HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: NHS Backlogs and waiting times, HC 747

Wednesday 15 December 2021

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Watch the meeting

Members present: Dame Meg Hillier (Chair); Mr Richard Holden; Kate Osamor; James Wild.

Gareth Davies, Comptroller and Auditor General, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Questions 1-118

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Amanda Pritchard, Chief Executive, NHS England and NHS Improvement; Matthew Style, Director General for NHS Policy and Performance, DHSC; Sir Jim Mackey, Director for Elective Recovery and Chief Executive of Northumbria Healthcare NHS Foundation Trust; Professor Stephen Powis, National Medical Director, NHS England.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

NHS backlogs and waiting times in England (HC 859)

Examination of witnesses

Witnesses: Sir Chris Wormald, Amanda Pritchard, Matthew Style, Sir Jim Mackey and Professor Stephen Powis.

Q1 **Chair:** Welcome to the Public Accounts Committee on Wednesday 15 December 2021. We are here to look at the very important issue of the impact of covid on the NHS, but not in dealing with covid; we want to look today at the impact on every other aspect of the NHS—mainly the backlog and waiting times for elective care, including cancer treatment, and the challenge for primary care of getting patients through the system in a timely manner and making sure that they get the treatment they need. We have all known that this was going to be a big problem from the beginning—the Department and the NHS not least, of course—but we really want to get to the bottom of what the impact is going to be on patients and, crucially, what the plan is for recovery.

I want to express the Committee's thanks for the evidence that has been presented to us by a number of organisations and individuals. It is more than we normally receive, and we will take that all very seriously. I thank people for taking the time to submit evidence to our hearing today.

I welcome our witnesses, who are all online today. We have Sir Chris Wormald, the permanent secretary at the Department of Health and Social Care. I am delighted to welcome, in her first outing in front of the Public Accounts Committee as chief executive of NHS England, Amanda Pritchard. With her is Professor Stephen Powis, who needs no introduction but is national medical director at NHS England. We also welcome back Sir Jim Mackey, director of elective recovery—a really crucial topic for today's hearing—at NHS England, who also remains chief executive of Northumbria Healthcare NHS Foundation Trust. Matthew Style, who is joining the permanent secretary today, is director general for NHS Policy and Performance at the Department. A very warm welcome to you all.

Before we get into the main session, I would like to ask you, Ms Pritchard, whether you have a few words to say to us. The particular question that I would like to ask is: when we talk about the booster programme, is the deadline of 31 December for everyone to get their booster, or for everyone to be offered their booster? If you would like to, you can say anything else about what is happening in the next few weeks.

Amanda Pritchard: Thank you very much indeed. I appreciate that this hearing is very much to focus on that important question around elective recovery, but as you say, the Prime Minister has given us a new national mission to offer a vaccine to all eligible adults by the end of the year, in response to this new omicron threat. What that means is a credible offer. We know that not everyone will be able to take up their offer, either because they will have recently had covid or because they may, for other

reasons, not be able to take up a date. The ambition for us is to make sure that anyone who wants to and is eligible is able to book their booster by the end of the year.

I can tell you that yesterday the NHS vaccination programme delivered 548,000 booster jabs. That is 70% higher than the previous Tuesday, and that is on the back of a record number of boosters given on Saturday, a record number on Sunday, a record number on Monday and a record number on Tuesday. Every single day, we are beating the previous high for that day. Indeed, Monday was also up more than 50% from the previous Monday. That is really down to the extraordinary hard work of NHS staff, the brilliant volunteers and the public, who have responded so magnificently to come forward for their boosters.

We need to keep going. This target, this challenge, this mission will require that whole national effort over the next few days and weeks. My ask of anybody listening is: if you have got time to come forward and volunteer or indeed to consider getting trained as a vaccinator, then please do. We really value the support from the whole nation to try to achieve this terribly important target. Of course we are doing this while also preparing for a potentially significant wave of hospitalisation. We do not know what is going to happen, and I am sure that others will want to talk more about that as we go on, but at the moment the indications are that it could be as big or even bigger than the previous wave this time last year. We are preparing for that, and we are dealing with current pressures, particularly on emergency and urgent care, and we are of course continuing to address the backlog.

Q2 **Chair:** Thank you. When did you know about the booster roll-out programme that was announced on Sunday?

Amanda Pritchard: The history of the booster programme has been a changing one right from the beginning, because we originally—

Q3 **Chair:** We know it has changed, because that is absolutely clear. When did you know that the target date of 31 December was going to be set?

Amanda Pritchard: We were working with Government closely over the weekend to agree—

Chair: Over the weekend, okay.

Amanda Pritchard: The important thing from our point of view was the change in information that occurred only at the back end of last week about the fact that two vaccinations were not going to give sufficient protection. That was the thing that clearly then led to what we now have as this new national mission.

Q4 **Chair:** In terms of the offer—that is 31 December—when do you think you will actually have boosters in arms by?

Amanda Pritchard: I think the question will, as ever, be about the public's continued commitment to come forward, plus our ability to ramp up supply in the way that we have just discussed. I think we can take

some confidence from the way that we have collectively managed to increase with the Saturday, the Sunday, the Monday and the Tuesday—we are going in the right direction—so what we will need now is the continued support of all our amazing staff in the NHS, the volunteers and the public to try to—

Q5 **Chair:** So from what you are saying, can I surmise that it will not be lack of capacity from NHS England that stops people getting jabs in their arms by the end of January, say? Would that be a fair summary of what you have said?

Amanda Pritchard: What we are absolutely doing is pulling out all the stops. I would like to be clear, though, if I haven't been, that we can't do this on our own. The NHS is absolutely dependent on the support of not just the public, but our brilliant volunteers and the whole national effort, to be able to do this.

Q6 **Chair:** You mention volunteers again, and you have said people are going to be trained as vaccinators. How long does it take to train someone to be a vaccinator?

Amanda Pritchard: It normally takes about three days. There are ways of now—

Q7 **Chair:** Three days—fine. It's just that we are halfway through December already. I am just wondering how long it will take for people to go through the system, get trained and actually be able to do this before 31 December.

Amanda Pritchard: That is the actual practical training. There is obviously a process that requires people to go through the appropriate check—

Q8 **Chair:** Exactly. So, realistically, if someone comes forward now, they are not likely to be doing a vaccination between now and the end of this year, but they will be in your bank of people to do it for anyone who needs it after that.

Amanda Pritchard: It is a really important point. We have some places that are doing fast-track training. For example, where I am sitting today, in Southwark, they are doing training that is enabling people to start working as early as next week. But overall, part of this is about making sure we have got a sustainable workforce to take us, obviously, beyond just these next few days and weeks.

Q9 **Chair:** That is partly what I was driving at, so it is good to hear that on the record. I want to ask Professor Powis, as medical director of NHS England, what the key—obviously, getting boosters in people's arms is good for individuals and communities. What about the impact on NHS England of this programme? Ms Pritchard referred there to this potential peak in cases that could be worse than the last one. What is your biggest worry, what evidence have you got to back up that concern, and how are you, as medical director, managing that?

Professor Stephen Powis: I think what's certain is that we will see an increase in hospitalisations. I think there's consensus amongst our public health colleagues about that. I think what's less clear—Amanda has said this—is exactly what that increase will be. I think that will become clearer over the next few days and into next week as we get more real-world data on what is happening in terms of hospitalisations. But our job is to prepare in the way we did last January for over 30,000 people in hospital, and in the first wave for over 20,000. And that's why Amanda and I wrote out on Monday to ensure that NHS organisations are already starting to do that work to generate the extra capacity that we might need.

Q10 **Chair:** Have you got any indication yet of the severity of those hospital admissions? We are hearing people—there's talk of this being not much more than a cold. I don't know whether you have got anything you would like to share with us about how accurate that description is.

Professor Stephen Powis: UKHSA will be doing that work, but it's too early, I think, to say with any confidence here in the UK. We have obviously been watching South Africa carefully, but I think there is always some caution in translating what you see in one country to another. The population structures are different. Their prior immunity has been different. They have had different waves at different times.

So although of course it is good to hear some of the reports out of South Africa in terms that it's not more severe and there may be a reduction in severity, that might be a combination of the virus itself but also the levels of immunity and the type of immunity in South Africa to particular variants that have come and gone over the last year.

So we have to be really cautious at the moment, until we get the data here in the UK, which of course will come as, unfortunately, more people get omicron and we see what happens. Remember: there's always a lag of around 10 days to 14 days between getting infected and requiring hospitalisation. It takes five to seven days to develop symptoms and become positive and then another seven days or so before you need hospitalisation. So I think we will get that data and it will become clearer as we get towards Christmas.

Q11 **Chair:** Well, that's potentially gloomy. We always want to be optimists, but this is certainly going to be a challenge.

Can I ask you, Chris Wormald, about lateral flow tests? I know this is directly the responsibility of Test and Trace, but it is obviously funded through your Department. We have heard of a shortage—well, concerns about access to LFTs. And I know Mr Wild will want to come in on this. Have we got enough lateral flow tests?

Sir Chris Wormald: Yes. As you say, this is the responsibility of my colleagues at UKHSA, who now run the Test and Trace system, and they have been putting out information about this. The challenge is not a lack of lateral flow tests; the challenge is the distribution system. This is now an absolutely colossal system. UKHSA sent out 230,000 boxes of tests on Monday—

Chair: We know the figures have been immense. Can I just ask you—

Sir Chris Wormald: Sorry, this is the point: the limiting factor is the ability to distribute, not the availability. We are expecting to make some announcements later today on that issue.

Q12 **Chair:** I will bring in Mr Wild in a moment, but given that the announcement on Sunday night suddenly got people not only queueing in vast numbers for their booster, but trying to order LFTs all at once—panic buying, if you like. Was that your choice of messaging or would you have done it differently?

Sir Chris Wormald: Once you know these things it is very important to communicate them, and you run the risks that we ran on Monday.

Q13 **Chair:** To my knowledge, although you may be able to correct me, there was no word of caution, such as, "Don't worry, you don't need to buy your tests; we've got plenty"—there was nothing like that. It was a bit like flour in the first one—

Sir Chris Wormald: No, I don't think we did do that and, in retrospect, we might have done. But I do think it is right, when you have this information, to get it out as quickly as possible. We wanted, as Amanda said, to get on with the booster campaign as quickly as possible and we did a lot of work over the weekend. I appreciate that it has been frustrating for people, but we are taking the action to put it right.

Q14 **James Wild:** Sir Chris, in October, I had a parliamentary answer that said that there were 325 million kits in storage. Are you able to update us now or after the session on how many kits are available? Are you continuing to buy them on an ongoing basis?

Sir Chris Wormald: Yes, I will write to you with the details. I don't have the exact numbers. As I said, the challenge has not been the availability of the actual kits; it has been the distribution system, but I will get my colleagues at UKHSA to update you on those numbers later today.

Q15 **James Wild:** I will just say a quick word on the vaccine: is the necessary clinical guidance now in place so that every vaccination centre has suspended the 15-minute wait after Pfizer vaccinations?

Sir Chris Wormald: Yes, I think that is all in place now. Amanda may correct me, but I think that the 15 minutes will be suspended from first thing Thursday. I think that's right, isn't it Amanda?

Amanda Pritchard: Yes. Steve might want to come in on this.

Professor Stephen Powis: Yes, I think the plan is to fully operationalise it tomorrow.

