part of the neighbourhood thrust to address that. I worked in Northumberland for many years before I moved to Newcastle and we introduced years ago a miles less travelled metric to bring visibility to how we were moving patients around for things that could be delivered locally. That was really effective for a long time there.

Separately on the rural-remote issue, just this week colleagues have been having an exchange about bringing that back to the fore, where there are specific challenges in rural, usually coastal, areas. We have generally had regulatory problems, safety problems, sustainability problems et cetera in those organisations over the years, because it is very difficult. We are going to re-energise that work so that, in a few months’ time, we have a bit more of a targeted approach and a bit of a plan for how we can make improvements there.

Samantha Jones: From a broader Department of Health and Social Care perspective, if the chief medical officer was here, he would be absolutely supporting what Jim was saying in terms of the focus on rural areas and health inequalities, particularly from a health prevention perspective.

Chair: We are going to have a short break now. We will come back at quarter past and start again.

Sitting suspended.



HOUSE OF COMMONS

On resuming—

Chair: We will resume the session now. We are going to try to finish this by 12.15 pm at the latest, so let us think about focus with regard to questions and answers. We now come on to NHS England's management of the whole programme.

Q52 **Lloyd Hatton:** In paragraph 2.10 of the NAO Report, there is an explanation or something as to why there was that shortfall of 3.6 million diagnostic tests. One of the problems pointed out is ministerial delays. Could you go into a bit more detail as to what those ministerial delays actually were?

Matt Style: As the report makes clear, the ministerial approval process was a really important part of the overall review of business cases within the programme. That takes time, but it was a very important part of the process. It was an important part of ensuring that we were targeting resources on the right programmes in the right bits of the country in order to have maximum impact for taxpayers' money. Yes, it takes time to do that properly, but it is a very important part of the process and of our overall architecture for safeguarding taxpayers' investment.

Q53 **Lloyd Hatton:** You do not think anyone could have moved more quickly or more efficiently, whether that is a Minister, the wider Department of Health and Social Care, or indeed NHS England?

Matt Style: Ministerial review of business cases is a very important part of the process. We are always looking for ways of streamlining that process and cutting out the bureaucracy. That is a particularly important priority right now as we are bringing together the Department of Health and Social Care and NHS England. That gives us lots of opportunities to make sure that we are moving as quickly as possible. Both Jim and Sam have been very clear that that is a priority for us nationally. Part of what we need our colleagues in local systems to see is us moving quickly and processing business cases and approvals as quickly as possible. We are always looking for ways to speed it up.

Sir Jim Mackey: Also during that period, we had all that industrial action, funding of industrial action and reprioritisation of the resource. There were long periods where we were going through really big reprioritisation processes to make sure that we could live within the overall financial limits that we had. When you look back now, it looks like there were unnecessary delays, but quite a lot of it was about that back and forth with Treasury colleagues and others to make sure we got the balance right.

Q54 **Lloyd Hatton:** Looking at the mistakes that were made there, how do you think NHS England could have done things differently to ensure that we got closer to, or better still actually met, that key 95% recovery target?



HOUSE OF COMMONS

Mark Cubbon: As Jim just set out, some of the delays were caused by the reprioritisation of resources that were being deployed to support the improvement in the provision, so more tests and improvements in performance. I suppose that some of those things were unavoidable because they were related to industrial action and that prioritisation process.

The processes we have put in place and the governance arrangements that we now have in place will help reduce any of the interface delays between NHS England and the Department. That is about how capital is deployed, monitoring the outcomes that the investment is achieving and the impact that that is having on performance. We have a much more joined-up set of governance arrangements between the Department and NHS England now than we had in the past years. That should help speed up processes and make sure we can divert resources more quickly to get the outcomes that we are looking for.

Sir Jim Mackey: That is evident in real life now. The closer working between DHSC and NHS England, and the mechanics we have in place with the ministerial teams et cetera, has massively improved and increased the pace of decision making.

Samantha Jones: Just practically on that, rather than how, previously, there were two teams and two boards doing things, we have single governance oversight arrangements. That is in terms of clearance processes for Jim and I, and making sure, as Matt says, that everybody across NHS England and the Department of Health and Social Care is living true to the principle that was set out in April of creating a new centre and as quickly as possible.

Chair: We will move on to the issue, which has been mentioned a few times, of industrial action.

Q55 **Sarah Hall:** Sir Jim, we have touched upon this quite a few times. Given the recent industrial action, what can NHS England do to plan for or mitigate the impact of that action?

