HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Clearing the backlog after the pandemic, HC 599

Tuesday 19 October 2021

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Watch the meeting

Members present: Jeremy Hunt (Chair); Dr Luke Evans; Barbara Keeley; Anum Qaisar-Javed; Dean Russell; Laura Trott.

Questions 139 - 197

Witnesses

I: Sarah Lambrechts, patient; Ben Zaranko, Research Economist, Institute for Fiscal Studies; and Siva Anandaciva, Chief Analyst, The King's Fund.

II: Amanda Pritchard, Chief Executive, NHS England; and Professor Stephen Powis, National Medical Director, NHS England.

Examination of witnesses

Witnesses: Sarah Lambrechts, Ben Zaranko and Siva Anandaciva.

Chair: Welcome to the third session of the Health and Social Care Committee inquiry into clearing the backlog in NHS treatment caused by the Covid-19 pandemic.

Later this morning, we will hear from the new chief executive of NHS England, Amanda Pritchard, in her first appearance before this Committee. She will be joined by NHS England's national medical director, Professor Stephen Powis. We will focus our questions on their plans for tackling the backlog and whether they have the resources and the capacity to deliver on that.

Before that, we will take evidence from Siva Anandaciva, who is the chief analyst from the King's Fund, and Ben Zaranko, who is a research economist at the Institute for Fiscal Studies. Thank you for joining us. We are going to probe the adequacy of the Government's funding announcements so far.

To start our session and to give some context to these discussions, we are going to talk to a patient. I would like to welcome Sarah Lambrechts, whose treatment has been delayed by the pandemic. I will ask my colleague Barbara Keeley to talk to Sarah about her experience with endometriosis and how that care was impacted by the pandemic.

Sarah, thank you very much for joining us at this morning's Committee meeting. We are delighted that you are here. You are our very first witness this morning, and you are going to create a very important context for the discussions that follow. As I think you know, my colleague Barbara Keeley is going to ask you a few questions.

Q139 **Barbara Keeley:** Good morning. Thank you for agreeing to give evidence to the Committee today. Could you start by telling us about your condition and your experience of seeking treatment during the Covid-19 pandemic?

Sarah Lambrechts: No problem. *[Inaudible.]* I have been diagnosed since 2017. I was meant to receive my second laparoscopic incision surgery at the beginning of March. Obviously, that did not happen, for reasons that we all know. The surgery was rescheduled and then cancelled, and then rescheduled and cancelled again. Finally, I had surgery in August 2020.

Unfortunately, that was not successful, so I had a follow-up with my surgeon that was delayed by about six months because of the impact of the pandemic on the NHS. When I had that in January this year, I was told that, unfortunately, I would have to have further surgery.

I was put on an interim treatment of Zoladex injections. I was on that for about six months, but, unfortunately, it made my condition deteriorate

quite drastically because of the side effects and the lack of relief from the pain that I experience. I am currently awaiting my third surgery.

Q140 **Barbara Keeley:** Gosh, that is horrendous. There was a slight sound problem at the start of what you said, and we missed the first part of the sentence. Could you say again the first words that you said to us?

Sarah Lambrechts: Of course. I said that I have stage 4 endometriosis. One in 10 women globally have it.

Q141 **Barbara Keeley:** Thank you for describing the treatment. What impact do you think that the Covid-19 pandemic in itself had on the treatment you received? What impact is it continuing to have?

Sarah Lambrechts: One of the areas where I would say it has had the most impact is the continuity of care that I receive. There has been quite a big disjoint between my primary care service—for example, my GP—and the staff whose care I am under at my local hospital, Saint Mary's in Manchester. It often meant that I was quite in the dark. It felt as if I was walking down a dark corridor and did not really know when I was going to get to the end of it. I was just waiting for a letter to come through the post. It felt like I was on my own, which not only confused me, in terms of how to plan my life around this and how to cope with those feelings, alongside the feelings of isolation from the pandemic, but it had an impact on my mental health. It continually felt like I was taking one step forward and then five steps back.

Q142 **Barbara Keeley:** Is it possible to point out anything that has gone well in your treatment? Has it mainly been things that have not gone well? You have had surgery that has not gone well, and you have had another course of medication that has not gone well. Has anything gone well?

Sarah Lambrechts: Yes, there are some things that have gone well. I am really lucky to have an amazing surgeon. Thankfully, I was not reallocated to a different surgeon throughout the pandemic. The continuity of the people I deal with has been fantastic. I have been really lucky to have a dedicated endometriosis nursing team. When I have had communication, they have been absolutely fantastic. They have always made sure that I felt heard, which can often be quite difficult with an invisible illness, particularly among the chronic illness community.

Another thing that has gone well is working with grassroots organisations like Endometriosis UK. The seminars they put on throughout the pandemic to make sure that they could fill the gap in communication have been absolutely fantastic. They have been the guiding voice I have listened to throughout the pandemic in times of uncertainty and lack of communication.

Q143 **Barbara Keeley:** The next question I was going to ask was, what would have improved your experience? It sounds as if a lot of it is about communication. Is that the case? If so, how might that be improved?

Sarah Lambrechts: I would say that the majority of it is communication. Unfortunately, the NHS has been under severe stress during the pandemic, and it has been somewhat inevitable.

The thing with endometriosis is that it is so debilitating. It is a spectrum disorder, so there are days when I wake up, am fine and can go about my daily life, but there are also days when my partner has to help me up the stairs or I cannot dress myself because I am in so much pain.

First, the communication could be better. That could just be regular phone calls, even from primary care providers such as GPs. Unfortunately, my GP was not the best during the pandemic. The second thing that could be better is making sure that there is a level playing field for women trying to access care. There is no continuity. It really is a postcode lottery. I feel that that adds to the uncertainty, because you do not know what you are going to get based on who answers the phone.

Q144 **Barbara Keeley:** How clear do you feel now about what will happen with regard to future treatment that you might need?

Sarah Lambrechts: Fifty-fifty. In January this year, when I had the follow-up from my last surgery, I was told that I needed to have another surgery. I would go back on the waiting list, and it would be about 12 months. In September, I had another follow-up, just to check in with me following the symptoms that I experienced during the interim treatment. I have been escalated up the priority list because of the impact it is having on my quality of life. I have now been told that I could be waiting for another 18 months-plus. It is also dependent on how the NHS copes with the winter flu season and the booster vaccinations, and the impact that has on hospital stress. It could be increased even further.

I am 25 years old. For the next 18 months or two years—however long—I cannot plan my life. I cannot plan my career progression. I cannot plan to have a family. I cannot take care of myself some days. The idea of being 27 or 28 and still having no solution and no idea of what the next steps are for me is quite scary.

Q145 **Barbara Keeley:** Thinking about your health and the other areas of life you have touched on, has the impact of your experience of seeking treatment during the Covid pandemic really made a difference, or do you think that some of those things about the treatment would have been the same whether there was a Covid pandemic or not?

Sarah Lambrechts: There were historical issues with waiting lists in the NHS already. I have experienced that since I was 11 years old, when I started to have this pain. It is something I have been dealing with for 14 years of my life. However, I think it has been exacerbated by the pandemic.

Pre-pandemic, there was excellent communication. I felt safe. However, during the pandemic there were times when I was completely incapacitated. I could not move. Honestly, I was scared for my life,

because I thought, "I can't manage this at home, but I can't go to A&E. I can't seek treatment." My GP complained to me that I should not be calling them and that I should just be grateful that I did not have Covid. There were times when I felt completely invalidated. Endometriosis is one of the 20 most painful conditions. That is what the NHS has said, but I genuinely felt at times that I did not matter.

Yes, there were waiting list issues that existed pre-pandemic, but we were given very clear guidelines—"This is when you should expect to wait. If there is no progress, we will call you"—and we always got a call. Now that does not exist. I feel that I will be waiting for years and that I cannot progress with my life.

Q146 **Barbara Keeley:** That is really difficult. Overall, if you could make one recommendation to support people whose treatment has been impacted by the pandemic—maybe other women, like yourself, with endometriosis—what would that recommendation be?

Sarah Lambrechts: Obviously, the first thing would be to have a good communication plan, to make sure that not just women with endometriosis, but anyone who experiences any form of waiting list within the NHS, has a clear idea of what to expect going forward so that they can plan their life.

Secondly, there should be funding for organisations like Endometriosis UK that provide support on a community-based level, be it through seminars, webinars or support groups. I am part of the Manchester support group. It is invaluable because they are the people we turn to when the NHS fails.

Q147 **Barbara Keeley:** It has been very valuable for the Committee to hear your experience this morning. I should tell you that I had endometriosis myself. It dogged me for years. I had a similar litany of surgery and other treatments, so I know where you have been with this. I hope your next course of treatment is better.

It should help you to know that we were due to have a debate on endometriosis in the Houses of Parliament yesterday. We did not do that because our colleague David Amess tragically died. In fact, David was an MP who started an all-party group to work on issues of endometriosis, so it is being covered here.