Q16 **James Wild:** Thank you.

Sir Chris will not be surprised about this, but I want to raise the issue of my local hospital, the Queen Elizabeth in King's Lynn. As this is your first appearance in your new role, Ms Pritchard, I certainly want to put it on

your agenda. As you may know, about 80% of the Queen Elizabeth Hospital's estate is made up of decaying concrete planks. It has the highest number of props—over 200—holding up the roof in different parts of the hospital, and the trust's risk register has a red rating due to the potential catastrophic failure of the roof, which the trust is managing. QEH put in expressions of interest to be one of the eight new schemes. The decisions on the longlist were originally due in the autumn. When can they expect a response, Sir Chris?

Sir Chris Wormald: Sorry, I don't have that information with me, but Mr Style may.

Matthew Style: We are currently expecting decisions on the next eight in the spring. Clearly, that may be affected by the other pressures arising in the meantime but, yes, applications closed earlier in the autumn. The shortlisting process is currently ongoing, and we expect announcements around springtime.

Q17 **James Wild:** But decisions on the first phase were due in the autumn ahead of the final decision in the spring. When can the QEH, and the staff and patients there, expect to know whether they are on that longer list? I understand that a decision was due at the beginning of next year.

Matthew Style: Decisions about the selection of the next hospitals for the new hospitals programme will be, as I say, made in the spring. Of course, several capital funds have been made available to support those hospitals, such as the one in your constituency, affected by the issues with aerated concrete. There is separate support available for those trusts as well.

Q18 **James Wild:** It is a two-phase selection process. The first phase is to longlist, so if perhaps if you don't know the answer now, can you come back with a response to me, please, on when the decision on the longlisting, ahead of the financial decision in the spring, will be taking place?

Matthew Style: We can certainly update you.

Q19 **James Wild:** Ms Pritchard, as the leader of the NHS, what is your message to staff and patients at QEH about how seriously you take this issue and the need for investment in the new hospital there?

Amanda Pritchard: I think the pandemic has really shone a light on the importance, across the whole NHS, of having an estate that is fit for purpose. We have seen that in the work that has had to be done to try to separate or segregate covid from non-covid patients. Professor Powis has been clear about the value of things like single rooms, particularly when we are trying to do some work to make sure we can maintain really very tight infection-control arrangements. Therefore, the message I would give to all staff in the NHS, whether in your constituency or elsewhere, is that this has to be high on all our collective agendas. It is one of those things that, if we are thinking about the long-term resilience of our health service and the ability to reform and transform in the way we want in the longer term, we are going to have to get right.

Q20 **Mr Holden:** Following up on some of the questions from Mr Wild, my local hospital, Shotley Bridge Community Hospital in my North West Durham constituency, is one of the 40 hospitals in the building programme. Some concern has been raised in the national press in recent weeks that some of the hospital building programme is going to be delayed. Mr Style, can you reassure my constituents that Shotley Bridge will indeed be going ahead in the near future?

Matthew Style: The Government remain fully committed to making progress on the health infrastructure plan and on the 40 new hospitals in particular. As I say, the Government remain fully committed to that. There are clearly issues across the construction industry, and I know things are proving challenging for a number of sites, but the Government remain fully committed to driving forward the health infrastructure programme.

Q21 **Mr Holden:** That sounds a bit waffly. Are we going to get our new hospital? I campaigned hard to get an extra 10 million quid so that we could get 16 beds there rather than the downgrade that was promised back in 2019. Will we see it actually happen in the timescale outlined by the Prime Minister not that long ago?

Matthew Style: As I say, we are fully committed to making progress with all the sites that have so far been selected for investment through the health infrastructure plan. We will continue to drive that programme forward as quickly as circumstances allow. Indeed, as I said earlier, we are also selecting additional hospitals for investment under the programme.

Q22 **Mr Holden:** Sir Chris, in recent weeks we have had the other Departments in, and it has emerged that there were certain Christmas parties at the Department for Education. I just wanted to check with you that no such events happened at the Department of Health and Social Care last year.

Sir Chris Wormald: Obviously, the Department of Health and Social Care has had some issues with social distancing, including one extremely famous event, but in terms of Christmas parties I am not aware of any that occurred last year. Should any evidence of anything come to light, it would be investigated in the usual way, but I am not aware that anything occurred in terms of Christmas parties in DHSC.

Q23 **Mr Holden:** You certainly were not involved in any events with warm white wine as a thank you to staff or anything like that.

Sir Chris Wormald: No.

Chair: Thank you very much.

We must now move on to our main session. For anyone following, we are referring to a very helpful Report from the National Audit Office called "NHS backlogs and waiting times in England", to which there is a link on our website. We will refer to a number of the graphs in that Report to discuss with witnesses what has been happening over recent years and how we will get recovery.

Before we go into our main session, I just want to ask Kate Osamor MP to declare her interest.

Kate Osamor: Thank you, Chair. I was previously a practice manager in a GP surgery.

Q24 **Chair:** So very much at the frontline of a lot of this. Thank you very much, Ms Osamor.

Let me turn first to you, Sir Chris, as permanent secretary. All the graphs in the Report show one thing: a growth in waiting-list times. If we take figure 2 on page 18, we can see waiting lists growing steadily from around 2009. There is also, at figure 7 on page 23, a very useful graph that shows that in February 2012 there was a very big problem with NHS trust performance. Can you tell us why you think NHS performance declined from that period onwards?

Sir Chris Wormald: I will ask Mr Style to comment as well, but I think it is exactly as set out in the National Audit Office Report which, with one exception, we all agreed the facts of. I am sure we will go into this as the hearing goes on but, at the top level, the equations are not very complicated. As the Report makes clear, demand has continued to rise both in the UK and internationally. While supply has risen and the NHS has continued to make exceptional efforts, supply has not risen over that period as fast as demand, which is of course declining. I am sure we will go into the exact reasons for that in much more detail, including with our NHS colleagues, but, as I say, the NAO Report has set the position out.

Q25 **Chair:** As I say, it did get worse from 2013 onwards, so had covid hit earlier, do you think the system would have been better able to cope?

Sir Chris Wormald: I am not sure that that is an answerable question. Obviously covid was an enormous shock to the system and had a significant effect on the elective—

Q26 **Chair:** Okay, let me put it a different way. The NHS is running very hot from 2013 onwards, with increasing challenges. Looking at the figures on the money, that is very notable. Let me lay it out very clearly. Under the Thatcher and Major Conservative Governments, so from 1979 to 1997, the average annual real growth rate in the NHS in terms of revenue was 3.3%. Under the Blair and Brown Labour Governments, from 1997 to 2010, the annual growth was 6%. Under David Cameron as Prime Minister in the coalition Government from 2010 to 2015, the average annual growth was 1%, and under the Government more recently it has been 1.6%. It is going up again but still considerably lower, per year, than it was in 1979, so the average increase has not been enough. Sir Jim has told us many times that you need about 4% a year to keep the NHS standing still. We saw the impact of that in the graphs, which rather clearly state it. Had there been more money going in and therefore you had been in a better standing state, do you think the system would have been better able to cope?

Sir Chris Wormald: It is a statement of the obvious that resources impact on these issues. I do not think anyone disputes that. Before the

pandemic, if we can just about remember, we were all debating a five-year plan, the extra investment that the Government were putting in, and how to get the best from that investment, including tackling the issue that you are setting out. Obviously that was completely thrown off course by the pandemic, but the issue was already on the Government's agenda, and that was one of the purposes of the five-year plan and the extra investment that we had announced. Did the rate at which the NHS was running affect its management of the pandemic? No, I do not think it did. Did it affect what the implications were for other services in the NHS? Just as a statement of the obvious, that must be true.

Q27 **Chair:** Ms Pritchard, as head of NHS England you were in the organisation before you became chief executive. Do you think you would have been better able to cope if the pandemic had hit when you did not already have the huge growth in waiting lists for elective care?

Amanda Pritchard: I agree with Chris's reflection that no hospital in the world was geared up to deal with the scale of the pandemic that we have experienced over the last two years. The urgent response that the NHS had to make, and also the rest of the world, was extraordinary and required extraordinary efforts, not just from colleagues across the NHS but from the whole country. What we have absolutely seen, which is the subject of today's discussion, of course, is then the unavoidable impact on other services. Therefore the recovery challenge is certainly significant, as in how much work was inevitably displaced.

The other point that Chris makes, which I agree with, is that it is clear that the NHS was in a position where there were a lot of things that we had identified that needed attention and improvement, and that was what the long-term plan was all about. Before the pandemic, we had an improvement agenda, and certainly the impact of the pandemic has added to that.

Q28 **Chair:** Certainly, you needed an improvement agenda. In June 2019, as Sir Chris will remember, this Committee raised concerns in a Report we did about elective care. Sir Chris, it was your Department that loosened the requirements on NHS England to meet its targets on elective care, choosing to focus on other targets. Do you now regret that?

Sir Chris Wormald: That's not strictly correct. The targets are part of the NHS constitution and did not change. What we reflected at that hearing is that in terms of how those targets are applied, clinical priorities obviously come first. As I remember, we went into some detail as to how those clinical decisions are made, both between the demands of elective care and of emergency care, and, crucially, the clinical prioritisation that goes on within elective care, in terms of the order in which patients are treated, which is to do with clinical need and not their rank on the waiting list, as it were.

We did not formally loosen the targets, but without question those clinical prioritisation decisions were taken by Professor Powis and his colleagues, completely rightly.

Q29 **Chair:** Okay, but as a Department, you are the ringholder for taxpayers—for Government—on making sure that NHS England is meeting the targets that, as you rightly say, are set out in the NHS constitution. That includes meeting elective care targets. We have seen waiting lists increase to incredible levels. Obviously, the pandemic has massively increased that as well. What are you planning to do now, Sir Chris, at the departmental end, to help the NHS focus on this? Money has gone in, but it is not just about money. How are you going to ensure that we see a drop?

To give a bit of background, this Committee may already be a little weary. It is backlog week on the Public Accounts Committee, in a "Let's get scrutinising" kind of way. We had courts on Monday; their backlog has increased and their targets to bring that down are going to take it still way higher than it was before the pandemic. We are worried that we are seeing a similar pattern here with NHS elective waiting times. What are you going to do to hold it to account and make sure they deliver?

Sir Chris Wormald: I don't think the issue is holding to account, although that is important, and I am sure it will come out throughout this hearing. Nobody wants to see waiting lists like that. It is not a question of—

Q30 **Chair:** We had the preamble and the chat; take it as read that none of us want to see that. I hope you don't want to see that, and Mr Pritchard doesn't want to see that, so what are you going to do about it?

Sir Chris Wormald: I'm sorry. The implication of your question was that holding the NHS to account more firmly was part of the answer, and I really don't think that it is. Were it not for the situation that we find ourselves in—

Q31 **Chair:** With all respect to the NHS England colleagues on this call, you are funnelling taxpayers' money into the NHS to make sure that they deliver on that spending. That extra money is going in, which no one would disagree with, but for that we want to see something.

Sir Chris Wormald: On that point, no one would disagree.

Were it not for the position that we have found ourselves in over the last week, which we have already discussed, this is exactly what we would be doing right now. We were planning to be having a large push on electives, for the money that you described, with a plan that Sir Jim and the others can talk to you about, which is not just about the money but crucially about capacity, workforce, organisation and clinical decisions. You need all of those things to have an elective programme, and that is going to be the big focus for us and the NHS going forward.