Sir Jim Mackey: I will bring other colleagues in as well. We changed our approach for the last industrial action quite significantly and that helped us maintain more normal planned activity than in previous times.

Q56 **Sarah Hall:** How did you change it? What was the change?

Sir Jim Mackey: We changed our approach to safety mitigations, in conversation with the BMA, and how those things were handled up front in preparation for the incident, but also in real time as we went through the industrial action process and the interactions, therefore, that happened in that period. We had a stronger, clearer message to the NHS as well about trying to maintain as much as possible. It is very easy to cancel or curtail a lot of activity and make yourself really safe and comfortable, but a lot of us felt in the previous rounds that we actually had quite a lot of spare capacity and could have done more, but the



HOUSE OF COMMONS

arrangements we had at the time did not allow that to happen. There was a really big difference in the focus and the preparedness.

I was at a trust two weeks ago that managed to maintain 98% of normal activity, which is absolutely incredible. We had a big debrief after the summer industrial action. We are going to make some changes ahead of the next one. We will do some of that in conversation and discussion with the BMA as well, all, again, with the objective of trying to maintain even more activity through the next round.

Mark Cubbon: If we take the 2023-24 year, where there were quite a significant number of episodes of industrial action, we managed to maintain 87% of our normal activity through that period. In the recent round, at the end of July, of industrial action, we managed to maintain 93%. This is an average across the NHS. Sadly, it is the case that we have got better at managing the arrangements, as Sir Jim has set out. I say "sadly" because of the eventuality of having industrial action in the first place. While we are trying to safeguard, and we are talking numbers and the amount of work we are able to maintain, we are still disrupting access to patients for every single episode.

It is difficult to describe the enormous clinical effort that goes in to prepare for industrial action, to go through the period of industrial action and then in the period afterwards, where we have clinicians working in really quite different ways in order to make sure our services are safe and we keep as many of our services accessible as possible. There is the administrative task with this, which is often a group of people in organisations that we do not talk too much about. They are the ones who do all the booking and scheduling. We have seen millions of patients throughout the periods of industrial action who have had to be rebooked, rescheduled and then rebooked again because of the delays that we have seen.

Professor Pandit: Industrial action has a profound impact on patients, staff and the organisation itself. In this particular last round of industrial action, I was personally involved with my clinical team and clinical colleagues in twice-daily meetings over the five days with the BMA resident doctors committee. That was to discuss patient safety. Overall, between 2022 and 2024, some 1.5 million appointments were cancelled, but the focus has always remained on patient safety.

From learning from that particular period and applying it to July 2025, we made sure that there was a lot of engagement and dialogue between me and my team and the frontline chief medical officers and nurse directors. We met with them before the industrial action, during and after, because they really know how their organisations work. They know how it is safe and what to do to maintain safety on a day-to-day basis. We allowed them to make those decisions, but escalate to us where they felt they did not have any mitigation. We then took that to the BMA resident doctors committee twice a day to negotiate with them. There was agreement



HOUSE OF COMMONS

among us that patient safety is the absolute focus and that is how we helped maintain safety.

Q57 Sarah Hall: Between those two different sets of action, was there a reduction in the number of procedures that were cancelled, or did it maintain roughly the same?

Professor Pandit: As Sir Jim has said, we managed to maintain 93%, on average, of elective activity, which is more than we did the previous industrial action period.

Sir Jim Mackey: We are trying not to use the cancellation metric because, in the 18 months or so that we had the industrial action, people got into the habit of not booking activity in. Rather than booking and then cancelling, people just were not booking the normal activity levels. We shifted our focus to try to maintain a normal level of activity and encourage people, therefore, not to stand the activity down in the first place.

To bring this to life, going back to the conversation about out-patient reform, we would all accept that we need to do more and will have to do more on out-patients. The very people Mark referred to who we need to work with clinicians to say, "We are going completely change this process. We are not going to book these patients in. We are going to do this remotely and digitally", were the people who were cancelling and rescheduling appointments for months on end. It is basically all they did for months: cancelled, rescheduled, cancelled, rescheduled. We thought that it was completely unreasonable to expect them to change the whole system at the same time.

Q58 Sarah Hall: Samantha, with this ongoing industrial action, do you think that the Government will be able to meet their 18-week waiting list target by 2029? Is that still realistic?

Samantha Jones: There is no change to that.

Q59 Sarah Hall: There is no change. What is the reason for that confidence?