Can I wish you all the best for your treatment? We will be thinking of you when we are having that debate in a couple of weeks' time. Thank you.

Sarah Lambrechts: Thank you very much.

Q148 **Chair:** Thank you very much for joining us, Sarah. We really appreciate it.

Now that we have had that important context, let me talk briefly to a couple of experts who are also going to help to set the scene before we talk to the chief executive of NHS England, Amanda Pritchard, at about

quarter past 10. We have Siva Anandaciva from the King's Fund and Ben Zaranko from the Institute for Fiscal Studies.

I would like to start with you, Ben. You are expert on maths and numbers. I am going to try to summarise in very layman's terms what I think you said when you published your data last week. Broadly, the new health and care levy is going to raise £12 billion a year. That is what the Government say. Social care will get about £1.8 billion a year, on average, over the next three years, and the virus costs about £5 billion a year, so, broadly speaking, there will be around £5 billion a year to deal with the backlog, which is what this inquiry is about. First, have I got my maths right? Secondly, is that enough?

Ben Zaranko: The £5 billion a year we have come up with for the pressures and virus-related costs for the NHS is not just for dealing with the backlog. It also extends to other things, like the mental health impacts of the pandemic and some of the impacts on staffing.

To construct the cost of how much we think is needed for the backlog, we have done a very detailed, bottom-up cost exercise. I can go into detail on that, but I suspect you would rather I didn't. Basically, we look at the specific types of activity, procedures and operations that we think would have happened in the absence of the pandemic but did not. We can cost all of those and combine them with assumptions about how many of the missing patients will come back and whether there is a cost premium associated with treating people now because of the need for more agency staff or making greater use of private sector providers.

Our central estimate is about £2.5 billion per year, which is £7.5 billion over three. On our best estimate, which, I should emphasise, is subject to massive uncertainty, that should be enough to deal with the missed activity, to get on top of the backlog and to have waiting lists more or less back to where they were pre-pandemic by the end of three years. There are also extra costs associated with the virus for the NHS. Altogether, those come to about £5 billion a year, under our estimates.

If you want to assess the adequacy of the Government's spending announcements, there are two parts to that. First, there is money specifically implied for dealing with the backlog. There is about £8 billion over three years. On our estimates at least—I should emphasise that other organisations disagree—that ought to be enough to deal with the backlog. Secondly, there is the money for the NHS overall. There, the Government have announced just over £10 billion for the next two years. Again, we think that is about the right amount.

Our concern is about the final year, 2024-25. If you had asked me pre-pandemic, "What will the NHS budget be in that year?", I would have guessed about £160 billion. Now that NHS England is set to have a budget of £160 billion, it is as if it is getting the budget that we thought it would have if the virus had never happened. To us at least, that implies almost nothing for dealing with ongoing Covid costs, should they still

exist at that point. That implies that, if those costs exist, we will be meeting them from other budgets, so we think that there could be a shortfall of something like £5 billion in that year.

The very simple summary is that it looks like enough to deal with the problems in the short term, but in the medium term that may no longer be the case. Either savings from elsewhere or future top-ups could well be needed.

Q149 **Chair:** Did you do any analysis of whether we actually have the extra doctor and nurse capacity in the country to provide the extra £2.5 billion-worth of care that will be needed to deal with the backlog?

Ben Zaranko: That is perhaps the most important question in all of this. It is all very well throwing money at the problem, but if there is no one actually to deliver the care, we will not get on top of the issue. We have not done the same level of detailed analysis of whether the staffing is there, but we know, for example, that we entered the pandemic with 40,000 nursing vacancies in England, and so on.

We think that the funding of £7.5 billion over three years ought to be enough to increase activity by about 10%, relative to what was previously planned. On our modelling, under some assumptions about how many missing patients will come back, that should also be enough to get waiting lists more or less falling again and on a positive trajectory, closer to where we would like to be. It is not as if we are asking for 50% more capacity overnight. To us, 10% is something that seems to be within the realms of possibility.

Q150 **Chair:** It is interesting that they say that they are going to get it up by 30%.

Ben Zaranko: By 30% by 2024-25, relative to 2019 levels; 10% above what was previously pencilled in under the long-term plan, as I understand it. We think that 10% will no doubt be challenging, but seems achievable, whereas much bigger numbers may not. Siva may have more thoughts on the staffing situation specifically. It is no doubt a challenging target, but it feels like this is the right time to be ambitious. To us, at least, it feels like it ought to be potentially achievable.

Q151 **Chair:** Let me bring in Siva, before I bring in my colleagues. Broadly, I think that Ben is saying that the IFS analysis is that the money is enough, but we don't yet know, certainly for the first two years, and there is a big question mark over staffing levels. From the King's Fund's perspective, do you broadly accept that?

Siva Anandaciva: I do. Could I make a few points? Like Ben, I am here mainly to talk about funding and money. There were bits of Sarah's testimony that are clearly not a money issue. They are about culture, quality of care and communication with patients, which are much more important than money.

On the money itself, the first thing I would say is that nobody knows. Nobody knows whether it is enough, really, because so many uncertainties remain over how many of the people who did not present for care, or were not able to, during Covid will come back and request treatment, and over what time period.

We have to try to break through that uncertainty with models. Most of the models I have seen suggest that the amount of money that the Government have provided is in the right zone, if your level of ambition is not to see 92% of people within 18 weeks, which is the constitutional standard—what has been promised to patients—but is a bit lower: to return to the performance levels that were in place before the pandemic. If your ambition for how quickly you are going to do that is also lower—if you are looking at putting the NHS on the path to delivering that level of performance in five to seven years, not clearing the backlog in three to four years—£8 billion over the next three years is in the right zone.

The second bit of your question was about what happens when these models meet reality and where the staff are coming from. Again, the honest answer is, "We don't know." We are still waiting for the national plan. We know that it is meant to buy 30% more activity, but we have not seen the national plan that translates the £8 billion into the extra staff and facilities that will deliver it.

From the local systems I have been speaking to, I think they are confident that they can spend the money in a way that delivers value for taxpayers. They are dividing what they are doing into two buckets. One bucket is quite traditional and familiar: paying existing staff more to work on weekends and evenings and to deliver Super Saturdays, Back2Backs and Bones R Us clinics; outsourcing to the private sector, where that is possible, accepting that staff work in the private sector who are also working in the NHS; and increasing international recruitment, particularly from countries outside the EU.

The second bucket of activities is also important. This is where the fact that we have a three-year settlement for the NHS gives you some certainty to plan. It is about investing in community diagnostics and some of the things that will separate planned elective care from emergency care, so that, as winter pressures rise, you do not have operations cancelled. Those are areas where you can spend the money as well.

Q152 **Chair:** This is the final question from me. You talked about what we heard from Sarah, and rightly said that it is not just about money, but about culture. The enormous waiting lists that we have now are the highest that they have been for 15 years. Are you at all concerned that the last time we had a big effort to bring down waiting lists we ended up in some parts of the NHS with a targets culture, which had unintended consequences— namely, things like Mid Staffs? Is there a danger that the safety and quality of care will be sacrificed in a big push to get numbers

down?

Siva Anandaciva: Good question. It is a real concern. When I started my career in health, it was just after Lord Darzi had started a review to put quality at the heart of the NHS.

First of all, there are different aspects of quality. There is safety, there is effectiveness and there is experience. On safety, there are certain hygiene things that will not go, regardless of whether the waiting list is 15 million or 5 million people. People are not going to stop doing safe surgical checklists, but as the push to deliver activity, activity, activity increases, there need to be things like balancing measures. For example, some A&E departments measure not just how quickly you are seen—the four hours—but the proportion of people who reattend within seven days, so it is not just about fast care, but about getting the right care.

On experience, when I spoke to someone who manages one of the largest waiting lists in England, she said that her job is going to change fundamentally. It is about getting better at communication, reducing anxiety, helping patients to feel like waiting is an active and shared process, not a passive process, and not leaving people in the dark, as Sarah was.

The third component, which is probably the one I am most worried about, is effectiveness. That comes partly from speaking to some clinical and medical directors. One gastroenterology team said that after the first lockdown they as a clinical team sat down and probably did more work on the Too Much Medicine agenda than they had done in the previous five years. They reviewed patient notes and said, "We're not going to be able to see this patient for a medical or surgical intervention, but did they need that medical or surgical intervention in the first place?" One of the clinicians said that the minute the dial started to get turned back up, those conversations stopped, and it was about how to get people in and out of hospital as quickly as possible. I worry about some of the conversations on clinical effectiveness and what matters to patients being dialled down, as activity, and that pressure and focus, is dialled up.

Chair: Thank you.

Q153 **Dr Evans:** I have a quick question for Ben, to pick up that point. Does your analysis look at productivity, and is it based on productivity currently within the NHS or on improving productivity?