In the medium term, it still will be. That is a clear priority of the Government and, as I say, Sir Jim and the others will be able to describe the thinking that the NHS has been doing on that subject.

Clearly, that is not our focus today. Our focus is on things we were talking about earlier in this hearing. But over the coming years, it certainly will be our focus. As I say, the NAO Report sets it out, and the NHS has done this

before. It is not simply a question of resources, although those are important. You have to have all those other things. That was the thinking and planning that the NHS was doing.

Q32 **Chair:** Okay, can I bring in Professor Powis? Earlier you said that it was, "Our job to prepare," and I think that is fair enough. Can you tell us what you have been doing to try and reduce this? Also, what will the impact be on elective care of this month of focusing on the booster? How much will it increase the already big challenge you are facing?

Professor Stephen Powis: The very short-term mission over the next three weeks will probably not increase it significantly. It is also the period of Christmas and the new year, when we would not usually be doing a huge amount of elective care because staff are taking bank holidays and so on. As you know, we have done a huge amount in between waves to make sure that elective care continues and waiting lists do not build. Obviously they have.

During the first wave we actively stood down all but emergency elective care, and the reason for that is that we really had very little information about what was going to happen. It was a new virus, and we didn't know how hard it was going to hit the NHS. We learned from that first wave, and in the second wave we did not stand down elective care. Wherever possible, we kept it going. That will be our approach to the wave that may be coming in January. As I said earlier, we don't know how big it will be, but we will not stand elective care down unless we have to. Of course, we will keep those high-priority emergency treatments—cancer operations and operations for life-threatening conditions—going, as we did in the first and second wave.

But let's not sugar-coat it. If we do see a large wave in January, we will see disruption again. Unfortunately, we will see cancellations, and I am sure the public will understand that. In primary care over the next few weeks, we are asking people to forgo some of those routine appointments, so that GPs can focus on the vaccination mission. Indeed, we have worked closely with the Royal College of General Practitioners and the BMA to issue further guidance to GPs, which we will be doing shortly.

Q33 **Chair:** As medical director you have many unenviable tasks, I am sure. One of which is that, if there is another peak, which you have been through before, you have to provide guidance on who gets an intensive care bed. Can you talk us through what decisions you would make that would hit elective care rather than people who are very ill with covid-19?

Professor Stephen Powis: We have always worked on the principle during previous waves—and we will during the next wave—that those urgent, life-threatening treatments will go ahead. That is why we have increased intensive care capacity. We have increased capacity in our general beds and put in additional capacity to manage both covid patients and non-covid patients. As I have outlined, there has been some disruption to elective services—the non-urgent elective cases—but we will minimise those in this wave, as we did in the second wave.

Q34 **Chair:** So there are non-urgent elective cases that get more urgent as time goes on? They may not be urgent, and they may survive a delay of a week or two, or even a month or two, but many people have been waiting a very long time, to the detriment of their lives and health. How do you strike that balance?

Professor Stephen Powis: The first thing to say is that clinicians know their individual patients best. That is what we are trained to do. That is what I did when I was practising. If one of my patient's condition deteriorated, I would prioritise them and we would treat them more urgently. Clinicians do that day in, day out in hospitals and in primary care. We have also worked with professional colleagues to issue guidance.

I mentioned the guidance going out to GPs shortly, but a year ago we worked with the Royal College of Surgeons and the Federation of Surgical Specialty Associations—to whom I am extremely grateful—to develop guidance around the prioritisation of patients on the waiting list. Clinicians have been working through waiting lists on that basis ever since.

That guidance is constantly updated, but essentially it says what common sense would tell you: very life-threatening conditions need treatment within a day or a couple of days, while treatment for very urgent conditions, such as cancer operations, is needed within a month. With less urgent and more routine cases, I think everybody would understand—while acknowledging that people are waiting, that it is frustrating and that it affects patients—that there is a rationale for treating urgent cases first.

The guidance, which I am happy to send you, very much reflects the common-sense clinical professional approach that clinicians would take—not least because it is produced by those clinicians, so it reflects what they do in everyday practice.

Q35 **Chair:** I do not doubt for a minute that individual clinicians are making difficult but rational judgments in the moment. Of course, we see the big picture, which is the backlog, and we all acknowledge the impact on people's lives. I am sure that we do not need to go into that.

Professor Stephen Powis: The other thing that I would say is that we have a real focus on the long waiters. Pre-pandemic, we had a focus on people who were waiting for over a year, and we were making progress. Now, of course, we are seeing those waiting lists grow, so we have an additional particular focus on the very long waiters—people who are waiting for up to two years or more—at the same time as having a real focus on the very urgent cases. It is getting that balance right that clinicians do all the time, assisted by our guidance.

Q36 **Chair:** We will come to the flow and the diagnostics later. Before I pass over to Mr Richard Holden, I want to pick up on the work of independent private hospitals in supporting the NHS at this time, because quite a lot of money went in during the early stages of covid. We are told in the NAO Report at figure 23 that 3.3 million activities were completed. A lot of it was used not for covid patients, but for other things.

Can you tell us what has been happening with the independent sector and how, or whether, that will be used to help to clear the backlog? We will go to Ms Pritchard on that.

Amanda Pritchard: Could we go to Jim, because it is part of elective recovery?

Sir Jim Mackey: The independent sector is helping a lot and has been doing so over recent months. Activity levels in the independent sector are at around 111% of 2019-20 levels, according to the latest statistics, and are still growing. There is variation around the country, and obviously the presence around the country is different, but the sector is absolutely working very closely with us to help to address the backlog.

Q37 **Chair:** Does that depend on region? Is there an even spread of independent private hospitals?

Sir Jim Mackey: No, it is very variable.

Chair: That is what I thought.

Sir Jim Mackey: There is very little in the north-east, for example, where I am today; it is very much concentrated in other parts of the country. That will be something that we will have to work through in our longer-term recovery.

Q38 **Chair:** How are you making sure? If it is there and we are paying for it, we need to be using it, clearly, but if you are living in the north-east, you probably would not have many private hospitals, as you would know. Do those patients get a rougher deal because they are waiting longer for the operations that are being pumped through private hospitals—hips, knees and so on?

Sir Jim Mackey: Generally, where there is less independent sector presence, NHS waiting times are better anyway. North-east waiting times are generally lower, and there is actually less need for independent sector provision there. But there is variation, and a lot of it is very historical—a lot of it goes back to the early 2000s and the NHS plan.

All I can say, really, is that over the last two months there has been an awful lot of interaction between the independent sector and the NHS at national, regional and local level. We have ironed out an awful lot of wrinkles in patient pathways and in what the capacity can be used for. Volumes have picked up really significantly since then.

Chair: We are here to talk less about the value for money than about the effectiveness at this point, but we will be doing some further work on private hospitals' provision in the new year.

You mentioned the north-east, so we will turn to our north-east correspondent on the Committee, Mr Richard Holden MP.

Q39 **Mr Holden:** Ms Pritchard, I just want to get a handle on the waiting list numbers. Where are we today with the millions of people waiting?

Amanda Pritchard: We published the monthly statistics last week, from which you will have seen that 5.98 million patients are currently on the waiting list. As I think we would all agree, that is far more than we would like.

Q40 **Mr Holden:** I am looking at page 4 of the NAO Report, which shows the big, key numbers. Under the heading "NAO projection of the size of the elective care waiting list by March 2025", the figures are between 7 million and 12 million. So at least 1 million more people will be on that waiting list, despite billions of pounds extra going into the NHS, and the extra money that I voted for in Parliament for extra support to get waiting lists under control. Why is it going up even by 2025?

Amanda Pritchard: I can start answering that, but you will probably want Jim to come in after. I think the Government have always been very clear that this was going to get worse before it gets better, because obviously what we are trying to do here is deal not just with the patients who are currently waiting—those who are absolutely in that clinical prioritisation long wait focus that Steve was just talked about—but also with the uncertainty of not knowing how many of the patients who did not come forward for treatment might still present for treatment, and that is a hugely important unknown in being able to predict where waiting lists might land.

The other really big unknown, which obviously has come to the fore in the last few days, is the impact of what might happen this winter. We were already concerned about the level of urgent emergency care pressure we were seeing, but now we have the additional uncertainty of what might happen with the next covid wave. It makes it very difficult to predict numbers on the waiting list.

That is why we keep coming back to the point that the priority has got to be doing as much work as possible on activity. Activity on elective is one of the things we have clearly committed to as part of the elective recovery plan, but we must also maintain that focus on those patients who are most urgent, and those who have been waiting the longest.

Sir Jim Mackey: It is very hard to predict, and we are now in another period of uncertainty, when it is hard to tell what will happen over the next few weeks. All I will add to what Amanda has said is that everybody in the NHS wants to recover as quickly as is humanly possible. There has been some fantastic engagement over the past couple of months, with lots of really positive signs of progress on slowing down the rate of growth for some of the long waiters, and really big efforts to increase activity, but it is very hard to predict over a two or three-year period, given the rate at which people who were not in the elective system last year might return, and the extent to which they might have appeared in the non-elective system. I think we just need a bit more time to be able to assess that. Obviously, now it is complicated by these next few weeks.

Q41 **Mr Holden:** I understand. Ms Pritchard said that this would get worse before it gets better, but when will it get better? That is what I want to

know. I am looking at the graphs, and I cannot see when it will actually get better, all the way to 2025. When will the numbers actually start coming down?

Sir Jim Mackey: It depends what you are looking at. We are already reducing the rate at which—

Mr Holden: I am looking at elective surgery.

Sir Jim Mackey: But there is a range of statistics. Our focus currently is on very long waits—people who have waited two years.

Chair: Just to make sure that we are all talking about the same thing, Mr holden is referring to figure 25 in the Report.

Sir Jim Mackey: You are talking about waiting lists. What I am trying to say is that there are a number of things that we need to focus on here. Our initial focus is on very long waiters. There are signs that we are starting to make an impact on stopping that number growing, and over time we are very confident that we will be able to reduce that. That is currently more evident for people who have waited a year than it is for those who have waited two years, but it is very early in the process of trying to make an impact on that. My point was that the waiting list could grow over this next period—it is very hard to predict how the missing referrals will clear back in and the extent to which they are already in our numbers. What we are trying to do now, going back to Steve's point, is focus on those with the highest clinical need and priority, and especially, in the short term, those who have waited very long periods of time.

Q42 **Mr Holden:** So basically you cannot tell us if or when it will get better.

Sir Jim Mackey: We were getting close to agreeing a plan with the Government until just before this latest covid episode began, and it would have allowed us to set out a recovery plan over a period of time. Obviously, we will now have to take stock and see what happens over the next several weeks as things are possibly curtailed, but at some point, the NHS will set out its plan to do that.

Q43 **Mr Holden:** I am glad, Sir Jim, that you are getting close to agreeing a plan. I was slightly concerned by Sir Chris's words earlier, when he said he didn't think that holding the NHS more to account was part of the answer. Do you think it is highly unlikely or highly likely, or likely or not likely, given this extra wave of covid, that the elective waiting list in 2025 will be shorter than it is today? What is your judgment? You are the chap in charge of elective recovery for the NHS. Do you think the waiting list will be shorter or longer in 2025?

Sir Jim Mackey: I honestly could not say. The indications are that it will be very hard to reduce it from where we are now, but there are so many variables that it is impossible to say at the moment.