Samantha Jones: It is still too early to understand exactly what is going to happen over the next few months and we said that we would take stock. The Secretary of State has been very clear all the way through that the training bottlenecks that the doctors are experiencing are unfair. In fact, NHS England published a 10-point plan recently in terms of how we can make the working conditions better. That is important. While the Secretary of State has been very clear about no movement on headline pay, we are doing an awful lot in terms of supporting the doctors, and the other professions, around their working conditions. At the moment, there is no change, as set out by the Secretary of State.

Sir Jim Mackey: To add to that, there were super stats today. There are statistics published today for elective care over the strike period. We have had a slight deterioration in the RTT performance, but not as big as



HOUSE OF COMMONS

we thought it might have been and the list grew by just over 30,000. That is fairly normal for this time of year as well. It did not have a massive hit in either of the main metrics.

We have to maintain this. Who knows what will happen in six months' time if we have continued industrial action? NHS colleagues, as Mark and Meghana have described, did a fantastic job to maintain the levels of activity that they did, also through a summer period when they had a lot of people off on holiday and stuff.

- Q60 **Chair:** In terms of the three programmes, so the diagnostic centres, the surgical centres and the out-patients, there have been different ways of reporting into the NHS system. It seems that some have been better than others at picking up problems, identifying them and making changes. Perhaps the diagnostic programme has been the best of those. What lessons have you learned from the way that reporting has happened in the past and what can be improved for the future?

Sir Jim Mackey: I was the director of elective recovery—that is partly Mark's role; his role expanded on the one that I did—through that period. I was leading the programme, but other big, important parts of the programme were being managed elsewhere and reported in different ways, just because of the way that NHS England was set up. We have learned a lot from that and have tried to make it more co-ordinated and more integrated. Mark has more oversight and control over all aspects than he did before.

Also, as I hope you will have seen, there was some stuff published today and earlier on this week about how we have massively increased the transparency of normal statistics and data, et cetera, to add to and augment decision making and to help understand where people are and how to drive improvement.

This is not finished. We are constantly reviewing. We are having a big conversation just now about the out-patient model, for example. Mark presented to some of our national groups last week about where we need to go next, and we will be having some clinical engagement on that again soon.

- Q61 **Chair:** So you are having a general review, which we discussed partly before, of how you deliver the programme in terms of the capacity, and then how you monitor whether the capacity is in place and what the capacity is actually producing in terms of service.

Sir Jim Mackey: When we were developing the pipeline of CDCs and surgical hubs, we probably looked at them as more of a supply chain exercise rather than an impact process. There was a lot of focus on how many, where they are, what their range is, and how we get these things delivered. We probably got too late in terms of what impact they were going to have to have, but again, Mark and colleagues have really



HOUSE OF COMMONS

materially adjusted how we do things, so that is much more central to what we are doing now.

Mark Cubbon: If I could just add to that, there is now a single accountable person for all three programmes, and we have one programme board that oversees all those entities. We have some subgroups there that look at transformation delivery, and also the allocation of the resource, to make sure that we can short-circuit any process delays that we might be running into. It also allows us, through the unified set of governance arrangements, to course-correct if some of the investment that is being put in is not quite having the impact that we need.

I chair the programme board, which meets on a monthly basis. We have colleagues from the Department of Health and Social Care on that board as well. There is also an open invitation to colleagues from the Treasury and from other Departments to attend, should they wish.

Q62 **Sarah Hall:** Matthew, what did DHSC do to improve NHS England's management of the programme?

Matt Style: The first thing that I would say is that what the Department is there to do in terms of supporting Ministers is very much to set out those clear goals for the programme. In both the 2022 and the 2025 plan, we have done that. It sets out very clear goals whereby everyone across the NHS, as well as patients and the public, can see what we are setting out to achieve.

The second thing is to make sure that we are really clear about the resources that we are allocating to support the programme. We have already talked about the work that we have done to ensure that approvals and so on are as fast as possible, so that those resources can have impact at the frontline as quickly as possible.

The final thing in terms of the role of the Department is to ensure that we support Ministers in their scrutiny of progress over the course of the programme.

We have succeeded in doing all three of those things. The report does set out, though, some very important lessons for us in terms of strengthening the governance across the full breadth of the programme. Jim and Mark have set out how we have already acted on that in terms of ensuring that Mark has oversight of the whole programme, that the programme board is looking at all of them, and that we from the Department are around the table with Mark, so that we are all looking at the same data and having the same view of performance, as it were.

Q63 **Sarah Hall:** Just going back to what was, and the lack of governance in at least two of the programmes, monitoring and accountability from your end must have been an issue at that time, which you can now hopefully rectify. You have clear goals, but they have to be monitored to see



whether people are meeting them.