Ben Zaranko: If anything, we allow for a hit to productivity, at least in the near term, from the need for ongoing infection control measures, perhaps the need for patients to be spaced out more and staff to change their PPE more often, all the sorts of things that slow down an already very busy team. We have allowed for some additional costs from that.

You asked about increased productivity. The healthcare system is extremely complex, and it is extremely difficult to try to put one number on what productivity means in healthcare. I am sure that you could make

the case that, with improved productivity, you could see more people with the same amount of resources. In the immediate term, at least, we think that you will be able to see fewer people with the same amount of resources. Boosting productivity and finding ways to do more with less will clearly be central to NHS recovery.

Q154 **Dr Evans:** That's right. There are trailblazing hospitals that are currently trying to get to 120% of their capacity. My local hospital is among those. That is why I asked the question. On the basis of history repeating itself, under Labour Governments one way was to put in extra funding. There is a big worry from politicians and the public that we are putting in £36 billion, but how will we see improved access and improved speed of operations in three years' time? Are there any tangible thoughts about how you break that productivity down from a financial perspective?

Ben Zaranko: When the Treasury is writing such a sizeable cheque to the NHS, it will clearly want there to be strings attached and clear, identifiable targets and goals for things that should be achieved. The ambitious national target for activity levels is a good example. Delivering a 30% increase in volumes of activity by the middle of the decade relative to pre-pandemic levels is ambitious. That is huge, and it is something you can measure the NHS against. Those sorts of things are valuable.

Clearly, as you delve deeper within the system and look at individual specialties, hospitals or cases, there will have to be differences and flexibility, but there is a level of ambition at national level. That is to be welcomed. We should be able to hold the NHS to account on that and observe whether it is actually delivered.

Q155 **Dr Evans:** That is really helpful. It leads on to my question for Siva. Given your background, do you think that the NHS is in a position to have time to think about productivity? You already hinted at it perfectly in your example about whether patients should get the care that is provided to them. Does your organisation have any thoughts about how we can improve productivity, to make sure that decisions are right both for patients' long-term care and for the taxpayer and the NHS?

Siva Anandaciva: Good question. One of my biggest concerns, which I know the Committee has talked about before, is headroom—the amount of headroom that you have in the NHS to plan and consider changes to how services are delivered. I vividly remember visiting an A&E department and being shown around by the general manager. You could not take two steps down the corridor without someone popping out and saying, "Ben, where's my bed? Have you found my bed yet?" Eventually, I just had to say, "Do you know what? You've got better things to do than show me around." Carving out time for headroom is one of the great limiting factors.

In the systems we have been working with, we have seen two things. The first is an understanding that systems are not magic. They will not solve

all the problems facing an individual clinical team. There should be a real focus on giving teams support, perhaps through quality improvement training, on how you take a patient pathway, remove waste and have the most streamlined, leanest process possible.

The second thing, which has been a feature of the last two years, accelerated by the pandemic, is what we can do as a system that no individual organisation can do by itself. It could be things like designating one part of our system as the place where we do vascular surgery at scale, to deliver both better efficiency and better clinical quality and safety, and separating hot, emergency procedures from cold, planned procedures. Those are the sorts of moves that we are starting to see as a system. It is also about reducing duplication and waste and standardising how things are done. The system working aspect of how the backlog is going to be tackled is one of the factors that we did not have 20 years ago under the new Labour Government, when backlogs were being tackled in a different way.

Q156 **Laura Trott:** Thank you both for coming. You have stated that you believe that the Government funding will be broadly adequate to cover the backlog, but that huge uncertainties remain. One of the key uncertainties is the number of patients coming forward for treatment. Can you talk the Committee through what you think some of the other big uncertainties are, which would mean that the funding would not be adequate?

Ben Zaranko: We think the biggest is the question of how many of the missing patients remain. One thing to add on that before I move on is that the national level data so far indicates that there is no sense of a huge rush of patients trying to get in. The number of people joining the waiting lists, at least in the national figures, is still below where it was. In August, it was still at 93% of where it was in August 2019. There is no sense that people are flooding forward for treatment. That might be good if all you care about is the length of the waiting list, but you might be concerned about the people who are perhaps not getting the care they might benefit from.

There are many other big uncertainties. Another huge one, of course, is the future course of the virus and the extent to which that requires both people to be directly treated for Covid and ongoing infection controls. There is spending on PPE and all those things that we cannot know with any certainty in advance. There are also uncertainties about the size of any sort of associated cost premium—in economist-speak, the marginal unit of care—so that for every additional person you want to treat it might become more expensive if you have to spill over into new facilities or make greater use of bank or agency staff by using independent sector providers. Other organisations, doing similar exercises, have reached different numbers for those things.

Finally, are the missing patients who return going to be in need of more intensive care? Are more of them going to need to be admitted than we

might previously have expected because they have waited longer? Will some of those people's conditions have resolved themselves? Will the treatment mix have changed? I guess that is the short version.

There are all sorts of uncertainties about these things, to which we have tried to test the sensitivity of our numbers, but ultimately they cannot be known for sure.

Laura Trott: Thank you.

Siva Anandaciva: I would probably raise four issues. The first is the same as Ben was saying about the volume and profile of the demand. The second is the acuity of demand. We do not know how serious the cases on the waiting list are. We have anecdotal evidence that patients are deteriorating and that their conditions are getting worse, so there are interventions that you need to make them better. Looking at the waiting list is a very dynamic process.

The third thing is supply. Again, it is incredibly hard to quantify, but staff have just had to run ultra-marathon after ultra-marathon. At what point do staff reach breaking point and we start to see exit from the healthcare system? That is very hard to predict and model.

The fourth thing is Covid, because we are still not out of the pandemic. I cannot remember how many winters I have been through saying broadly the same things about winter pressures in the NHS. It used to get really bad when we had a bad flu outbreak or norovirus. With Covid, I was speaking to one trust where basically the entire anaesthetic team was taken out by Covid, so the theatre shut down. You cannot do anything else. I think Covid is such a game-changer that the path of the disease will be the single biggest factor affecting whether the funding is adequate or not.

Q157 **Laura Trott:** We have Stephen and Amanda sitting behind you, who are in our next panel. What should we, as a Committee, be asking them about funding for the NHS?

Ben Zaranko: Are there any other areas of Government which have not got a three-year settlement from the Treasury already and are not benefiting from a manifesto-breaking tax rise to pay for additional funds that, if not adequately funded, might spill over on to the NHS? I guess the most obvious would be local government. If local government is squeezed to accommodate an ever-growing NHS budget, are you concerned about the possibility of inadequate social care spilling out on to hospitals and other health services?

Q158 **Chair:** Thank you. Siva, briefly, on that.

Siva Anandaciva: I would be interested in knowing this. The Government have given £8 billion to tackle the elective backlog and have said that they want to see activity rise by 30% by the end of the period

because of that. What is the plan, the connective tissue that translates the money into the reality of extra activity?

Laura Trott: Thank you.

Chair: A brief question finally from Barbara.

Q159 **Barbara Keeley:** I have a couple, but I will try to be as quick as I can. First, I want to ask about the distribution funding. Covid hit the poorest areas more, and those areas have the longest waiting lists according to your recent work with Healthwatch England. Should the distribution change? Should we have a different formula, recognising those two factors?

Siva Anandaciva: Good question. The formula by which funding is flung to systems across the country takes into account the deprivation of the populations. I think the questions we are asking systems are, "Do you understand the profile of need in your population?" and, looking at waiting lists by deprivation, ethnicity and factors like learning disabilities, "Do you really have a detailed picture of what your waiting list looks like?" Secondly, "What action are you taking with the money that is already available to make sure that whatever action you take to tackle waiting lists does not widen health inequalities but reduces them?"

We have run the numbers, but from some of the conversations we saw the classics of making every contact count. You have hospital staff who go to food banks and say, "If you want to treat the most vulnerable parts of your population, you have to go out and find them." It is about proactive case finding and seeking people out.

We can look at how the money is allocated to different systems and different population groups, and I would say that as much should be done to change how the money is being used operationally on the ground to understand and meet the needs of more deprived communities.

Q160 **Barbara Keeley:** A quick question to Ben, if I may. There are clearly worries in the care sector that funding for social care of just under £2 billion will be insufficient to deal with the pressures they face. I think you just touched on it. What do you think is the risk to the care sector in the NHS if social care remains inadequately funded?

There is an extra point to throw in about distribution. It is looking clearer that the social care funding will go to certain parts of the country. It will go to self-funders, given that 90% of the funding is going through the cap on care costs. That is a further imbalance added to the imbalance I have just talked about with Siva.