Q44 **Mr Holden:** But is it your honest assessment that it will be very hard to reduce the waiting list from where it is today?

Sir Jim Mackey: It will be, yes. I would be more confident of reducing very long waits for those patients who have been waiting a very long time, but I would be less confident of reducing the size of the list.

Q45 **Mr Holden:** Sir Jim, obviously in recent weeks we have voted for the extra £8 billion as part of the social care package for the NHS to help with this recovery. What impact do you think that extra money will have? Will it help to flatten out the potential rise? What numbers can you put on it to reassure my constituents that their money is being well spent?

Sir Jim Mackey: We have already started that process, and in H2, the second half of this financial year, we have invested around £700 million in the NHS to create additional theatres, dedicated surgical capacity, surgical hubs and diagnostic facilities—and, importantly, to start the separation of urgent care and elective care, so that we can protect elective care streams by building in resilience against urgent care and other potential shocks. That is already happening. The half-year plan buys just short of 600 dedicated elective beds and dozens of other bits of capacity—MRI scanners, CT scanners and surgical robots. Before Christmas, we will start a more medium-term planning process to nail down how that investment works and what we get from it, in terms of value for money.

Q46 **Mr Holden:** Immediately, this year, from that extra funding, we will start to see an extra 600 beds across the country for elective surgery, which will be increased next year. That is just with £700 million. Are we talking of tens of thousands of extra operations a year because of that funding?

Sir Jim Mackey: Yes, absolutely. The actual figure is something like 566 elective beds, but there will be a range of other capacity. Importantly, going back to some of the Chair's questions, we have been trying to build in resilience, to separate urgent care and elective care, and to create dedicated elective capacity, so that people can have a scan or have their day-case procedure, or whatever, without worrying about it being disrupted by urgent care. That is a very big step, and it will flow through in future years from this planning process.

Q47 **Mr Holden:** I understand that, and I know it is difficult to put a broad number on it. In terms of the raw number of patients coming off the waiting list for elective surgery, are we talking about hundreds of thousands of people over a four-year period?

Sir Jim Mackey: Yes, absolutely. Overall, we are trying to ramp up activity over two or three years, but that is very difficult to do because of the complexities with which everyone is coping at the moment.

Matthew Style: The resources that the Government have made available to 2024 will enable at least 9 million more checks, scans and procedures over that period, and such longer-term certainty is very important. That will allow the NHS to make best use of the resources that the Government have made available, and to invest with the certainty that is necessary not only to maximise the activity that can be delivered, but to transform the way that care is delivered in the way Jim was outlining. That way, we can

not only tackle the backlog, but make great strides in the productivity of the system at the same time.

On the point you were discussing with Sir Chris a moment ago, the Government are very clear, as was the planning guidance issued through the NHS this year, that our focus now is on restoring activity to the highest level possible across the NHS—to pre-pandemic levels and beyond—as quickly as possible. That is what we are focused on. That is what the colleagues I meet on the frontline across the NHS tell me is their focus, and what they want to do. The financial certainty that we have provided as a Government is supporting that agenda. As Jim and Amanda have said, what that means in practice will become clearer over time as the longer-term impact of the pandemic and the winter become clearer. Right now, I think there is no doubt that we are together—the Government and the NHS—focused on restoring activity to the highest possible levels.

Q48 **Mr Holden:** Mr Style, I think we have got your message: you want to restore levels. I want to be clear. The extra money that was voted for will deliver 9 million—ballpark—more diagnostics, operations and so on, particularly in the elective sector, by 2025. That is what you are aiming for. You are the head of policy and performance, and that is what you are driving for.

Mr Style: That's right. That is all part of the overall ambition—

Q49 **Mr Holden:** That's fine. I just wanted to nail down that number. Thank you. It is something we can hold you to account on, which is helpful to know. I am sorry, Chair, I know I have been digging into that a little bit more than planned.

I wanted to look at a bit more data in the NAO Report, and at what we are putting in, compared with other nations around the world. Page 31 includes "healthcare resources: international comparisons", and I also have numbers from the OECD on international comparisons. Colleagues from across the House want a bang for the taxpayers' buck in the NHS. According to OECD 2019 figures—the nearest year—health expenditure per capita in the UK is roughly $4,500 per head, which is more than Italy or Spain, pretty comparable to Japan, and slightly less than Ireland and some other countries. Looking at the healthcare indicators on page 31 of the NAO Report, we are lower across the board than most others for hospital beds per 1,000 of population, for nurses per 1,000 of population, and for doctors per 1,000 of population. Other countries vary in the nature of their healthcare systems. Why, despite the money being pretty good in the UK—it could be higher, and there is more going in, as we have just said—are we lower on all those things across the board than comparable countries?

Sir Chris Wormald: I am not sure that chart does show that.

Mr Holden: Are we looking at the same chart? We are second lowest in terms of hospital beds—let's make it clear—third lowest in terms of nurses, and fourth lowest for doctors.

Sir Chris Wormald: As I said, I thought it was an interesting chart. As you said, Japan is top of one of your charts, but it is bottom of the other. There are a lot of choices going on—

Q50 **Mr Holden:** Indeed, but no other country is consistently down at the bottom of everything.

Sir Chris Wormald: If you have a look at the ranking produced by the Commonwealth Fund, which is generally considered to be the most comprehensive analysis of healthcare systems, the NHS scores rather well across its measures for the amount of resource that is put in.

What I thought was really interesting about the chart was the different choices that countries make about how their healthcare systems are structured. Certainly, there were things we can learn from other countries.

Q51 **Mr Holden:** As ever, Sir Chris, you have predicted my next question. Clearly, there are different models from the way the different countries operate. We are putting a huge amount of extra investment into the NHS. What other countries are you going to, to learn from examples at the moment? Other countries are facing similar issues with coronavirus, but they will be tackling it in different ways. I am interested in what you think.

Sir Chris Wormald: I might pass to Amanda to talk about the transformation programme that the NHS is running, which draws very heavily on international best practice.

Amanda Pritchard: The short answer is there is a lot to learn from a lot of different places. Clearly, we are trying to take the best of what we can see across the world. One of the big focuses of the transformation work is around digital and being able to support more people, particularly in their own homes, through things such as the virtual wards and crisis response services—that has been crucial through the pandemic. Once again, that will make a big contribution this winter. But going forward it is the kind of thing we need to do. If we don't have those beds in hospital, and you can see we haven't, we have to learn lessons from places such as Australia and Israel, particularly on the digital and data side, to enable us to find other ways of supporting patients effectively outside those hospital beds.

Equally, one of the big areas of focus is diagnostics. Again, the chart is very illuminating on that, because you can see we have fewer CT and MRI scanners than comparative nations. That is one of the drivers for the big push on diagnostic reform and the setting up of community diagnostic hubs. One of the lessons we learned from looking at other countries is that the ability to separate elective and emergency flow is absolutely critical to protect our elective work against some of those pressures from emergency care. There is a big focus on that.

You have hit an incredibly important point on workforce. We might be about to go there anyway, because we cannot do anything in the NHS without our workforce. It is not just about supporting the brilliant people across the NHS today who, once again, are pulling out all the stops and

have done all the way through the last two years and beyond, but the ability to plan more effectively for the future.

The final point I would make is the data one. One of the things we have learnt internationally and are beginning to lead the way on is our use of data to get upstream on prevention. We have used it with the vaccine programme to understand local communities, to be able to serve those who have traditionally been underserved. We have a great opportunity to build on that as we think about that wider prevention and inequalities agenda.

Q52 **Mr Holden:** One of the things I am particularly interested in, Ms Pritchard, is Spain. Government and compulsory spending in Spain is 25% less per head than in the UK, yet its number of CT, MRI and PET examinations is 25% per head more than in the UK. That is the diagnostics. In essence, they are spending a quarter less and getting a quarter more. Have you gone and found how they are delivering that?

Amanda Pritchard: That might be one for Chris about the distribution of funding and the decisions about the prioritisation.

Mr Holden: I'll bat it over to you, Sir Chris.

Sir Chris Wormald: We have certainly looked at Spain. Spain was one of the countries that runs systems that are one of the precursors to the ICSs that we are developing. There are very interesting things that happen in Spain.

I would say not to pick on a single measure; as Amanda laid out, countries make very different decisions about how to use their healthcare resources. As the charts show, we have made the choice to have fewer hospital beds and more in the community than some other countries. I don't know how Spain goes across the board, but your general point is absolutely correct. Spain, along with other countries, do a lot of very interesting work that we definitely look at and need to learn from.

Matthew Style: May I give one very specific example? Picking up on what Jim said earlier, one of the priorities for capital investment in the second half of this year to support elective recovery has been the greater separation of facilities and pathways for planned care, as opposed to emergency care. As Jim said, that is a priority for us as part of our investment programme, but it is also something that we have seen and drawn on in other countries. In Germany, for example, that is a much more established part of their healthcare model. That has influenced the investment plans that are taking place right across the NHS this year as part of tackling the backlog.

Q53 **Mr Holden:** Sir Chris, one thing I am interested in before we move on: obviously, we are looking at other countries and how they do things. Who is coming to us to ask, "How do we do things better?"

Sir Chris Wormald: That is an extremely good question. Actually, you see a lot of other countries who come and look particularly at things that

happen in individual trusts. What you find when you go round the NHS is extremely interesting innovation everywhere. That is certainly looked at across the world. What we have not had, and what Amanda was describing, is about how you scale those interesting innovations into things that are having whole-system impacts. The kind of thing that Amanda is talking about, and it is a theme of our Getting It Right First Time programme that has been running for a while, is how do you take the great innovation that undoubtedly happens in our NHS all over the place—people flock to our great teaching hospitals for learning—and actually use them for system-level transformation.

Q54 **Mr Holden:** Okay, so nobody is coming and looking at the NHS system, and the system that is run out of DHSC, and saying, "That is the model that we need to be pursuing for our country."

Sir Chris Wormald: Sorry; at a system level, no, and we are not doing that, either. Everybody looks at each other's systems for what is good and takes things from them.

Q55 **Mr Holden:** Sir Chris, I want to drill down into the specifics of that a little bit. I understand that great research goes on across the UK. We have got some great pharmaceutical stuff happening as well. What are other countries looking at from the UK on the bigger picture? Like you are looking at how Spain delivers integrated care, which we just talked about briefly, what are they looking at? Are they looking at any of those overall system approaches and saying, "The UK does that well"?

Sir Chris Wormald: I could not give you a validated list. I know Jim wants to come in. We certainly get people who want to talk to us about how we use data and some of the advantages we have by being a very large jurisdiction. We have international interest in all those things. Everyone is always interested in NHS reform. I could not give you a validated list of what people turn up to look at, but I think the areas you picked around innovation, research and clinical practice are probably what we are most famous for around the world.

Q56 **Mr Holden:** A couple of final questions before we go back to the Chair. In terms of spending per head and the comparisons with other countries, obviously, we are seeing big increases in the NHS budget over the coming years, but is that going to be enough to deliver the healthcare that you want to see delivered in the country, especially given the pandemic?