Matt Style: As Mark has set out, we have improved the monitoring and the flow of information, so that we all have a common picture of delivery in a timely way across all those programmes.

What I would say—again, the report makes some reference to this—is that the focus of the Department through the early phase of the programme was very much on making sure that money was being spent in the most effective way. We had what is affectionately known as CDOG—the capital delivery oversight group—which is scrutinising the business cases for all the programmes that we are looking at today, to make sure that, for example in community diagnostic centres, each of the investments complied with the criteria for those capital schemes; i.e. it had the right range of tests, was in a location that supported the programme's broader objectives in terms of accessibility for patients, and so on.

Q64 **Sarah Olney:** Mr Style, in my constituency, we believe that we are facing the closure of one of the community hubs. I am just concerned that, where we have this lack of oversight, it is not leading to the dynamic decision making that we need to see on the ground. ICBs have difficult decisions to make. I am talking about the Queen Mary University in Roehampton, which is not in my constituency but serves many of my constituents. I just wonder whether, perhaps as an impact of this failure to properly track how the spending is leading to results, that might lead to some of the decision making on the ground not supporting the outcomes that you want to see.

Matt Style: I do not think that we have had a failure to track the impact of programmes. As we have discussed, we have had pretty good oversight of that. We have strengthened that, but the report says that there has been a failure to track the impact.

At the end of the day, we are always striking a balance between targeted investment from national programmes to stimulate the delivery of particular outcomes across the system, and the flexibility for local systems to, at the end of the day, decide where investment is best targeted to have maximum impact for the local population. That is an age-old problem in running any public service, but particularly in the NHS, and we are always trying to get that balance right.

Samantha Jones: If I may build on that, the purpose of the new centre is to do exactly what Matthew just described, which is to cut out the man marking and the duplication that takes place between NHS England and the Department of Health, and to push as much of the local decision making down locally, while still being very clear about the national outcomes that need to be delivered. As Matthew says, it has been a constant thing, but, with the creation of the new Department, that is what we are focusing on and doing at the moment to clear away some of that duplication.



HOUSE OF COMMONS

Q65 Sarah Hall: I would like to carry on with that theme and the tracking of spending on the transformation programmes. Sir Jim, why did the elective recovery board, which you chaired, not track spending on the transformation programmes, despite being responsible for oversight of the programmes?

Sir Jim Mackey: It was a decision for the NHS England board and management team at the time that the tracking of the financial aspects were dealt with in another part of the organisation. It was very clear that it was not part of the remit of the elective recovery board.

Q66 Sarah Hall: The impact of having it done elsewhere must have been significant.

Sir Jim Mackey: Yes, it was a bit frustrating at times, which is partly why we have adjusted it all now. Mark has more oversight and control of those things. Right at the beginning, out-patients, for example, was in a different part of the organisation, in the transformation function. CDCs were in that part of the organisation, and how they were monitored and overseen was in different parts of the governance structure at the time. That has all been consolidated now.

Q67 Sarah Hall: In terms of whether the programmes had capacity, or resource delivery, was there a delay in getting that information to you so that you could respond?

Sir Jim Mackey: We were working very closely together at the time and there were a lot of interactions, so I was not completely blind to it, but other people were making the decisions about prioritisation and overall resource. We were in consultation and discussion about it all, but it was very much a different team and a different part of the organisation.

Q68 Sarah Hall: Having that fragmentation must have had an impact.

Sir Jim Mackey: It did not help.

Q69 Sarah Hall: Samantha, was NHS England doing enough to understand the costs and benefits of the programmes?

Samantha Jones: I will, if I may, hand to Matthew in terms of the governance at the time—she says, having been here for eight weeks. However, the revised governance processes that are in place are exactly as Jim and Mark have set out, which is that we have brought together the spending, the profile, the activity and the demand into one place, so that we have a collective oversight.

Matt Style: NHS England was doing enough to track the impact of the programmes. As I say, there is a very difficult balance to strike between seeking to minimise the reporting requirements and the amount of the bureaucratic load on people at the frontline who you are asking to go very much further and faster on delivering the services that matter most to patients.



The way that I would look at it is that there are definitely lessons that have been learned in ensuring that that information is all brought together in a consistent way, and that the SRO can have appropriate oversight of all aspects of the programme that influence delivery of the overall goal. The fundamental building blocks were in place, but it is about making sure that we are using that information as effectively as possible to drive delivery and to respond as rapidly as possible to changes.