Ben Zaranko: That is a huge amount to cover. I will have to be really quick. The money will not be sufficient to achieve everything that the Government have stated they want to achieve. It will be sufficient to achieve some of that, but it will not be enough to increase fees paid to providers, improve pay and conditions for care workers, meet the cost of the cap and the more generous means test or to relax the needs test so

that more people get the care they need. It will not be enough to achieve all of those things. The Government will have to prioritise. Yes, the cap will primarily benefit people who are wealthier, but the more relaxed financial means test will benefit people of more modest means as well. It will not just be the very rich with houses in Surrey, which seems to be the trope.

The idea seems to be that this is £12 billion a year, and at the start about 85% of that is going to the NHS. Over time, that balance will shift and more and more will go into the social care sector. I would be concerned about whether that actually ever materialises, or whether—let's assume we are right that the NHS might be about £5 billion short in 2024-25—if we are right and that £5 billion is found from the health and social care levy, social care providers will be the ones perhaps making up for that. I would be concerned about whether, given the lessons of history, that money for social care will actually materialise on the scale at which it is being promised, or at least implied.

Barbara Keeley: Me too. Thank you.

Chair: Thank you both very much for joining us and setting the scene. It has been very helpful and useful. We will feed your comments into our next set of questions to the new chief executive of NHS England and the medical director of NHS England. Thank you both very much for joining us for this part of the session.

Examination of witnesses

Witnesses: Amanda Pritchard and Professor Powis.

Q161 **Chair:** Good morning and a warm welcome to the still relatively new NHS England chief executive, Amanda Pritchard, and the national medical director, Professor Stephen Powis. We are very grateful to you for joining us.

I must apologise. We have Health questions at 11.30, which we obviously must attend as the Committee, so this will not be one of our marathon seven-hour sessions, which I know will be a disappointment to you on your very first appearance before the Committee. We want to talk about a lot of things in an hour.

I start by congratulating you, Amanda, on your appointment. In terms of the number of employees for whom you are responsible, it is the biggest health job in the world. You got it in the middle of a pandemic. Can you tell us what your personal reaction was when you found that you had got the job?

Amanda Pritchard: Thank you very much. We are delighted to be here with you this morning.

It is a great question. I have worked for the NHS for 20 years. I have been very proud to be part of the NHS, and never more so than in the last couple of years. The report that your Committee recently produced

highlighted some of the things that caused me great pride in what the NHS has achieved over the last two years, such as the way that critical care services were stood up and expanded, the speed of new treatments like dexamethasone and the roll-out of the vaccine programme, all of which meant that the NHS was not overwhelmed. Sadly, we saw that not every country was in that position.

There is no doubt that we are in a new phase now. We still absolutely have Covid with us. We are treating thousands of in-patients every day. We also have new challenges created by the pandemic, long Covid being just one example. There is demand on the NHS, partly from people who did not come forward through the pandemic. Part of what we now face is a challenge that is about continuing to recognise the reality. We are working to support the NHS to continue to look after patients with Covid and those who have urgent emergency care needs, but also responding to the new demands that the pandemic has thrown at us. We need to maintain the momentum on recovery in all the services that were inevitably displaced by Covid over the last two years. That is what we will be talking about today.

The other thing not to lose sight of, and certainly why for me, in some ways, there is no more important time to take up this role, is that we also still have all the things that we were trying to do before the pandemic, which remain as important, if not more important now. We think about things like inequalities, prevention and some of the long-term plan commitments around mental health and cancer diagnosis, and so on.

My immediate priority as chief executive—I have already mentioned a couple of them—is to keep up momentum to recover services that were displaced, while absolutely supporting the NHS to continue to look after Covid patients and those with urgent care needs. We must do so in a way that is cost-effective but also inclusive, sustainable and continues to have our focus on the long-term planning goals that really matter.

Thirdly, and perhaps the most important of all, we must support our workforce because the impact of the last two years has been profound. I have a very personal commitment on this, to make sure that we are doing all we can to support the people who have been with us over the last two years, while at the same time of course trying to recruit more and making sure that we have a pipeline secure for the future.

Q162 **Chair:** Thank you. Our inquiry is into your plans to tackle the backlog caused by Covid. We have just heard two experts from the King's Fund and the IFS, who said that, broadly, when it comes to money, they think you have enough to tackle the backlog. We are going to talk about the other challenges, but do you agree with that broad analysis? The IFS said £2.5 billion a year for the next three years. That is obviously covered in the health and care levy that was announced last month. Do you agree with that?

Amanda Pritchard: What we now have is very welcome certainty on the revenue funding for the next few years, which allows us to commit to 9 million additional checks, treatments and tests over that period. I just caught the end of the last session. I heard people talking, quite rightly, about uncertainty. I think it would be very difficult for us to say at this point in time what will happen around the number of people who will now come back into the NHS seeking treatment who did not over the period of the pandemic. Indeed, it would be very difficult for us as we sit here now to say with certainty what this winter is going to look like, and what the course of the pandemic is going to be.

We know that we have a really secure place from which to build, and where we can absolutely now deliver significant improvement in our elective activity. How that will translate into the backlog would be very difficult to say at this stage.

Q163 **Chair:** We understand that there is uncertainty about how many people emerge who did not emerge during the pandemic, and that could add to the waiting list, but you have been very clear that 9 million additional checks and treatments are made possible by the funding.

The Health Foundation told the Committee that you would need another 4,000 doctors and 18,000 nurses to clear the backlog. Does that number sound right to you?

Amanda Pritchard: The point about workforce is incredibly important. It is why, for me, supporting our workforce is at the heart of everything we need to do. Without trained, supported people who are able to do their jobs as brilliantly as they have done them over the last two years, we will not be able to achieve the goals that we have around all of the things I have just spoken about, including elective recovery.

Over the past year, we have seen a substantial increase in the number of staff in the NHS. We have 29,000 more full-time equivalents now than we had a year ago, of which nearly 10,000 are nurses and 3,900 are doctors. It is absolutely critical that we recognise—

Q164 **Chair:** I am sorry, I am going to push you a bit there. You are going to get nearly £10 billion more, starting from next April. You are going to need quite a lot more doctors and nurses, even on top of the numbers that we have had additionally during the pandemic, to be ready to start by April.

Question one is, do you agree that it is 4,000 more doctors that you need? Let's just stick with doctors for a moment and then we will come to nurses. Do you agree it is 4,000 doctors? Question two, is there a plan to recruit a large number of additional doctors to start by next April when the funding starts?

Amanda Pritchard: I was just about to say, "but obviously that is not enough". That is how I was about to finish my sentence. It is great that so many people have wanted to come and support the NHS over the last

two years, but we absolutely recognise that we need to maintain that momentum and indeed accelerate it. On the point around doctors, I think Stephen will want to pick that up.

Professor Powis: Yes, I think we need more doctors. The UK has 2.8 doctors per 100,000 population, including GPs. The European average is 3.7. The OECD average is 3.5. We need to increase all clinical staff, but you asked specifically about doctors. I do not know whether 4,000 will be the right number, but I certainly think we need more. Of course, when you were Secretary of State, you increased the number of medical student places. That was a very welcome increase and means that we will have 3,000 additional registered doctors coming through in 2026-27. That extra number will build year on year, but my personal view is that the number needs to be kept under review, and I think there is a case for increasing the number of medical school placements further.

Having said that, it is a long time from medical school through to becoming a consultant, although of course in training our doctors contribute a lot to the service, too. It is not just about extra doctors in the short term. It is around extra clinical staff across the board. It is around more flexible working. We have a long history of developing extended roles for professionals. Nurses, paramedics and pharmacists do jobs that doctors would have done 10 or 20 years ago. We need to keep doing that, too.

Of course, the third thing we need to do is to ensure that people do not leave the health service. Everything that Amanda has pointed to about the wellbeing of staff and ensuring that staff want to remain working in the NHS is important. It is not just one thing, but supply is really important.

Q165 **Chair:** Excuse me, but I am going to push you a bit. I completely understand that the announcement of the extra money was only last month, but it is going to start next April. It is a lot of money: nearly £10 billion. You must have a number not just of doctors but of additional clinical staff that you would like to see in place by next April. I know that it is not entirely within your gift. Is there a plan to recruit X more doctors, Y more nurses, Z more midwives, AHPs and so on? Is there a plan to improve retention rates? We obviously have a crisis at the moment in general practice, among many other specialties. Is there a plan so that you will be ready by April?

Amanda Pritchard: As Steve said, there are three clear elements to this. We have activities going on in all three. On health and wellbeing, we have a national offer. It has been accessed over 1.3 million times, which shows how valued it is for staff across the NHS. A lot of that can be supported nationally, but local support is the absolute key. We know that. It really matters which team you work in. I give credit to all my colleagues across the NHS, who I know are taking this very seriously.