Sir Chris Wormald: It is a constantly moving target. A lot of the countries you quote are also raising their health expenditure. I would not like to leave you with the impression that we thought money was the only issue. I will not name them, but there are some exceptionally high-spending countries that score rather lower than us on many measures as well, and clearly how you use the money is just as important as how much there is. Clearly, given the investment that the taxpayer is making, we need to see the kind of improvements that Mr Style was talking about. Obviously, whether that means we go ahead of other countries on some particular things—

Q57 **Mr Holden:** It is good to hear that you're also talking about outcomes rather than just resource increases because, as we can all see from these figures, those two things actually do not correlate with each other that much once you hit a certain level of resourcing. What I am actually interested in—perhaps you could start with this, Chris, and then we could go over to Mr Style—is the key indicators. We have seen some of the broad indicators in the international comparisons. What indicators do you monitor so that you can see that the NHS and the UK are actually making progress?

Sir Chris Wormald: I will ask Mr Style to contribute as well. There is a sort of graduated system. As we were discussing before, there were some things set in the NHS constitution, which are the legal targets. There is then what the Department and the Government put in the NHS mandate every year, which is our top level of measures for the NHS. Then, for the long-term plan—which was interrupted, as you know—there was a whole series of metrics about the investments made in the long-term plan and what the NHS was offering back.

Q58 **Mr Holden:** Okay, Sir Chris. Perhaps we could ask Mr Style about what those are.

Matthew Style: As Chris said, the long-term plan is the reference point here. In the long-term plan, we look back at how we compared internationally on outcomes for some of the major health conditions.

Q59 **Mr Holden:** Indeed, Mr Style. I know that it can be difficult over Zoom. Obviously, we are monitoring lots of things, but one of the key indicators is the elective waiting list. Is any other country that you are aware of predicting that, after massive increases in investment—plus the extra £8 billion we voted for as part of the health and social care levy—they will have longer waiting lists in four years' time, or is it just the UK?

Matthew Style: I can tell you that most health systems in Europe cancelled non-urgent elective surgery in the first wave of the pandemic.

Mr Holden: I appreciate that, Mr Style.

Q60 **Chair:** Mr Style, that is not the answer to Mr Holden's question. We know that everyone cancelled elective surgery, but will they have longer waiting lists after recovery?

Mr Holden: Four years of recovery.

Matthew Style: As Jim said earlier, there are very significant uncertainties about the future path of waiting lists and waiting times. All countries like the UK, like the NHS, will be grappling with uncertainties about the impact of the pandemic. Our focus right now is on ensuring that we can restore activity across the NHS to the highest possible levels, make the best possible use of taxpayers' funds in doing so and, while tackling that backlog, transform care and the quality of treatment across the NHS. That is our focus.

Chair: Thank you, Mr Style; we've got the point.

Q61 **Mr Holden:** Mr Style, none of us deny that Sir Jim, Sir Chris, Amanda, yourself and others will be doing everything you can to improve things. I just wanted to know whether you are aware of any other country that is planning to have a million more people on waiting lists in four years' time than they have today.

Matthew Style: All countries will be facing uncertainties about the future demand for healthcare and the impact of the pandemic. What we are focused on here in the UK, and what the NHS is rightly focused on, is restoring activity to the highest possible levels and doing the best for both the patients and taxpayers. That is what we're focused on; that is what colleagues in the NHS are focused on.

Q62 **Chair:** I was going to come to you, Sir Jim. Earlier you said it is very hard to reduce the backlog from where we are today, and you have always been a very candid witness at this Committee. You told us a number of times that hospitals—and I summarise what you said—did not really have enough resources to deliver day to day on the money that was coming in. It was you who gave us the 4% figure as a very clear need for hospitals. What do you need to reduce this? People, presumably. Who?

Sir Jim Mackey: There are a few things here. First, going back to the earlier point, it is very hard to make international comparisons. A lot of these other countries are very heavily reliant on the private sector in their systems. They are very difficult systems to compare the UK with. Almost none of them declare national waiting lists in the way that we do, and I am not aware of any of them that have published a recovery plan yet. So hopefully, when we publish ours, we will be the first of all of these countries to do so. If we just go back to your point, Chair, it will be very hard to reduce the size of—

Chair: Sir Jim, Mr Holden just wanted to come back on that one.

Mr Holden: I am just going through these figures, Sir Jim.

Chair: Can we be clear which figures we are looking at? Is it the OECD figures?

Q63 **Mr Holden:** We are looking at the OECD figures on healthcare expenditure. Norway, Sweden, France, Japan and Italy all have lower private-sector spending per head than in the UK, so the idea that this is all on the private sector, voluntary and out of pocket is not true. They might have slightly different systems, but they are essentially delivered free at the point of use, like the NHS.

Sir Jim Mackey: They are all different systems. As Chris said earlier, we would generally refer to the Commonwealth Fund, but apart from that, the systems are hard to compare. On your point earlier about whether anybody comes to us to try to take ideas from the NHS, that happens all the time. Generally, the view is that the NHS delivers good value for money overall compared with others. In my view, reducing the list will be very hard, but the NHS will definitely reduce long waits. I am very

confident we will be able to make an impact on very long waits. The size of the list is a much more complicated dynamic.

Q64 **Chair:** Yes, which is what I want to get into a bit more. You have said it is very hard to reduce, and you have repeated that. Can you tell us what you would need to reduce it? You have the Committee, Sir Chris and Amanda Pritchard here—tell us what you would need to deliver effectively on your job as director of elective recovery.

Sir Jim Mackey: We have a very large investment and we need to make really good value judgments on that. The first thing is that we need to get a plan published and start a medium-term planning process to help the NHS think long-term. That sounds easy, but we have been thinking very short-term—

Q65 **Chair:** Sorry—I am aware you are all busy and we want you to get away as quickly as possible, so let me be really direct in my question. We always hear about plans. We know that. We are here trying to drill down a bit below that. You will need that money to spend presumably on people in the system to do this. Which areas do you need more staff in and how quickly, realistically, in your plan will you be able to get the people you need to help deliver a reduction in waiting lists?

Sir Jim Mackey: We will make investments in buildings to create the capacity and create separated capacity. It is important to build resilience in the urgent care system as well, so that that does not disrupt the elective system. We will start that in December and there is already work going on trying to work out what capacity is required there so that we have two strong parts of the system with enough beds and enough capacity to be able to cope.

Q66 **Chair:** Buildings take a while to get through, as we have heard clearly from two of our colleagues here today with their hospitals. When you say buildings, is that the new hospital programme? Is it improvements?

Sir Jim Mackey: That will be modifications and extensions to existing hospitals—largely modular builds, which are quicker, so an awful lot of it has already been ordered and will start to be built in the new year.

Q67 **Chair:** When will patients be able to start using this?

Sir Jim Mackey: Some of them will be available and being used in the spring—

Chair: I just wanted to get an idea of timescale. Buildings sound like a longer thing.

Sir Jim Mackey: Out of those 82 plans that have started, we have started recruitment processes to build the human capacity so that people can deliver what they need to do with the technology and equipment as well. That will take time. I understand the point that we are always talking about plans, but this does need a medium-term approach. It is not going to happen overnight. We will need time to recruit people, train people, get them from other systems if we need to and get them into buildings that

are purpose-built and protected, with up-to-date scanning capacity and so on. On the comparators, we are making a huge investment in diagnostic capability as a key priority, because we are out of step with other systems.

Q68 **Chair:** So how long will it take? For diagnostic capability, for example, that is a very clear gateway in. Your clinician will only know if you are urgent if you have had the diagnostic testing done. How long will it take to get the right people in the right places to make sure that that bit of the waiting list is moved forward?

Sir Jim Mackey: Some of that is already happening. I can't give you a national number yet, because of where we are, but some of this is already happening now.

Q69 **Chair:** Okay, but I am just trying to get an idea. We know there are shortages of certain staff groups in the national health service. Everyone talks about doctors and nurses, and you of all people in this room—or in this virtual room—know it is a lot more complicated than that. So which professions do you need most of, how quickly can you train or recruit them, and how are you going to go about that?

Sir Jim Mackey: We need more of everything—

Chair: Exactly.

Sir Jim Mackey: One of the things we have learned in the last few years is that the NHS is one just massively flexible huge team, so we are recruiting on pretty much every front: doctors, nurses, physios, ODAs—you name it. That is happening all over the NHS.

We do need to be training more, and there is a separate conversation going on about how we expand our training capacity and our production capacity. As we have discussed before, when you are talking of the very specialised staff—doctors and specialist allied health professionals, etc.—that takes time, because they need to go through education processes.

To try to get to your point, it will be two to three years before there is a material increase in capacity. That is not to say that we cannot be very productive, change the way our systems work, adopt technologies and accelerate volume, which is what we are already doing, to make an impact, but in terms of really significant additional capacity, it will take time.

Matthew Style: I would just add to what Jim has said that we are investing now—in the second half of this year—in digital technology to improve the productivity of our existing workforce, particularly in diagnostics, with digital pathology, digital imaging and the use of AI to increase the volume and the speed with which results can be gathered and processed, and to increase the speed with which clinicians can then get on with doing what they want to do, which is treating people who most need help soonest.

We are also investing in, again, innovative models to make the best use of our workforce—for example, cancer pathway navigators. These are non-clinical professionals who have training to help support patients to move as quickly as possible along their pathway, again to mean that our most highly trained staff have more time to give patients the treatments they are qualified to deliver.

Q70 **Chair:** With covid money—let us go back to that just as an example of how sometimes it does not always go quite to plan when you are putting money into new staffing roles—roles were created but, by the time they were recruited, the peak was over. Who was ever assessing or what work were you doing, Mr Style, in the Department to assess whether the money invested in those people was actually delivering better outcomes? It is always wonderful, I am sure, for every ward—and every ward matron would want—to have an extra member of staff on the ward, but were you looking at productivity in terms of better pathways for patients, faster pathways for patients or releasing specialist clinical staff to do other things, or what metrics were you using to look at whether the roles you are looking at are actually going to make a difference overall to the waiting times we are looking at today?

Matthew Style: I think I would start by paying tribute to the efforts that the staff, both new and old, across the NHS made—

Chair: Sorry, Mr Style, but we are halfway through a hearing here. I know everyone wants to thank NHS staff, and we do, but we take that as read. We thank everybody, and we all appreciate massively what NHS staff have done, so let us not repeat it with every question, because we do need to get to answers.

The best way we can all support those staff is to help get waiting lists down and make sure they have the resources to do that. How are you, at the Department, going to make sure that the people you are putting in and the money you are putting in is actually going to deliver on a reduction in waiting times? We have heard from Sir Jim some very clearly laid out challenges. How are you going to measure at the Department whether it is actually making a difference?

Matthew Style: As I say, it is those staff, many of whom were recruited over the last year or so, who have done the hard work that has restored activity levels and elective treatment levels back towards pre-pandemic levels, and helped to support that recovery from the earlier waves of covid. Actually, I think that recruitment has had a tremendously positive impact.

It is also why we are investing, as I said, in the technology and the support roles that will help to make best use of the clinical staff—the expanded numbers of clinical staff—that have joined the service, and that is what we are focusing on right now. As I say, we are really clear that it is driving up levels of elective activity that is our priority.

Q71 **Chair:** As Mr Holden has highlighted, we are still going to have a very long backlog in a few years' time, for some of the practical reasons that

Sir Jim outlined.

I will now go into the waiting list issue. It is going to take two or three years, says Sir Jim, to make a material difference because of all the challenges of building and getting staff trained—we all get that there is a challenge there. Sir Jim, you said that the priority was the very long wait list—that is the two-year wait list—and you are now beginning to tackle the one-year wait list. What is priority two?