- Q70 **Sarah Hall:** Presumably, you will be taking that forward with other programmes that come forward as well. As you said, having that collective oversight makes it easier to be able to respond in real time. As I said before, in terms of capacity and financial management, if you have it in lots of pockets rather than under one umbrella where the decision makers do not have access to that real-time information, that seems like an unnecessary blockage.

Samantha Jones: Yes. Jim and I are very clear that clear lines of accountability mean that we are also accountable for delivery across the whole, in terms of how we are forming the new Department, but also how we are working in practice now, being very clear on that accountability and giving people the tools to do that, which means giving them the information that they require as well.

- Q71 **Lloyd Hatton:** We are going to see this huge change, with the abolition of NHS England and a lot of the duplicated work that it did subsume into the Department of Health and Social Care. Can you explain how we can make sure, with that huge process taking place over the next couple of years, that we meet those recovery targets at the same time, which is what we as a Committee, and particularly as constituency MPs, are keen to see?

There is a huge piece of reform to the way that the NHS is run. How do we make sure that, at the same time, we see that those targets are hit, particularly in those areas, as we have touched upon, where we are furthest away from meeting those targets?

Samantha Jones: I will start and then hand over to Jim. It is fair to say that this is something that Jim and I discuss 95% of the time: how we make sure we both deliver and create the new Department but do not lose the delivery as we go through, in terms of our teams and the performance that is required.

Just very practically—I am sorry to keep repeating this—we are setting out the transformation over the next couple of years. We will have a single executive team between the Department of Health and Social Care and NHS England. Indeed, subject to commissioner approval, we will be moving to a single interim executive team, so that we do not have this duplication that we have, and we will be doing that very quickly.

At the same time, those individuals will be doing two things. They will be responsible and accountable for the delivery and oversight of some of the



key targets that, for example, we are discussing today, and for forming the new Department, in terms of the teams they need, the data they need and your colleague's challenge to us, rightly, about whether we have pulled things into the right place.

While all of that is happening—and it is a significant transformation—Jim and I have agreed who will lead on particular areas across this transformation. I say that because, if we are not careful, we could be seven-year-olds playing football in terms of both the Department and NHS England trying to do things. Some very practical examples include Jim being NHS facing and making sure that the accountability through the regional directors and through the line continues.

Sir Jim Mackey: Right through into the NHS, we are having an active conversation about this. As an example, we just published the model region. We have been having a discussion with oversight and performance management responsibilities, moving from ICBs into regions. That is translating into a conversation between regional and national colleagues on key programmes, ICBs and trusts, to make sure that there is a transition that is managed, everybody understands what is moving when, nobody falls between any stools, and we do not drop a ball. That is a very active, ongoing conversation at every level between national colleagues, as Sam has described, and our organisations, right through into the systems.

One of the big changes in this change programme is how the national programmes interact through into the system and right into individual organisations out there. We cannot just look at it at one point in the system. It has to be right throughout. We are going to be held to account on results; the key test, in the end, is whether we have achieved what we set out to. I am very happy for us to continue to give you assurance at fixed points, not just on the results, but also on the management of the transition, and that the required oversight and management arrangements are in place to deliver that.

Q72 Lloyd Hatton: Just building on that, if you could give us a bit more detail, with the loss of NHS England and it all being run from the Department, will there be that ability to reach out and engage in a clinical setting with those areas that perhaps are struggling most to meet their performance targets, particularly in terms of meeting that 95% target that we have been discussing today? With that big change in the way that the NHS speaks, engages and consults, will it be able to go into those areas where performance is worst?

Sir Jim Mackey: Yes, absolutely. Again, that is live now. The reason that I was slightly late in the break was that I was taking a call from a colleague. Mark has identified a handful of organisations where we are significantly away from plan and where there will be some central interaction—next week, the Secretary of State will be involved personally—to understand what is going on and make sure that we are



HOUSE OF COMMONS

providing the required oversight, support and intervention where necessary.

Mark has a very active chief exec engagement group. Meghana has engagement mechanisms with colleagues and services as well. They will maintain themselves, and develop and adopt through this process as we are changing the more formal governance.

We are all really committed to making sure that this change works and that it simplifies, speeds up, brings clarity and is agile enough as things change. It has been really interesting preparing for this process, because the report goes back quite a long time. It is quite hard to remember what was happening during the first rounds of industrial action and what happened with the money in that year and the reprioritisation. For me, a big part of this is how we respond when something does go off track, because things will, and how we regroup and make sure we have not missed something between us, but, importantly, get back on the bike and get on to delivering it.