That leads into retention. Part of that is definitely flexibility. I met some colleagues yesterday at Imperial. Louise, a midwife, talked to me about how she was now doing a flexible role, partly research and partly clinical work. She had been considering her long-term future and whether it was in the NHS. She has chosen to stay. I talked to another colleague, Godfrey, who started as an HCA and has been supported to do nurse training, so again keeping him and his astonishingly impressive skills within the health service. We have a very substantial national programme on the retention piece, again absolutely supported by local support for staff.

Supply is the other critical piece. We have six programmes actively under way nationally at the moment. They are seeking partly to build on some of the success over the last two years of people coming into the service. We have things like the Landmark programme and the health and care reservists, to try to make sure that colleagues who joined us to support things like the vaccination programme and test and trace can see a long-term future in the health service and the reservists. It is a slightly different model for people who want to give some time but not full-time support to the NHS.

International recruitment continues at pace. At the moment, in the year to date, we have brought in 12,000 new staff through the international recruitment route. We have also been successful in particular in recruiting more healthcare support workers. We have 14,000 to date.

There are two other things worth mentioning. We have 250 additional medical support workers who joined the NHS this year through that route. That is partly Steve's point about new roles and thinking flexibly about the kinds of roles that people might want to do, and how we can bring people in more quickly and support them through their careers. We have just launched a really important programme around midwifery—the 1,200 full-time equivalents we are now seeking to bring into the midwifery profession.

It will need all three. We absolutely need to keep the people we have. We need to find a way of supporting them to stay well, to stay at work and to continue to do their best work. We need line of sight on supply, which is partly continuing to have some of the flexibility of the last two years baked into the way we work in future.

Q166 **Chair:** Thank you. Perhaps you could write to us with details of all those plans and what you think they will mean in terms of the additional supply of staff by next April, when the funding starts. Would you also let us have an estimate of what "enough" looks like? In other words, it is not just how many you think you are going to get from these programmes but how many you actually think you need to deliver the backlog programme, and whether the supply will meet the demand for staff.

The thing that is really of immediate concern is something that Professor Powis mentioned, which is that the supply of doctors for the long term—

given that it takes seven years to train a doctor—is not going to change the number of medical school students we train now. It will not have an immediate impact, but it obviously has a very profound impact in the long run. Next week, we will hear the Budget and the spending review, and the settlement for Health Education England. This is not a matter for NHS England, but obviously if that settlement is not what it needs to be, it could have a big impact on the supply of staff to the NHS. How important is it for NHS England that HEE gets a settlement that allows it to continue to increase the supply of trained staff to the NHS?

Professor Powis: It is absolutely critical. The question was asked of the last witnesses, "What other parts of the system need funding?" Local government was mentioned, but HEE would be the one that springs to mind first for me, for exactly the reasons that you said, Chair. The training and the supply of future clinicians is critical. It is not just doctors; HEE supports the training of all clinicians. It is really important that we have our mind on the medium and the long term as well as the short term because, unless we get that supply right, we will be in a perpetual circle of worrying about the future workforce. The funding of HEE is absolutely critical.

Q167 **Chair:** If its budget was frozen or reduced, that would be a real concern to you.

Professor Powis: Yes, it would be.

Q168 **Chair:** And to you as well, Amanda?

Amanda Pritchard: Yes. To build on what Steve said, clearly from our point of view, anything we can do that gives us greater predictability about the future of the training and supply side on workforce would be hugely beneficial.

Q169 **Chair:** Two very brief final questions from me before I bring in colleagues. We have just concluded evidence sessions on children and young people's mental health. Will the mental health investment standard apply to the additional funding that comes through the health and care premium?

Amanda Pritchard: It is worth saying at the outset that we obviously remain completely committed to the mental health investment standard. That requires CCGs to grow mental health funding in line with CCG allocation growth. This year, we have had positive assurance that that was achieved across 100% of CCGs. That is an important sign that it is not just words but is followed through into practice.

What that means for us by 2023-24 is that an additional 2 million people will receive mental health care, supported by at least £2.3 billion of additional funding over that time. I think the Government have been clear, of course, that as we think about the new moneys there is a particular focus on the elective recovery challenge, recognising the inevitable displacement of activity over the pandemic. Some of that, of

course, reflects the higher costs of running health services at the moment while we still have Covid with us. Some of that funding, particularly the funding that goes to recognising current costs and demand, absolutely needs to go to mental health as well. That is clear. The Secretary of State is on record saying that mental health will need to be supported as part of that package. However, the technical description of the mental health investment standard applies to the CCG allocations and not to that additional funding.

Q170 **Chair:** But within those CCGs allocations, for example, funding to roll out the schools' programme will continue.

Amanda Pritchard: Absolutely.

Q171 **Chair:** That came across as being very successful in our evidence sessions.

Amanda Pritchard: Yes. I visited a school in Bradford recently and saw for myself just how effective that is. It is part of the long-term plan investment and, yes, it is absolutely part of our commitment.

Q172 **Chair:** Thank you. Because you were probably on your way here, I do not think you will have heard the very powerful evidence at the very start of this session from a lady called Sarah Lambrechts about her endometriosis. She talked about the delays in her treatment caused by the pandemic. She also talked about things that were not to do with the pandemic or money but were to do with culture. She used a phrase that was very striking. She said, "I felt I didn't matter to the NHS."

When we are focusing on big numbers like reducing the number of people waiting for elective care, whether it is 5.7 million, 6 million or 7 million down, how are we to avoid the risk of a targets culture that we know in the past, completely inadvertently and no one would have wanted it, led in parts of the NHS to problems like Mid Staffs? We now have a similar problem in a way to the early 2000s with these large waiting lists. How will you, as chief executive, make sure that that does not happen again?

Amanda Pritchard: I was really saddened to hear about the experience that Sarah Lambrechts described. The NHS is for patients. That is our purpose. It is a hugely powerful illustration of why it matters that we make sure that patients are front and centre of our thinking and that we now do the serious work on recovery that we are here to talk about.

It also goes to a really important point about communication. Part of what we are thinking quite a lot about at the moment is that it is good when we get it right, but we know we do not always get it right in the health service, so how do we make sure that we are providing the right support to people whose care has been disrupted and who may now wait longer than we would have wanted, and certainly longer than in the past?

The critical point you are asking about is safety, and how we make sure that we do not lose sight of that. Steve wants to talk a bit more about

that, but I would say that it is now part of the DNA of what the NHS is all about. Anyone like me who was in the health service when the Mid Staffs situation happened does not forget that overnight. I think it has been inculcated now into the culture of the NHS through things like the CQC and through some of the safeguards that we now have in place around quality, which we are very clear are not up for grabs as we think about some of the challenges in front of us around recovery. I know that Steve wants to pick up this particular point.

Professor Powis: Yes. I think we are in a much better place than we were at the time of Mid Staffs on oversight of quality and safety. I would add a couple of other things. The first is putting clinicians at the heart of systems and organisations. That is why we have issued guidance that doctors and nurses should be on the boards of integrated care systems, to ensure that they always have a laser focus on quality and improvement of clinical care.

The second thing is that standards are important—I use the word "standards" rather than "targets"—but in designing those standards, you need to design them with patients, the public and clinicians at the heart of the design. That is exactly what I have been doing in the review of standards that the previous Prime Minister asked me to do a few years ago.

To go back to mental health, we have just consulted on a set of access standards for mental health, because it has not had the same set of access standards that physical health has had. We are about to publish a response to that consultation. I will not pre-empt it, but I think I can say that those proposals have been warmly welcomed. It is a big move for mental health in its journey to have parity of esteem with physical health.

Q173 **Chair:** Sadly, we cannot do this for every patient, but can I ask you to look into Sarah Lambrechts's situation and make sure that she is getting the care that she needs on a timely basis?

Amanda Pritchard: Of course.

Chair: Thank you.

Q174 **Dr Evans:** It is nice to see you, Amanda. Standards is quite an interesting point to come in on. I would like to talk about GP access and your report, "Our Plan for Improving Access". It uses a stat that, in August, 15% of GPs recorded less than 20% face-to-face consultations. Talking about standards, what is the correct percentage that the NHS is looking for?

Amanda Pritchard: Thank you for that. I am really conscious that the vast majority of colleagues in general practice have worked, and continue to work, absolutely tirelessly. They do a really essential job. They are the building block of the NHS, and they continue to be. Putting together the package that we announced last week was really trying to recognise the enormous service that GPs do, how important they are to the public, and

the necessity of recognising that they have been at the heart of a very successful vaccination programme and continue to support urgent access and all of the proactive care. Therefore, we need to put some money behind supporting general practice.

The £250 million is a lot of money, but it feels absolutely necessary to make sure that we have the ability to support access across the board. Part of it is additional investment in things like technology to help with things like answering the phones—

Dr Evans: I will pick up some of these—

Amanda Pritchard: I know you want to come back, but I was going to say that we have really tried to steer away from saying that there is a right number for face-to-face versus other types of access. What is clear is that many people absolutely prefer face-to-face access. GPs are required to provide it. It is part of the contract. For some populations, it will be a particular number and for others it will be different. It depends on the nature of their condition.