Sir Jim Mackey: The focus of this year is the two-year waiters, and we will carry that through into next year. We are hoping to get those numbers down.

Chair: We have got that.

Sir Jim Mackey: Then we will move to 78 weeks, and into 52 weeks. Also, through this process we will be making sure that those parts of the NHS that have already got to that point keep moving. We will be agreeing stretching plans and targets with individual systems and providers going into next year, to reduce the overall wait experience. The focus for the next 18 months to two years will be on very long waits—two-year and one-year waits, initially.

Q72 **Chair:** Okay, and what about the people lower down the list. I know that Ms Osamor is going to cover some of this, so we do not want to go too much into primary care now. However, regarding early diagnostics, we have seen the figures about MRI scanners and so on. When you are looking at the longer waits, are you also trying to put effort into getting that pipeline unpacked?

Sir Jim Mackey: We are, absolutely. It is also worth remembering that a very large proportion of the waiting list are patients who will not go near a hospital bed or theatre. Around 80% of the waiting experience ends with outpatients or a diagnostic process. It is right that we build surgical and bed capacity, but we also have an awful lot of work going on to improve outpatient and diagnostic pathways—and to shorten waiting times there. Looking at winter, where we could have some disruption and problems with bed capacity, for obvious reasons, we will continue to focus on those non-admitted and diagnostic pathways and potentially accelerate diagnostic waiting-time improvement where we can.

Professor Stephen Powis: Can I put some flesh on the bones? I think the diagnostic parts of this are really important. As you correctly say, Chair, the quicker we can get people through diagnostics, the quicker we can get through that part of the waiting list and the quicker we can get to their procedures. Sir Jim has mentioned the community diagnostic centre programme. To give you some figures: 55 of those are now operational, with a full complement of 80, including 37 early adopters, anticipated to be running by the end of March next year. We anticipate—obviously omicron might disrupt this—that that will deliver over 1 million more tests by March 2022. This is work that is already underway, and people are already benefitting from it.

Clearly, there is more to do on the diagnostic side, as you quite rightly said. The workforce is really important; it is not just about more people, it is about flexing the skill mix that individual professionals have, which is part of the transformational work. This is one of the things we can learn from other countries—how you flex the workforce. Indeed, what we have done in the pandemic has shown very starkly that the workforce can flex if it needs to.

Q73 **Chair:** The workforce can flex but it has been massively stretched and is exhausted.

Professor Stephen Powis: Yes, I think both are true. We need more, but we also need people to continue to work differently, as we have done as healthcare has evolved—both are true.

Q74 **Chair:** Okay, it is all very well saying that people can work differently, but people have been working differently because it has been forced on them. Many, as we know, are absolutely exhausted. Are you worried that they are going to be saying, "Bend over, here it comes again; another initiative to work efficiently and differently," and therefore not rise to it? I do not mean that in a pejorative way, but will they feel weary about more expectation that it is down to them working flexibly?

Professor Stephen Powis: Clearly, I am concerned that staff are exhausted; we are putting a lot of support, as are individual organisations, into staff wellbeing. That is absolutely critical—particularly if we go through another wave. I think the history of the NHS is that staff have evolved, both in the model of how they work and what they do. What we have seen is that the traditional work that doctors have done in the past has, over time, been taken up by other professional groups. We have seen that in primary care. That is part of the long-term plan.

There has been a big investment in putting more physiotherapists and more pharmacists into primary care, as well as more paramedics. The reason for that is that medicine is a team-based approach these days. A pharmacist can do an awful lot of the work, for instance, on reviewing prescriptions and medications, which would have been done by doctors in the past. That is something that healthcare professionals are well used to. It will evolve further, and we need to assist in that evolution; it is around the transformation of how we work together, in addition to additional staff.

I think that we need more doctors—I have said that—but it is not just about more doctors; it is around evolving that role extension that all professionals have. Professionals actually enjoy it when they can take on additional things and additional skills; it is very fulfilling to be able to do more.

Q75 **Chair:** Okay, but those are all things that take time to deliver, as we have heard, very clearly, from Jim Mackey, and we know from our previous work.

I will just ask this to Amanda Pritchard before I go back to Mr Holden: if it is going to take two to three years to see a material increase in

capacity—therefore beginning to dent this long waiting list—what is your message to patients in the meantime? Have you got the strength of character to be tough on making the medium to long-term decisions that will really make the transformation? This money that you've been given, from the taxpayer, can only be spent once, can't it? We have seen quite often that the NHS can absorb—because of the need and the demand—more and more money.

Amanda Pritchard: Look, I think we all feel a huge amount of sympathy for people who are waiting. I know, just from having talked to people all across the NHS, that that is something people feel really acutely. Of course, many of our NHS staff are themselves patients and are experiencing this from the other side. As you say, we don't need to keep saying how much this matters, but it does, and it is worth saying that again. We are hugely aware of how much this means to people who just want to get on with their lives, and we can help them do that.

What are the things that we need to do? Well, I think that Jim set it out very clearly. Doing the things that we talked about around elective recovery will require us to be really clear eyed about those sets of things that will increase capacity. That is about the physical estate, about the workforce, and about us continuing some of those innovations, which we have just talked about and some of which were done through necessity over the last couple of years—the separation of elective and emergency, the community focus, the hubs and the use of digital will all be crucial. That is where the money is going, so we have a line of sight. On your question about whether we have the strength of character to do it, well, we've got that line of sight and we've made those commitments.

One commitment—to return to the discussion earlier—is absolutely about seeing that supply side increase over the next few years. The uncertainty, as we have said, is around demand. That is the bit that we cannot control for at the moment, but the bits that we can are those areas that we have just talked about.

Chair: I'll leave others to pursue this further. First of all, Mr Richard Holden, MP.

Q76 **Mr Holden:** Thank you. Ms Pritchard, one of the issues that you raised earlier on, and has been raised by other witnesses today—if you look at page 10 of the NAO Report—is around these missing patients who may return. Those are people who have avoided seeking healthcare during the pandemic. There is an estimate that there could be between 250,000 and 750,000 missing urgent GP referrals for suspected cancer issues. Which of those patients—both elective and cancer care—worry you the most? Which areas are they in, and who are they?

Amanda Pritchard: The patients we would always worry about the most are the ones we don't know about. I think that is true of urgent emergency care or elective care. That has been why, right through the pandemic—Steve has talked about this—and right from day one, we have said, "Anyone who has symptoms that they are worried about, we would

really urge them to come forward." Although we all know and understand why people chose to stay away in some cases, the NHS is open for them and we would urge anyone who is concerned to come forward.

The figure that we would recognise—I think we and Macmillan are all in the same place on this—is that about 36,000 fewer patients that you would have expected to have been diagnosed with cancer are currently in our system. We are absolutely focused on the identification of those 36,000. You asked where we are most concerned; looking at the statistics, it looks like more than half of those missing patients are for prostate cancer. Again, it is a particular focus for us to try to say to people, and in particular older men, "If you are worried, come forward. The NHS is absolutely here to treat you."

Another group of those missing patients is for breast cancer; some of that is associated with the disruption to the screening service. We are on track to have fully restored the breast screening service by March of next year. That is another area that—no matter what happens over the next few weeks and months with omicron—we say must be retained.

The third big area is lung cancer, which is the only area where we have seen a significant lag in referrals. We saw a big reduction in referrals in the early part of the pandemic, but we have actually seen cancer and suspected cancer referrals back to well over 100% of pre-pandemic levels over the course of this year. That is just what we would want.

However, referrals for lung cancer are still below pre-pandemic levels. Steve might want to come in on this, but obviously some of the symptoms overlap with covid, such as a long-term, persistent cough. We want to get out the message to people who have those symptoms, as we are doing with the "Help us help you" campaign: "Don't assume it's long covid, don't assume it's covid—seek help." That is where some of the initiatives such as our targeted lung trucks come in. We have 23 of them up and running in the areas with the highest level of presentation and unmet demand, and they are already seeing referrals. We are seeing a much higher conversion of the patients who come through the lung cancer trucks, who are being diagnosed at an early stage—stage 1 or 2. That is really what it's all about and, of course, what the aims in the long-term plan reinforce. The earlier we can get people with symptoms to come forward, the earlier we can make the diagnoses and the better the outcomes.

Q77 **Mr Holden:** That is really helpful, Ms Pritchard. I wanted to ask you about the first cancer you mentioned, which was prostate cancer. Did you say it was half the number you were previously expecting?

Amanda Pritchard: Sorry; about half of those 36,000 patients are for prostate cancer.

Q78 **Mr Holden:** I understand. Obviously, one of the issues we are facing at the moment with covid is the cancelling or pushing back of routine GP services. Would these cancers—particularly prostate, breast and lung—normally be picked up among older age groups in those GP

appointments?

Amanda Pritchard: Breast cancer is most associated with screening. Lung cancer is slightly different—it is more about getting people to think, "Could this be something more serious?", rather than just assuming it's covid. Steve might want to come in on this, but prostate cancer is certainly one of the reasons that, when we have given guidance—I know we are about to confirm this, with support from the RCGP and BMA—we have said very clearly that in prioritising activity to support vaccination, urgent care and suspected cancer must also absolutely be prioritised. That has remained a consistent message throughout the whole pandemic. We have reinforced that recently as well. Steve might want to say a bit more about that.

Professor Stephen Powis: Amanda is exactly right. We have not asked GPs to step down referrals for suspected cancer. That is a very important part of what they do, and they should continue doing it for the reasons Amanda has said.

Q79 **Mr Holden:** Quite. I don't think anybody was thinking that they should step down referring people; the issue is if people are not going in to see their GPs. I can imagine the scenario, particularly with prostate cancer, as Ms Pritchard referred to, where that might be the sort of conversation a gentleman in his 60s or 70s would have with his GP, and probably nobody else. If you do not have those routine appointments, you are going to have an issue.

Professor Stephen Powis: Yes, but with a lot of the symptoms—for prostate cancer, that may be blood in the urine or a urinary infection; for breast cancer, it could be somebody detecting a lump—if GPs are contacted by people with those symptoms, they should obviously see them. They should see them as a matter of urgency, as they would do normally.

Q80 **Mr Holden:** Well, quite. The issue I was raising is that these are perhaps the things that people will speak to GPs about in those routine appointments. Ms Pritchard, would you have expected to pick up a lot of these things in those routine appointments, or is this the sort of stuff where people refer themselves in?

Amanda Pritchard: That is a really good question. We are really thoughtful about this; one of the things we have been most focused on is trying to encourage an uptick in query cancer referrals across the whole system.

Sadly, the truth is that a lot of these referrals do not come through the GP route; actually, sometimes, too many people present in A&E—they present through the urgent emergency care pathway—hence the focus on really trying to get upstream.

Certainly, as Steve says, many of the people will have pretty obvious red-flag symptoms and will come through that route, but the purpose of the "Help us help you" campaign we have been running throughout the

pandemic has been to try to make sure that people are also aware of some of the less obvious symptoms. It is difficult to answer your question by saying how many routine appointments we would expect to pick up certain types of cancer, but the best safeguard for us all collectively is to try to make sure that the public are as informed as possible about what some of those worrying symptoms—

Q81 **Mr Holden:** I can understand that. Are you doing any targeted advertising? I am thinking of places such as my constituency of North West Durham, where there are obviously more issues around lung cancer and things like that. Are you doing that targeted advertising on cancer?