Samantha Jones: If I may, the new Department is not something that is going to be delivering this from Whitehall. The Secretary of State and the Prime Minister have been very clear. That is going to be a fundamental north star through what we are doing, which is to maintain the engagement and, as we have talked about before, make sure that as much as possible happens locally and does not happen from sitting in Westminster. That is how we are building the new Department, absolutely with clinical engagement and stakeholders coming out rather than doing it internally. The other thing would be oversight and scrutiny from the Secretary of State, as you would expect.

Matt Style: I just wanted to add a point to the remarks that Jim and Sam made about how we will ensure that focus remains on delivering the things that matter most to patients and your constituents. In the spirit of lessons learned, as we were touching on earlier as well, it is going to be critically important that we set out, for the remainder of the Parliament, clear objectives for the system, and clarity about the resources that are available to deliver those on a multiyear basis and, effectively, what the rules of the game are over a multiyear period.

We have a multiyear spending review settlement, and we are now translating that into allocations and operating instructions for the rest of the system. Giving frontline leaders certainty over that over a multiyear period is going to be a critical way in which we ensure that we deliver what we are setting out to do.

Q73 **Lloyd Hatton:** That leads me quite nicely to where I wanted to go next in terms of questions. A theme that has come through in today's session, which many members of the Committee have picked up, is that there have been some areas where, when there has been a transformation programme with significant additional resource and funding, there has been a really good outcome, or certainly a big improvement in capacity



and the number of diagnostic tests completed. There, I am talking about the CDCs.

In other areas, it is less clear whether, where there has been that additional funding and resource, it has led to a big expansion in capacity and has contributed to targets being met. There, I am looking more at the surgical hubs.

What would be helpful for me to understand is, in the future, how you are going to make sure that, when there is more funding and more resource put in, there is that ability to monitor and track that it produces the outcomes that we expect it to and contributes significantly to the key targets being met around diagnostic tests. At the moment, one of the things that I felt, reading this NAO Report, was that sometimes it is clear, and sometimes it is far from clear. I do not want us to see a repeat of that in a few years' time.

Sir Jim Mackey: Right at the beginning, when colleagues were doing business cases for CDCs and surgical hubs, there was no requirement to say, "We will deliver X or Y" or, "You must deliver X or Y. Give us assurance that you will deliver X or Y", in terms of waiting times or impact on the waiting list. For all future investments, that will be a key requirement. We have absolutely learned from that, and that will be embedded into all our processes as we make investments over the next few years in line with the spending review.

Just going back to agility, there will be something that we are worried about in two years' time that we are not talking about just yet, so we have to make sure that that process is adaptive and changes according to the circumstances at the time.

Samantha Jones: It would be remiss of us not to talk about the 10-year plan and the reform associated with it. What we are describing is doing more activity, which is absolutely right, in terms of treating patients and delivering the standards that have been set out. To do that over the next few years, we have to change the way that care is delivered, whether it is through analogue to digital or through treatment to prevention.

We need to work very closely in terms of the activity that is being delivered now, but also the challenge around out-patients, changing the way that care is delivered, using digital in a different way and looking at how the 10-year plan that is set out will shift and support care to be delivered in the future.

We are doing two things at the same time—making sure that we deliver from an activity perspective, absolutely, and changing the way that care is provided and delivered.

Q74 **Josh Fenton-Glynn:** Is it patient behaviour or physician behaviour that needs to change?



Samantha Jones: It is a collective. As we were talking about earlier, the model of care now is almost as it has been for hundreds of years. What we need to do is the work that Mark will talk more about, which is more of the transformation involving the patient, the families and the clinicians, and making sure that they have the data, that they understand their own performance, and that the set-up is incentivised from a financial perspective to do the right thing. It is not one or the other. Of course, society and the way that people access care have changed, so it is about bringing that together.

Mark Cubbon: We know, through feedback that we get, that different cohorts and age groups of patients want to access care in different ways. Sadly, some are used to waiting—which is what we want to change—because, whenever they have had interactions with hospitals, they do it face to face with a clinician. We also know that other age groups are not expecting to wait. They are expecting to use technology, because they can access health advice through other routes, outside the NHS, where it is on the phone or on a video call, with much speedier access to some of the diagnostic tests. That is exactly what we are embedding in the model for the future.

We are working really closely with the Patients Association and other stakeholders to make sure that we have a deep understanding of that transition in terms of how care is accessed by patients so that we get it right. A really important focus for us is that we do not isolate patients who need to access care.

Q75 **Josh Fenton-Glynn:** So we have some physician change and some patient change. It is a 10-year plan. You just said that the current model has lasted for about 200 years. We also have a document here that shows that we have not been terribly effective at changing physician behaviour. What gives you confidence that it is deliverable?