Q175 **Dr Evans:** You had your review, which closes on the 28th, on Thursday, where you asked all GPs to say what their reflections are on what that should be. My concern, and the way I see it, is that on the one hand you have the public who want to get back to face to face. On the other hand, you have GPs who are saying, "We're working in a different way and seeing more patients." I put it to you, as leader of the NHS: isn't the debate we should be having to be about what people should expect? On the one hand, a clinician would argue that they are providing on the basis of clinical need. On the other side, the patient has the right to determine the right service for them. How do you solve that conundrum?

Amanda Pritchard: What we talked about in the document is respecting patient preference. I hear many people say that it is hugely convenient being able to phone a GP or have a digital consultation. It saves lots of time unnecessarily travelling to a GP practice, but it is absolutely right that that is not going to work for everybody. It is not going to work for every circumstance. Therefore, respecting patient preference is the bit that we have said is really important. That is why, for those practices—you have talked about them—where the percentage of face-to-face care is very low, it feels out of step with what we are hearing across the rest of the country. We need to give them particular support.

Q176 **Dr Evans:** The practices that are working harder want to know what feels about right. Is it 60% or 70%? It is going to vary across the country.

I would like to pick up on your £250 million. It gives examples of how people could spend it. It talks about more sessions for existing staff, locum calls, extra admin staff or extended hours. Staff in that situation would say, "We are already under pressure, and we cannot do any more than that, even though there is money there." What is the response to that?

Amanda Pritchard: As part of the package, we have also tried to look at where we can take some of the burdens away from primary care colleagues, particularly administrative burdens. It is certainly where the ability to use the wider multidisciplinary team is important. Primary care is a team sport. It is not just about general practitioners, although they are hugely important. Thinking, therefore, about how we can give local systems the flexibility to work out what is going to work for them is the right way of doing it, rather than, if you like, us trying to determine nationally what is going to work best in different parts of the country.

Q177 **Dr Evans:** There is some really good stuff in there about taking away some of the admin roles and improving things like the cloud-based telephone service. Those are fantastic things that will make a difference. When I have asked every clinician who has sat here doing this backlog how much time they spend on admin, each one says that on average it is about 10%.

Again, I put it to you as the CEO of the NHS that one of the areas you could focus on most is dealing with that 10%. That would automatically increase productivity. What do you think the impact of that would be?

Amanda Pritchard: Of being able to reduce administrative burden?

Q178 **Dr Evans:** Yes, chasing a scan; finding a letter; the interface between primary care and secondary care. If you opened up access so that hospitals could put blood tests into GPs and share scans immediately, that would take a huge administrative burden off GPs, and indeed the hospital, and give continuity of care for the patient, who is not chasing a letter.

Amanda Pritchard: I completely agree with you. One of the reasons why continued investment in our digital infrastructure is so important is the ability to share records and do exactly what you have just described. It is absolutely clear that those parts of the country where they have integrated IT systems and can work really effectively as systems to do what is right for the patient, using all of the assets and all of the workforce they have in their system, in a way that is streamlined and avoids multiple letters, multiple calls and all of the overheads you have just described, is absolutely where we want to be.

Chair: Thank you.

Q179 **Laura Trott:** Following up the point about GPs, the Royal College of Emergency Medicine set out its belief that virtual GP consultations and call-first services had led to increased demand in emergency departments. It is fair to say that, when we had the head of the Royal College of GPs in, he refuted that. Where do you stand on it, Amanda?

Amanda Pritchard: Do you want to pick this one up, Steve?

Professor Powis: The most important thing is that patients are seen in the right setting for their condition. Even pre-pandemic we were putting in a lot of work to ensure, through 111 for instance, that people were

directed to the service that best suited the particular need they had at that time. Sometimes, that is a GP. Of course, GPs are often the first route in, but it could be a community pharmacist. Indeed, one way to take some of the work off general practices is to use community pharmacies more. We are doing that. It might be an urgent treatment centre. It might simply be telephone advice.

That is work that was going on during the pandemic, and we need to continue that work, as Amanda said at the start, after the pandemic. There is no doubt that the NHS is busy at the moment. Emergency departments are busy for a variety of reasons. As Amanda said, GPs are busy as well.

Our answer to the question is that we will double down, as we did beforehand, in ensuring that we help patients to access their care in the most appropriate setting for the particular condition that they are phoning about or presenting with.

Q180 **Laura Trott:** Do you think that lack of access to GP appointments has been a contributing factor to the pressure on emergency departments that you talk about?

Professor Powis: There is no doubt that there are some patients still attending A&E who would be better off being seen in another setting. That was the case pre-pandemic as well. For exactly those reasons, the use of services such as 111, and the use of digital online 111, is all designed to ensure that people do not make a trip to a service when, actually, they could be dealt with quicker and more efficiently in another service. We will continue that work. As we have seen activity rise again in this stage of the pandemic, it is important that we continue our focus on that work.

Q181 **Laura Trott:** Obviously, 111 is part of the response to the pressure that we are seeing on emergency departments at the moment. Can you talk through some of your wider plans for dealing with that because, obviously, the levels of waiting that we are seeing at the moment are very concerning?

Professor Powis: The first thing that it is very important to realise, as Amanda and the previous witnesses said, is that as we sit here today there are almost 6,000 patients with Covid in our hospitals in England. Those are 6,000 patients with a respiratory illness who normally would not be there in autumn. The consequences of having those 6,000 are the infection, prevention and controls that we quite rightly have to put in place. Essentially, we have to ring-fence beds for those patients. We are also losing several thousand more beds because we cannot use them due to the inefficiencies of having to ring-fence beds for Covid patients, which we quite rightly have to do.

Of course, we have staff absences as a result of the pandemic. It is not just the direct effects of those 6,000 Covid patients. It is the

consequences as well. All that puts pressure back through the system on to the ability for emergency departments to get patients on to wards. That puts pressure back on to the ambulance service.

What to do about it? Perhaps one of the most important things is that infection rates need to be kept under control. That means vaccination. I urge people to come forward for boosters. If you have not had the first vaccine yet, you absolutely need to get it because that will be an important part of the response. The public have responded magnificently to the messages of caution around the pandemic, and I think that is why we have not seen a peak since opening up in July, but it is important that people remember that the pandemic is still there and that they still act cautiously, with masks in enclosed areas where there is risk.

In addition, of course, having good functioning social care, which we talked about earlier, means that we can discharge patients from hospital who are medically fit to go. That frees up beds and frees the pressure on A&E. It is all the support we have been talking about for general practice, for the reasons you mentioned, and for the 111 services and ambulance call responders. It is a whole set of things, all of which are important.

I come back to the fact that we would not normally have this number of patients in beds with a respiratory illness in October, and we have lost additional beds on top of that because of the nature of the virus we are dealing with.

Q182 **Laura Trott:** You have talked about an enormously challenging situation, yet with the money to address the backlog that we have talked about you have said that you need a 30% increase in activity. One of the questions that Siva posed earlier—I think you were sitting behind him when he said this—was, how is this achievable given the many challenges you have just described?

Professor Powis: The question of achievability relates to the demand that we will see over the next year or two. As you heard from previous witnesses, and as we have said, there is uncertainty around that. There is uncertainty around whether we will see patients coming back who did not present or come forward during the pandemic. There is also uncertainty about what we call acuity, which is the seriousness of their condition.

As Amanda said right at the start, the good news is that we have certainty of revenue. The difficult bit at the moment is that we do not have certainty of demand. I think that is just where we are in the pandemic at the moment. That is what we will be watching very closely. It comes back to the heart of the Chair's question about how many staff we will need. It is the demand part of it that is still uncertain because we are still in the middle of a pandemic and we are still dealing with the consequences of 18 months of the actions that, quite rightly, had to be taken to manage the pandemic.

Amanda Pritchard: I wonder if I could possibly build on what Steve said.

Chair: Sure.

Amanda Pritchard: Thank you. I think we are in for a tough winter. I know that the chief medical officer has said the same. We have 5,900 people with Covid in our beds at the moment, and that number is going up. When you add on all of the things Steve has just said about the impact of reduced capacity and the impact of other patients needing to come forward for treatment, that is a lot of pressure. Your question about whether we can protect our elective services through this winter is really important.

We are doing some of the things that I heard a previous witness talk about. We are looking, as far as possible, at trying to separate emergency and elective care with things like surgical hubs, community diagnostic centres and continuing to do things like out-patient activity and things that do not require a bed. Those are all areas that we are really trying to make sure absolutely get protected through winter, but there is an inevitable interplay with in-patient beds. If we have Covid patients in our beds, obviously that has an impact on how many elective patients can be in those same beds. We are trying to make sure we do everything we can to use the money we have as wisely as we can to continue to do the elective work in a protected way, but I think we need to recognise that we are in for a difficult winter.