Amanda Pritchard: Yes, absolutely. We have a series of campaigns that we are continuing to run on that.

Q82 **Mr Holden:** Fantastic. Sir Chris, moving to cancer services more broadly—obviously, this is something that the NHS, and the UK across the piece, have been a bit mid-table on, given our levels of spending—to what extent do you think we can prioritise cancer services so that activity remains as high as possible? It is one of those things that people will be massively concerned about across the country.

Sir Chris Wormald: The basic answer to your question is yes. Central to the long-term plan was improving our cancer outcomes, and that ought to remain our objective, for all the reasons that Amanda and Professor Powis have set out.

Q83 **Mr Holden:** Ms Pritchard, you mentioned breast cancer screening. Obviously, that will be of major concern to a lot of people. When is the screening programme going to be back up and running in full? Is it going to be affected by this latest coronavirus—

Amanda Pritchard: As I said, it is on track to be fully restored—fully recovered—by March 2022. We have been very clear, as we were in the big second wave that we saw this time last year, that cancer screening services must be protected. Our other cancer screening services are already fully restored; breast cancer will be within the next few months, and that will remain a priority.

Q84 **Mr Holden:** Sir Jim, obviously there is potentially a backlog here in diagnosis. Is this something that you are looking at, or will it be picked up through a speeded-up screening process?

Sir Jim Mackey: It is a combination. We will pick it up in our work, the cancer team will pick it up in theirs, and it will also be picked up through the screening programme. It will get an awful lot of attention from lots of different directions.

Q85 **Mr Holden:** That is good to hear; it seems like this is something you are all very aware of across the board.

Sir Chris, let me return to something that the Chair was asking you about a little earlier about independent provision in the NHS during the pandemic. With £2.1 billion-worth of spend, did we get bang for our buck

from the independent providers during that period?

Sir Chris Wormald: I do not think that was a conversation with me; I think that was with Amanda.

Chair: It was Sir Jim.

Sir Chris Wormald: Oh, was it Jim?

Sir Jim Mackey: I was not around, to be fair, at that point—

Mr Holden: Okay, well don't answer. We will leave it with Sir Chris, in that case.

Sir Chris Wormald: This was an NHS contract, so it does have to be answered from the NHS side, I am afraid.

Chair: Everyone wants to pass this one around. I think it is with you, then, Ms Pritchard.

Amanda Pritchard: I think Jim referred to this slightly earlier, but the independent sector has played a different role at different parts of the pandemic. It is playing a crucial role now in—

Chair: It is about value for money. That is the bit that Richard Holden—

Q86 **Mr Holden:** I am not interested in its current role or its future role; I am interested in the role it played during the pandemic—the £2.1 billion.

Amanda Pritchard: Looking back, the role that it played at the beginning of the pandemic was different. What that allowed us to do was take the whole of the independent sector facilities—obviously it was not the whole sector; I think only 27 providers were part of the deal—and turn that over. The figure of 3.3 million patients treated is something that we absolutely recognise, and of course they are 3.3 million patients who potentially would not have been treated otherwise or who would have displaced other activity elsewhere.

That does not tell the whole story, however, because in many cases, it was the physical facility that was of value and the NHS was able to move whole services into some of those physical facilities to continue to provide them in a different way. In other places, it was independent sector staff who came over and supported the NHS by doing work within their own facilities. It is quite a complicated picture for us to really disaggregate what that whole contract bought, but it was certainly an invaluable support to the NHS in particular over that first phase of the pandemic.

Q87 **Mr Holden:** Yes, quite, but I think that we actually need to disaggregate it—we spent an extra £2.1 billion on that stuff. Before the pandemic, we were treating 110,000 elective care patients a month in the private sector via NHS money, which dropped to 20,000 in May before slightly recovering. We took a huge chunk out of the capacity there, so what did we do with that capacity?

Amanda Pritchard: As I said, it was used in a variety of different ways. Some of that was about using the staff, some of it was about using the facilities and, in some cases, it was about using the kit. You probably remember that there was a point when we were using ventilators across the NHS—

Mr Holden: I think we do remember that.

Chair: We did a whole session on that, so we do not need to go into it.

Amanda Pritchard: It made a very big contribution to that. Part of what the independent sector also started to do, of course, was to look at different types of activity—for example, in some cases, the ability to put that much more complex cancer work through the independent sector, which you would not normally do. That is one of the things that, certainly in London, they did quite a lot during the second wave in particular. That was an invaluable way of protecting the really high priority work.

Obviously, you would expect to do less of that high acuity work than you would perhaps some of the other traditional elective work that the independent sector did. Indeed, of course, the independent sector played an invaluable role in continuing to do a lot of the diagnostic work, which as we have just said, is critical if you are then going to be able to assess risk and make sure that you have made a good clinical judgment on the next steps.

Matthew Style: I would just add that the NAO's own Report makes it clear, on page 33, that some of those figures are not comparable over time for exactly the reasons that Amanda said.

Q88 **Mr Holden:** We are fully aware that they are not comparable because of the pandemic. What concerns people, and what concerns us on the Public Accounts Committee, is that £2.1 billion of public money was funnelled over to the private sector. Many of those doctors and nurses, especially on the doctor side, will also be NHS staff for part of their time. Is there any chance that some of that money was essentially double-dipped, Ms Pritchard?

Amanda Pritchard: I understand your question, but I wonder whether Matt Style might be best placed to answer, partly because he was in the finance team at NHS England.

Mr Holden: Go on then, Mr Style. Give it a go.

Matthew Style: I think there are very extensive and independent audit arrangements that underpin and support the contract to which you refer. Indeed, those reconciliations are still ongoing such is the thoroughness with which they are being conducted.

Q89 **Mr Holden:** Ms Pritchard, it sounds like you might not do exactly the same thing as you did last time with the independent sector, as you were paying for an insurance policy that you were not really using to the full extent that you should have been. Is that fair enough?

Amanda Pritchard: It is definitely right that we have learned through the pandemic. There are lots of things that we did in the first wave that we have amended and adapted as we have gone through. Now, I think, we are very clear that the way that Jim set out the role of the independent sector in our elective recovery and going forward is certainly the right shape for the time being and for the future.

There is more we could do, particularly around thinking about some of those cancer pathways and the ability to do more through the independent sector to protect that urgent work. There is probably also more that we could do with the independent sector around longer-term plans so that we really make sure that we are not just operating in that short-term timeframe again. I know Jim talked about that in terms of needing to take a more medium-term approach to recovery. We are in a position where we can say for certain that the independent sector continues to play an invaluable role in supporting both—

Q90 **Mr Holden:** Nobody doubts that. You have a massive task on your hands, particularly on the elective side with what Sir Jim's work is seeing.

One quick question from me that refers a little bit back to those concerns around cancer diagnosis that I mentioned, especially in parts of the country like mine where there are some of these issues. Figure 16 on page 29 of the NAO Report shows the 62-day pathway from urgent GP referral to first treatment. There are staggering differences in parts of the country. In Kent and Cornwall, it is low at between 19% and 27%, but almost triple that in other parts of the country. Sir Chris, why are waiting times for elective and cancer care varying so much across England at the moment?

Sir Chris Wormald: Again, I will pass that to Amanda.

Amanda Pritchard: Variation has always been a feature of the NHS because of different levels of demand, workforce, estate—we all understand that—but the pandemic of course hit differentially. We know that some parts, as you know yourself—the north-east, the north-west, the midlands—have been hard hit by the pandemic, and we have got therefore a different kind of position now from what we have in other parts of the country, where they have had a different experience over the last two years.

But there is no doubt that what we are also seeing does reflect some of the conversations that we have already had. It reflects where we have diagnostic capacity and where it is more stretched. It reflects where we have got a skilled workforce and where it is more stretched. It reflects where we have a high level of demand—legitimate demand and need—and where it looks different.

Part of the task—in a sense, this is very much why it dovetails so importantly with the elective recovery programme—is to get systems to work together in ICSs and in regions so that, rather than end up in a situation where you can have that kind of variation even around an

individual organisation or individual hospital, people are working together in exactly the way—

Q91 **Mr Holden:** I understand that. I have just one question to follow up on that with you, Sir Jim. It is about my local area and the primary care networks in County Durham. They are very concerned that they are going to be thrown in with both Sunderland and South Tyneside, when they work quite well together at the moment, contiguously, with the local authority at a local level. As we move towards those big integrated care systems, is this something that you are looking at? As we try and catch up on primary care, I do not want to see structural changes impacting on local delivery and catch-up, which is obviously what we all want to see across the country. Would you, for me, take away this conversation and perhaps have another look at whether the current structures, particularly in primary care in County Durham, are something that you would have a quick look at to see if it can be done in a different way?

Sir Jim Mackey: Yes. Okay.

Chair: Sir Jim knows the area very well. A good try, Mr Holden, to get your local issues in, but we need to move on. We have important people from the NHS who need to get back to their desks to help tackle omicron. I call James Wild.

Q92 **James Wild:** I will hopefully be relatively brief. Sir Jim, will part of the recovery plan be to address the disparity that Mr Holden has highlighted? In my area, Norfolk and Waveney, 12,000 people have been waiting over a year for treatment—10 times the number in south-west London.

Sir Jim Mackey: Yes. There is a bit of this happening already where we are trying to help people in localities, but also across regions where necessary. We will absolutely be looking at how we try and help the whole country recover at a similar pace, recognising that we are all starting from different positions.

Q93 **James Wild:** How detailed should my constituents expect outcomes to be when it comes to getting that number of 12,000 down to a much lower, more acceptable figure?

Sir Jim Mackey: Everybody's got the same expectations to try to reduce the two-year waiters by the end of year, if we can, but certainly into next year. However, it is very clear that some parts of the country will struggle to do that, so we are working on mechanisms to see how we can build additional capacity, modify and change the systems, and help each other out across the country where necessary. That means sometimes moving clinical teams or patients between regions. We will do that, and it is also happening currently to try to reduce the long waits.

Q94 **James Wild:** Thank you. Going back to Sir Chris, you rightly passed us on to Ms Pritchard for the operational delivery, but how are you holding the NHS to account to ensure that very low levels of treatment within the timeframes in certain areas, including mine, as shown in figures 11 and 16, are not the case in the coming years?

Sir Chris Wormald: Earlier, I set out the accountability system on the levels at which we set targets. How that turns into practical action is that we talk to the NHS about it every single week—about what is being achieved and what the priorities are. Of course, the crucial thing is the absolute transparency of the data, as the NAO has shown here; that is frequently the most powerful thing.

Specifically on electives, as Jim develops his plan in consultation with the Department, we expect to get to a set of metrics, and we expect the NHS to report against those metrics. I want to emphasise that the process of asking the NHS questions about those things does not in itself improve anything. The key bit is the capacity building and the transformation that Jim and Amanda mentioned. We will scrutinise the outcomes, but the actual practical work of what makes things better is those pieces of activity.

Q95 **James Wild:** Yes, but if you are one of my constituents and you have been waiting over a year for treatment, I want the Department of Health to be holding the NHS to account to deliver against the targets that have been set.

Sir Chris Wormald: That is done in exactly the way that I have just described. As I say, there is what the Department does and its discussions with the NHS, and then there is the transparency of data. Those are the two crucial elements of the accountability system.