Mark Cubbon: I will come in, and then Meghana can, being a clinician herself. We recognise that the way that we access specialist care needs to change. It is probably unsustainable to continue with the model that we have for the future, because, year on year, it is growing and growing, and we know that there is technology that will enable services to be accessed in better ways.

Q76 **Josh Fenton-Glynn:** You are telling me that you recognise that we need to change, which is what you just told me in your last answer. We have tried change here, but it has not really worked. What makes you confident that it will change?

Mark Cubbon: We are working really closely with the royal colleges. We are working really closely with a group of clinicians inside NHSE, who all work in the service as well, and with groups of clinicians who work only in the service, to make sure that we can get as much consensus around the model that is going to be fit for the future. It is still not going to be easy, because most clinicians have progressed through their career working in



a model where they are seeing a patient face to face for every single interaction. That is something that we are looking to change in the future. We want to set more of this out in a few months' time.

Q77 Josh Fenton-Glynn: Is the essential problem that the senior clinicians who you need to get on board and who make a lot of the decisions are, in fact, senior?

Mark Cubbon: Meghana is probably the best-placed person to respond to that one.

Professor Pandit: Having been involved in a lot of quality improvement activity across the NHS trusts, it is clear that clinicians at every level need to buy into the process change. What I have experienced is that, when they come up with an idea, it is our role to facilitate that and to ask, "How can we unblock any obstacles to you making this happen and run?" With those smaller-scale pilots of change, which they take pride in because their patients are doing better because of that change, it is easier to then spread that as an effect.

I will give you an example in job planning, which is really close to every consultant's heart. It is a requirement that all of them have a job plan. A typical job plan is 10 programmed activities, each being worth four hours of work. The direct clinical care that they do, which involves seeing or treating patients, or patient-related admin, has traditionally been very difficult to adopt in terms of saying to everybody, "You need a job plan that is signed off".

Now, we have shown almost a doubling over the last eight months, because of the work that we have done with them. They say to us, "The demand on our service is X, and the capacity is Y. We want to reshape our job plan", and we say, "Yes, let us look at that. We understand that, but this core activity needs to be provided". That had a doubling effect on that. You are absolutely right that clinicians have to be engaged, and there is a way of making them appreciate what their patients need.

Q78 Josh Fenton-Glynn: It sounds to me like you want to convince them that it was their idea.

Professor Pandit: They often have very good ideas.

Samantha Jones: If I may, the 10-year plan had one of the largest engagement exercises, including clinicians and users of the services. Lord Darzi's independent investigation identified where the challenges were. The 10-year plan and the way in which it was created involved many of those people who we are describing in terms of creating the new future. I would just relate it back to that.

Q79 Lloyd Hatton: There is just one final question from me. Again, it would be really helpful to understand what the thinking is at a time of significant change in the NHS with the 10-year plan and the abolition of NHS England. Figure 4 in the NAO Report shows that meeting the 5%



HOUSE OF COMMONS

target by March 2025 did not happen. When do we project that we will hit that target?

Mark Cubbon: Can I just check that the target that you are talking about is the diagnostic standard?

Lloyd Hatton: Yes, diagnostic waiting time performance.

Mark Cubbon: We have not set a specific requirement in this year for the NHS to deliver a target for a basket of diagnostic tests, but it remains a target that we want every organisation to work towards, because it is such a critical target to support continued access and improvement in access to electives, as well as for waiting times for other types of services.

We recognise that there is still more to do. Organisations are still working towards improvement at a local level. As part of our efforts this year through the planning guidance, we wanted to reduce the number of targets that organisations were focused on in order to get the greatest impact and buy-in from organisations and clinicians, to simplify the ask and to drive up the improvements that we needed to make this year.

Sir Jim Mackey: We are doing the work now to determine what will go into next year's planning expectations as well as for the following two years.

Q80 **Lloyd Hatton:** I appreciate that that work is happening now. It would be useful for the Committee to know whether, having not met the March 2025 timeframe by which you wanted to reach the target, there is a fixed projection for when the NHS is likely to meet the target of 5%.

Mark Cubbon: As Sir Jim said, we are currently looking at the requirements that we will place on organisations for next year to deliver improvements across a range of standards, and we expect diagnostics to be featured as part of that review.

Q81 **Lloyd Hatton:** So there will be a fresh date published next year for when we meet this 5% target. There is not one right now, but one will be published next year.

Mark Cubbon: It is definitely one of the targets that we will be considering.