Q183 **Chair:** Before I bring in my colleague, Dean, I want to ask you a follow-up question about that. At the height of the vaccine programme in the spring, which obviously the NHS is responsible for, you were doing 400,000 doses a day. Now, we are doing less than 200,000 doses a day, yet we have the highest case rate and the highest death rate in Europe. We have winter coming, the risk of flu and real problems in our emergency care and our GP systems. Isn't there an urgent need to turbocharge both the booster programme and the teenage jab programme?

Amanda Pritchard: I am really pleased you asked that question because it is an incredibly important issue. When JCVI made the recommendation, and Government made the decision on boosters, that was 14 September. We did our first jabs on the morning of 16 September, two days later. Since then we have given 3.7 million boosters and third jabs in less than a month. That is literally twice the rate we were giving vaccines at the start of the programme last year.

The JCVI advice is very clearly not to give boosters before six months have passed since the second dose. At the moment, everybody who needs one gets an invitation within a week, within days, of becoming eligible. At the moment, there is plenty of capacity, so it really is important that when people receive their invitation, they do not hesitate to come forward and have their booster vaccine.

Q184 **Chair:** Correct me if I am wrong, but 40% of the over-50s who are eligible have passed that six-month date and have not yet had their booster. I think a third of the over-80s who are eligible have not had their booster. What can be done? This is going to create a real crisis in the winter ahead, which you have just been talking about.

Amanda Pritchard: We are at the point in the booster programme where the number of people becoming eligible every week is quite high because it matches what was happening six months ago. Literally, this week, we will be sending out 1.8 million additional invitations. That is the sort of volume per week we are now sending out. There is no delay in sending out invitations. Literally, within days of people becoming eligible, they will get their invitation.

What we are seeing—this is absolutely the crux—is that, while it is great that people are coming forward for their booster, they are not coming forward as quickly when they receive their invitation as we certainly saw for the first jabs. It is really important that we now get the message out that Covid is still with us. It is serious. Boosters really do make a difference in boosting immunity. If people get their invitation this week, or they have already had it, there is plenty of capacity, so please come forward and book as soon as possible.

Chair: Thank you.

Q185 **Dean Russell:** Amanda, I want to pick up an earlier comment about digital. I am the chair of the APPG for digital health. We have been doing a lot of work around data and the importance of that. One of the words I see a lot is "efficiency", when it comes to the challenge of the 10% of time spent on paperwork or notes and so on that my colleague mentioned earlier.

Is there a concerted effort at the moment to look at how digital can help improve efficiencies, effectiveness and patient outcomes? I hear it talked about a lot. I know there is NHS Digital, NHSX and all of those things, but one of the things I never quite hear is that there is a programme to say, "We are going to fully digitise the NHS," and that in 10 years' time a patient will not have to repeatedly put in the same information, and the GP will not have to give the same information to a pharmacist that they have done 10 times over. Could you give me an update, and if that is being looked at, please?

Amanda Pritchard: We would completely agree with your findings. Two things are probably worth saying. We would absolutely agree that if we want to achieve a modern, efficient health service, we will not do it if we are not able to put that digital underpinning in place.

There are two big things that are the focus at the moment. One is frontline digitisation. About a fifth of trusts in the NHS are still largely paper based. We have some that are absolutely at the other end, but that is a very important thing to be able to fix if we are to achieve some of the interconnectivity we were talking about earlier.

The second thing is that we have seen, particularly over the last couple of years, the value of the NHS app and the ability for people to access their own care record and access services through the app. Another thing that colleagues are working on is how we can continue to build more sophisticated functionality in the app so that we are doing both the work that is needed to put frontline digitisation in place and the piece that then makes it accessible to patients, recognising that there will always be a really important element around digital inclusion that needs to be considered as part of that.

The point you will be all too well aware of is that we can only go at the pace we have funding available. What we are determined to do is make the most of the money that we have to continue to put that into the digital transformation space.

Q186 **Dean Russell:** Words that came up repeatedly were beds in hospitals and their utilisation. I know that in my local hospital they have been doing some great work around virtual wards, for example. Has there been an analysis, looking at the next 10 to 20 years, to say how many beds we actually need in hospitals, which of course is critical, and what the opportunity is through digital to enable greater use of virtual wards to enable people to stay at home, for example, where they can, and be looked after at home but with access to facilities?

Amanda Pritchard: I think Steve might want to come in on this because he has already talked about some of the pressures on beds we have at the moment in the NHS. We have about 5,000 beds out of normal action at the moment, with a combination of necessary infection control measures to make sure that patients are safe when they are in hospital, and the inability to use beds when we have Covid patients in them. We need to keep the surrounding beds free to make sure that infection control arrangements are secure.

There is clearly an immediate challenge for us around capacity. Part of what we are doing to mitigate some of that is looking at how we can build on the very successful virtual wards that exist across the country. Some of them were set up in Covid specifically to look after patients with Covid, but some were pre-existing. There is a huge amount of potential and enthusiasm to build on that success to see how much further we can safely take it. Again, of course, it requires the right workforce. It requires digital underpinning. We have seen some real successes over the last few years that we are extremely keen to build on for the future.

Professor Powis: I think we need to do a number of things. Of course, we need to use beds efficiently. That goes back to the sort of clinical pathways that we were hearing about before, ensuring that we have the most efficient use and throughput of patients coming through beds. The virtual ward, in a sense, is another journey beyond the day-case surgery move that we made a number of years ago. When I was a child, I remember being in for two weeks after a tonsil operation. Now, it is much

more a day case. Virtual wards are part of that journey, where we can treat people at home rather than bringing them in.

We need to ensure that we have efficient discharge in place. That goes back to making sure that social care is working well so that patients who are fit to leave hospital do not end up staying in hospital longer than they need to.

We need to do things such as the hot/cold splits that you have heard about, to ensure that we separate emergency beds from elective beds. Probably, once we have done all that, we need more beds than we have at the moment. One of the things that we need to think about post pandemic is exactly the headroom in the NHS. If you recall, prior to the pandemic, Lord Stevens, Amanda's predecessor, called for extra beds, particularly as we get into the winter. I think the pandemic has highlighted that we need to have a sensible discussion about the level of headroom in the NHS to ensure that either during the winter, when emergency services run hot and we know that elective care gets impacted, or for unusual events such as pandemics we have that reserve in place.

Q187 **Dean Russell:** On a more practical level, as I have mentioned in this Committee before—forgive me for repeating it—I volunteer at my local hospital, very much so last year during the pandemic, and I continue to. One of the aspects of that is very mundane stuff, but it makes a difference. It is making teas and coffees, taking patients' gifts and belongings to them when people come to drop them off. It seemed to me that that takes an awful lot of strain off the nurses and staff who are doing their jobs. I made the point to the Prime Minister in PMQs a while ago about an NHS cadet scheme. There is a St John Ambulance version, but my take was broader and more available across the UK.

Has there been any more discussion of that? My sense is that that volunteering group—they can't really be called a workforce—especially young people, seem to add a huge contribution and take a lot of strain off the staff who are already very busy. It also enables them to see what the NHS is like up front and close, and has probably inspired many of them to want careers there. Has there been any more talk post pandemic of how we encourage more volunteering in the NHS?

Amanda Pritchard: Again, it would be almost impossible to overstate how valuable the volunteers have been for the NHS over the last couple of years. I do not think anybody wants to go anywhere other than forward in trying to make sure that volunteers are welcomed as a core part of the wider NHS and social care workforce. We have lots of different schemes going on. Certainly, the work that you have just described around the cadets is part of that. Broader partnerships with the voluntary sector at both local system level in individual organisations and nationally is very much what we are keen to do to build on some of the experience of the last couple of years.

Q188 **Dean Russell:** But is there infrastructure being looked at to be able to monitor, manage and train those volunteers at the moment? Is that being looked into officially?

Professor Powis: I was going to make two additional points, but, yes, there is. Amanda mentioned the sort of reserve force that we are putting in place. The ongoing training and readiness is part of that.

The two additional points I was going to make, which go back to your original question on digital and on beds, are around capital. We have had the discussion about revenue funding, but we need to think about capital funding as well. Of course, that is really important for the long term. Ensuring that we have the capital investment to deliver digital services, put them in place and ensure that our estate and our beds are fit for purpose is really important. Obviously, that is a discussion we are having with Government.

The second thing is around the type of estate. Personally, I feel that coming out of the pandemic, one of the things that we really need to think hard about is the number of single beds we have. We need to move much more in our hospitals to single rooms being the default for privacy and dignity, for infection control and for the flow issues we have been talking about. That is something we need to think hard about as we build the hospitals of the future.

Chair: Thank you.