Q82 **Chair:** I have just a couple of final points. Samantha Jones, reference was made to the fact that this cannot be delivered from the top. It has to be within the organisation. There has to be a real culture change to deliver that, has there not?

I talk to GPs who just get very frustrated. They say, "We know what to do. We have been doing it for years. We are fed up of being told precisely how to do it. Give us some flexibility and freedom. Tell us what the targets are, but we will get on and deliver them". At the same time, you have others in the NHS who literally do not want to move until they get a



HOUSE OF COMMONS

directive. How are you going to change that? Who is going to be responsible for that? Is that a prime focus?

Samantha Jones: First of all, everything that we do is about ensuring that clinical engagement leads this. We are working to deliver and then hand over the power to the patients in the way that was described. That overrides everything that we are doing.

There are always people on a change curve, as you will know—those people who want to be further ahead. Indeed, the Secretary of State announced the 43 that I mentioned earlier, for example. Those are the people who want to go ahead and make things happen. There are others who perhaps need a bit more support, in terms of the data that I am sure Meghana and Mark will come with about what this looks like and how we do this peer transformation. There are others who will need some different type of “support” that the oversight framework in NHS England has set out.

Important through all of that is making sure that it is as local as possible, and those people who want the freedoms will get them in terms of the delivery.

Q83 **Chair:** Clinicians, and GPs in particular, say to me, “We do not want one bureaucrat at national level replaced by another bureaucrat at local level telling us what to do”.

Sir Jim Mackey: Just to add to what Sam said, what we have been trying to do this financial year is create a more rules-based system, where we are less specific about specific instructions nationally. We create the environment in which people can do what they need to do, with frameworks, guides and payment mechanisms, et cetera. It is mixed, as you have described, so we can get criticised for being too loose, but also not precise enough in not having given the instructions. That is just about being in a very complex transition.

With a slimmer, thinner and more agile centre, more of a rules-based system, and clearer mechanisms to support and intervene where necessary, the service will get a hold of this and deliver, as it has done fantastically well over recent years.

Q84 **Chair:** In the past, the Committee has heard about the digital platforms and legacy systems that exist throughout public service. We have also heard about countries such as Denmark, which has really reprogrammed its digital base in the last few years. We still have a system here where there is no digital plan for the NHS, really, is there? We talk about the link between GPs, hospital trusts and consultants, but they are working on completely different IT systems. They cannot talk to each other. Patient records are held in different places. How do we move a system forward with such fundamental contradictions?

Sir Jim Mackey: There is a lot in the 10-year plan and in other plans especially about that integration and record sharing across the system. It



HOUSE OF COMMONS

is a key weakness of our system. A lot of foundations have been laid in recent years, with new electronic patient records coming into service, but technology is moving really quickly. A lot of the value over time will be driven more by patient and consumer-led technology that allows people to manage their own care and interact with clinical teams.

A lot of technology is now being made available to the NHS. We are going to have to spend a bit of time in the autumn to work out the role of the centre in that. How do we make sure that there is a healthy market? How do we have payment mechanisms that enable organisations to adopt this technology and move away from big capital, central bidding processes and into more agile and rapid processes? A lot of this technology is much more agile now. It is cheaper and easier to procure, but our processes currently do not support that. We are dependent on it, and the rest of society is changing in this way.

I always get a bit irritated when people compare us with other systems. They usually compare a massive, full, comprehensive system, which is our NHS, to quite small, discrete systems. A lot of the countries that we often get compared to are the size of an ICB or the size of Mark's organisation, for example. There is no other system that is as joined up and as comprehensive as ours. When we are trying to make technological change and make it consistent across that kind of footprint, it is very complicated.

Samantha Jones: The 10-year plan has set out the requirement for the single patient record, with the NHS app being the front door to the NHS. As we would do in any other part of our life, it is about making it as easy as possible, through the join-up, to reduce the fragmentation for patients and carers who are using the services.

Q85 **Chair:** I get that, but I would hope that we would not take the view that we cannot learn anything from other countries as well.

Sir Jim Mackey: We are not saying that.

Q86 **Chair:** It still is a challenge. The patient records held by a GP are different from those held by a consultant. It is not a great place to start, is it?

Sir Jim Mackey: There should be full integration, or at least visibility for everybody of what the whole patient record is. Importantly, the patient needs to see it.

Chair: Thank you all very much for coming today and answering our questions across a range of subjects, and probably additional ones to those that we set out to look at. An uncorrected transcript of this hearing will be published on the Committee's website in the coming days for anyone who wants to read it. We are now going to consider the evidence provided and will eventually produce a report, which you will receive in due course. Thank you once again.