Q189 **Barbara Keeley:** I have two quick questions because we are nearly out of time. I want to go back to clearing the backlog, which we were talking about earlier. The pressure is clearly on how to get people in and out of hospital as soon as possible, but now we are into the discharge-to-assess area. I want to read you the Government's impact assessment on that change in the ways of discharge and when assessment happens: "There is an expectation that unpaid carers might need to allocate more time to care for patients who are discharged from hospital earlier. For some, this could require a reduction in workhours and associated financial costs."

That is a pretty staggering statement for the hundreds of thousands of carers up and down the country who have actually taken the brunt, pretty much, during the Covid pandemic. There could clearly be a very great impact on them of suddenly expecting people to drop everything and provide care and even, as it suggests, cutting their work and losing pay. Do you recognise the impact that that change is potentially having? What can be done to mitigate the impact?

Amanda Pritchard: Probably the most important thing to say is that the role that carers play is completely invaluable. It is not just around healthcare but social care more broadly. We need to be careful never to take for granted what carers will do and what they do every single day to look after people.

On discharge to assess specifically, what I think we have heard is that part of what makes it work is the resilience of the arrangements around it. When you were talking about beds earlier—I heard a colleague say this just before we came in—one of the things we are thinking a lot about is the resilience of social care.

Social care is incredibly important in its own right and not just because of the overlap with healthcare services. People work very hard to do very important jobs for children, for working-age adults and for older people. What we would say, though, is that where there is an overlap, particularly with healthcare services, often around discharge and supporting people in their own home as well as in care facilities, particularly this winter, the resilience of the social care service will be absolutely critical for the ability of the health service to keep going and to keep doing what it needs to do. There is the ability also to think about what the long-term reform of social care needs to be, to make sure that it has what it needs in its own right as well as the overlap with health services. That will be crucial. A really important component when thinking about discharge to assess is making sure we have got the package right.

Q190 **Barbara Keeley:** It does not sound to me as if you have got the package right. People are outraged. People who work with carers are outraged by the wording that the Government are using in the Health and Care Bill. There have been issues that carers' organisations have raised since the start of the process because they were not thought of, and they were not mentioned. That wording suggests a totally different, new and wrong way of thinking about carers, which is, "When we want to discharge this person, you will drop everything. It might mean you have to cut your work. It might mean that there are financial implications."

Broadly, that is what falls on to family carers, but in this place for 20 years people have worked to try to create rights for carers. The important rights are to consult them about whether they are able and willing to take on a care burden, not just to say, "Here's a care burden. Here you are."

Amanda Pritchard: Certainly, in relation to the health service, managing patient discharge remains very important; it is complex and it needs to be done thoughtfully and well. That needs to be done, of course, with the individual, and with their family in many circumstances. I think the discharge-to-assess arrangements have been invaluable during the pandemic, in particular to help make sure that people were not unnecessarily—

Q191 **Barbara Keeley:** I can see that it helps to clear people out of hospitals, but it does not help carers.

Amanda Pritchard: It has been invaluable because it has meant that we have not had people in hospital when they do not need to be and it is not the right place for them. For us, it is certainly not just about counting beds. It is about what is right for that individual. Being in hospital for an unnecessarily long period of time is very rarely the right thing for a

patient. What we are seeking to do, certainly from a health perspective, and in the spirit of partnership and doing what is right for a patient and also right for their circumstances, in partnership with social care and others, is to make sure that the discharge is well managed and that people are supported effectively to leave hospital, when they are ready to leave hospital, and then to stay well and well looked after in their own homes.

Q192 **Barbara Keeley:** Do you agree, though, that that wording is unfortunate to say the very least? If that is the expectation that is built into this process, that wording really has caused outrage once people realised what the Government were saying there. That is built in now because it is there in that process. I will leave it with you. I think it was important to flag that. It is important to say that it has been an issue since the new process came about, and in the last week it has had quite some impact on carers. You rightly understand the impact on the workforce of the pandemic, but we have to understand the impact on families of the Covid pandemic, which, in many cases, was worse because there was a great deal more looking after people at home.

I have a final quick point on a related thing about clearing the backlog. I do not know if you were here when we were discussing with Siva the fact that Covid hit the poorest areas more and that those areas have the longest waiting lists. What is NHS England doing to ensure that the backlog is cleared in a way that does not exacerbate health inequalities, so that those who need care most get it first? There are new imbalances to juggle with, aren't there?

Amanda Pritchard: Yes, I heard Siva talk about the fact that allocations already have an element built in for deprivation. Certainly, we have been absolutely clear that this is about an inclusive and fair recovery and not just about numbers. Right from the very start, our elective recovery programme has had our health inequalities team as a fundamental part of it, making sure that we are looking at waiting lists, for example, from the perspective of deprivation and from ethnicity. We are tracking waiting times to give local teams line of sight to what they might need to do to make sure that there is no unintentional widening of inequalities. It is quite the opposite, because that is very much the intention.

Q193 **Chair:** Thank you. There are a couple of very brief final things, if I may. I have been getting anecdotal reports of very long periods of time waiting for 999 calls to be picked up. Sometimes it is as long as 10 minutes, which obviously, if someone is having a cardiac arrest, is far too long. Have you been hearing any of those reports as well?

Amanda Pritchard: We are really conscious of the pressure that, in particular, ambulance services are under. I think it has been widely reported. One of the things we are doing to try to support ambulance services is very specifically around the recruitment and training of call handlers, to try to put more resilience at the front end of the process.

Q194 **Chair:** Do we have a shortage of call handlers? Although it is obviously very regrettable, we can understand why there are sometimes delays in handovers at A&E departments and that holds up ambulances from doing as many calls as they would like to, but a delay in actually picking up a 999 call suggests that there might be a shortage of call handlers. Is that the case?

Amanda Pritchard: We have a very significant increase in demand. Hence, part of the answer to that is the recruitment and training of additional call handlers to respond to that increase in demand.

Q195 **Chair:** We have a shortage relative to the demand that we currently have.

Amanda Pritchard: At the moment, we absolutely need to make sure that we have the right capacity in place—

Chair: But we don't—

Amanda Pritchard: —for 999 and 111.

Q196 **Chair:** But for 999 specifically?

Amanda Pritchard: Part of the answer, definitely, is that we need more capacity in the call handling part of the process. It is part of the £55 million we have given to ambulance services to help them now invest in additional resilience over the winter period. It is linked to the whole pathway because part of the challenge, of course, is that ambulances are finding it more difficult to get patients safely into A&E departments. That also means that there are then more people making repeat calls to 999 because they are worrying about where their ambulance is. It is partly about call handling, but it is partly about improving the flow so that we are able to release more ambulances back into service more quickly.

Professor Powis: That was exactly the point I was making earlier. The flow is connected throughout, and the ambulance service is affected when that flow is not working efficiently. Amanda is right. Of course, once there are any delays people phone back, so the number of calls goes up because some of those are repeat calls. There may be different ways of handling those repeat calls to reassure people that the ambulance is on the way or to let them know if there has been no clinical deterioration. Of course, absences due to Covid affect the ambulance service and call handlers too. There are multiple reasons. We are putting more in, and we are looking to ensure that we can handle those calls so that the responses to people who need them, and not just calling back to say, "What's happening?", are prioritised. It is that and other things.

Q197 **Chair:** On a very brief final note, in the last week it has been announced that Lord Prior is stepping down as chair of NHS England. I want to put on record my thanks to him for his service chairing NHS England during the pandemic, and for the time that I worked together with him as a Minister at the Department of Health, where he would frequently say

things that would get him and me into hot water. His commitment to the highest standards of care for patients was absolutely superb throughout. I just want to formally thank Lord Prior for his service. I do not know if you want to add anything, Amanda.

Amanda Pritchard: Thank you. It has been a great pleasure to work with Lord Prior over the past two years. He will be missed as much for, as you say, his absolute commitment to patient care and his absolute determination to see the NHS be as good as it possibly can be, as for the unexpected question at the end of a public board meeting that you were not expecting but that sometimes exactly got very much to the heart of some of the issues that are really challenging us and that we really need to think about. He will be missed for lots of reasons, but he has done great service for us. Thank you for those very warm words.

Professor Powis: As you know, he is passionate about life sciences. One of the things that we have seen during the pandemic is how the interface between science and the NHS can work at its best, both in the whole vaccine development and then roll-out, and in the trials that have been done in the NHS that have identified new treatments that are saving people not only in the UK but across the world. The interface of life sciences and clinical care in the NHS is as crucial as ever.

Amanda Pritchard: There is one thing I meant to say earlier, which I now feel I might just sneak in, to build on the life sciences and the NHS being the best it can possibly be. It is that to make the most of half-term we will be opening the national booking service for young people, 12 to 15-year-olds, to have their Covid vaccination at existing vaccination centres. That is to make the most of half-term. For the next two weeks in particular there will be a big push on trying to offer additional capacity for kids, which means that they do not have to come out of school.

Chair: That is a good and important note to end on. Thank you very much for your time this morning. That concludes this morning's session.