Q96 **James Wild:** I would encourage you and Ministers to be as activist as possible to ensure that this money is spent and that we get the reductions that everyone wants to see.

Sir Chris Wormald: Absolutely. The point that I am making is that the conversation that we have at the NHS is more often about that practical bit of, "How is that transformation happening? How is the capacity being built?", as Jim was describing. That should then lead to the improved outcomes. We, of course, have the conversations about outcomes, but what we really want and what the NHS wants is to get those things right, because those are the lead indicators that things will get better.

James Wild: Thank you.

Chair: Last but certainly not least, over to Kate Osamor.

Q97 **Kate Osamor:** My questions will look to the future and how the NHS can recover its elective and cancer care performance. The Committee is keen to know more about the real, material constraints that the NHS will face in recovering and improving its performance over the next few years.

I am sure that all of us will know how frustrated people are with the already high levels of delays, with people waiting for many years to access healthcare services. It is crucial that we are realistic about the challenges that we face.

Earlier, my colleagues asked you about the extra £8 billion that goes across electives and cancer care. Some organisations have suggested

that greater funding will be required to clear the known backlog, treat missing patients, and return the NHS performance on elective care to the 18-week standard. For example, the Health Foundation estimated that almost £17 billion will be needed to achieve these aims. Sir Jim, do you think you need more money?

Sir Jim Mackey: There is never enough money. As the Chair pointed out earlier, the NHS is an enormous sponge, so whatever we get we are going to soak it up. It is our job to get the best value for that so, with Amanda and colleagues, I really want to massively reduce the backlog with the money that we have and make a very strong case that we continue to build capacity for the NHS because we can deliver fantastic value for money. Whether it is enough, time will tell, but I doubt that anybody in NHS history has ever said, "It's enough money." We can always use more money.

Q98 **Kate Osamor:** Amanda, do you think the £8 billion is enough to clear the backlog?

Amanda Pritchard: This goes back to the conversation we were having earlier. We are absolutely clear about two things: we are clear about what we now need to do to increase supply—we talked about that 9 million figure earlier—and, on Jim's point, we are really clear that we absolutely need to do that in a way that demonstrates value for money, because this is public money we are talking about.

I know we have rehearsed this a few times, but I think the bit we are still unclear about is what will happen on the demand side. Whether it is enough will be so dependent on what actually happens with demand and, in particular, the impact of covid, as we have discussed. That is why I would be hesitant to give you a yes-or-no answer at this point, but we know what it buys and that is what we are really focusing on.

Q99 **Kate Osamor:** Sir Chris, how do you intend to return to meeting your legally required elective care performance standards?

Sir Chris Wormald: Well, that is the process that we have been describing, and Jim's work. To emphasise what Amanda said, there are, of course, two components to this: the increase in supply, in respect of which we can be reasonably firm about what public money will buy, and therefore what is expected of the NHS and what they have promised to deliver; and then there is huge uncertainty on the demand side. What percentage you get in any particular month is the interaction of those things.

Our focus is to ensure that those bits that we control—the increase in the capacity and the supply that we have been discussing in this hearing—ramp up in such a way that, as Mr Holden described, the taxpayer or a constituent would think, "Yes, my money has been well spent." How that turns into the target is, as I say, very dependent on those demand uncertainties. We will be focusing on that: are we hitting those capacity increases that my colleagues have described?

Q100 **Kate Osamor:** Are performance standards still meaningful?

Sir Chris Wormald: Yes, they are very meaningful because, of course, they speak to the patient. It is completely crucial to be absolutely clear about and measure how what we do turns into what the patient experiences from the NHS.

I should make it clear—because we have talked about both in this hearing—that the absolutely key thing is the waiting time, not the waiting list. What an individual cares about is not whether they are on a list of 6 million people or 4 million people or whatever, but whether they are getting the treatment they need in a timely and responsible manner. That is why some of the things that Jim was talking about—focusing on the long waiters within the waiting list—are so particularly important.

Q101 **Kate Osamor:** Thank you. I want to go back slightly to those patients who are still waiting. As the Report says, "there were between 240,000 and 740,000 'missing' urgent GP referrals for suspected cancer" between March 2020 and September 2021—we all have the figures—compared with what would have been seen as normal over the same period.

Matthew, how are you going to monitor the performance of the NHS in the coming years to find those missing patients? Amanda spoke to my colleague earlier about the work that will take place to find patients, whether with prostate cancer or breast cancer, and so on. Matthew, we did not actually go to you to ask how you, in your role, will be monitoring the performance of the NHS in the coming years, and what tools you have to hold it to account. Do you need new tools to be able to monitor the patients who are still waiting?

Matthew Style: We work closely with NHS colleagues on precisely the initiatives that Amanda described, ensuring that we are reaching out, in a very targeted way, to the communities where people will have perhaps not come forward with problematic symptoms and also the population groups and so on. First, we worked very closely together on initiatives to tackle this problem. That is very important joint work. Again, with the NHS we will, as part of the elective recovery programme, be monitoring the rates at which we see those referrals continue to pick up, as well as the progress in delivering both diagnostic interventions and treatment interventions once those referrals have come forward. As Amanda said, we now have very good data in place to enable us to get a good handle on what the NHS is delivering in what are very difficult circumstances.

Ultimately, what is most important here is the progress we make on the measures set out in the long-term plan, not just in terms of early diagnosis but five-year survival rates and so on. That, at the end of the day, is what it is all about and clearly the Government are completely committed to those goals.

Q102 **Kate Osamor:** I now want to move on to GPs. GPs are crucial to part of that pathway, making 60% of referrals to elective care waiting lists as of March 2019, yet they are at risk of being overloaded and creating a bottleneck in the system, potentially meaning further missing referrals.

How are you supporting GPs in dealing with the additional pressures they are facing as a result of the backlogs? That question to Ms Pritchard and Jim.

Amanda Pritchard: This might be one that Steve wants to come in on as well. I know I will be told off for saying this, but primary care really does need to take credit for being absolutely at the heart of the vaccination programme. We were talking earlier about what the—

Kate Osamor: I am not referring to the vaccination programme.

Amanda Pritchard: I know, but I would just say that the world wants to learn how we have done the vaccination programme, so that is just one to put down on how we have done something across the whole NHS so swiftly, as they want to know how we have rolled out things like dexamethasone and so on. Because primary care has taken the lion's share load of the vaccination programme all the way through, that has of course been, in the main, on top of the other things it has done. That is why now, although it was, of course, putting so much effort into restoration and we put in the extra £250 million to support the winter access fund, as well as specific support to take away various burdens and put in support for things like telephony and so on, all of which is the first time we have ever done that for primary care over winter—despite all of that, the new challenge on vaccination clearly presents a game-changer for what we are now asking of primary care. That is what then comes behind the decision we have made in response to the Prime Minister's challenge, with the support of the RCOG and the BMA, to give some guidance on how primary care can flex to be able to step up to that new challenge, but do so in a way that safeguards the most urgent cases, cancer being one of the most important.

Matthew Style: To add to what Amanda said, we are also investing significantly to ensure that clinicians in general practice can access prompt specialist advice when they need to, to help them support their patients in the quickest, most effective way without necessarily having to refer to secondary care, and also to ensure that they can get the support they need to help and support their patients while they are waiting. That is actually a big focus of the overall elective recovery programme as well—that better communication with both patients and clinicians in primary care, who will often be the people to whom patients will reach out first and foremost for support.

Q103 **Kate Osamor:** I want to plug my own area—as we all seem to be doing that today. In my region of north London, 35% of elective care patients have been waiting for 18 weeks or more, and 6% have been waiting for more than a year. That latter group total more than 8,000 people. What are you doing to support those people with the longest waits? I also want to focus a little on low clinical priority. That group seems to be pushed to the side slightly, but there are people who come into that group who might need pain management, such as epidural injections. As we can all imagine, if you are in pain you might not be able to move around, go to work or look after yourself or your family. If you answer all that in one

go, it would be really appreciated.

Professor Stephen Powis: You are absolutely right: as well as getting on top of the elective backlog, we need to focus on supporting those patients who are part of that waiting list. Various programmes are under way to support patients. I can point to the Best MSK Health Collaborative, which is working in orthopaedics—hips, knees and similar conditions—to do a variety of things, including removing unwanted variation, as we talked about earlier, but really to support patients as well.

Obviously, general practice has a role in that, but we acknowledge that we are asking general practice to do a lot at the moment. As part of the validation exercise on waiting lists, we have been asking secondary care clinicians to ensure that patients are informed of where they are on waiting lists. There is a variety of ways into this by different groups of professionals, but I absolutely acknowledge that what patients want to know, when they are on a waiting list, is a likely time—that is, how long their wait is likely to be—and if they need additional support because their pain worsening, that they can get that support.

Sir Jim Mackey: May I come in now? We have been trying to get the NHS to review regularly patients who have been waiting a long time and to have conversations with those patients. That also allows, or encourages clinical teams to review constantly the clinical prioritisation. The prioritisation changes over time, depending on what is going on in the patients' lives, what their conditions are and so on. That is happening around the country. It is obviously variable and it is not working as systematically as we would like it to yet, given other pressures, but we will build capacity to do that.

Also, there are technologies in place in the NHS that we will want to scale up. They give patients the ability to interact with clinical teams, have conversations, order follow-up appointments or maybe even change provider, if necessary, over time. That is in place—there are about six or seven systems in place in the NHS around the country. A key part of the plan will be enabling that all across the country, so that everyone can do that. Key is clinical teams with patients—constantly reviewing, having conversations with patients, and trying to make them aware of where they are in the queue and what is going to happen next. We realise that this is a big weakness, but some parts of the country are accelerating and making improvements to that.

Q104 **Kate Osamor:** Thank you, Sir Jim. I wanted to ask you another question. I am interested to know how a patient or a GP knows that a patient is urgent without taking up the time of the GP or any practitioner. How do you encourage patients to understand when they should approach the GP or not?

Sir Jim Mackey: That is a really good question. One of the things we do worry about is patients who are less assertive, maybe less confident, less able to have those kinds of conversations and pushing themselves forward as a priority. On Amanda's point and when we are talking about

inequalities, that is the thing that we worry about most. A huge amount of effort is going on all over the country within organisations and systems to understand the local population and how we give everyone the best chance.

In reality, it really rests on that first conversation with the GP, on having an open and honest conversation about what might be going on, what might happen next, clinical urgency—whether it is something to worry about. We all know that sometimes what is said is not always interpreted in the way that was intended, so again, there are approaches around the country to try to standardise that.

I am aware of a GP here who, 20 years ago, used to give his patients a list of questions to ask in outpatients. He would often attend outpatients with the patient to be their advocate. Now, with the technology we have, we should be able to scale those sorts of things up and improve the interaction, so that we can give everybody the best chance of understanding where they are, how urgent it is and what could happen next.

We will build the technology to do that. When we build it, we have got to make sure that it covers people who cannot use the technology or do not have access to it. That will be very much reliant on personal support, telephone contact and contact centres—those sorts of things.

Q105 **Kate Osamor:** Sir Chris, what are the most difficult challenges ahead, and what are the real-world consequences of not addressing them sufficiently?

Sir Chris Wormald: I think this hearing has identified all of them. Jim set them out very clearly in terms of the capacity we need to build. We have the dual challenge of getting as much out of the current system as we can, in the way that my colleagues have described, while building the capacity, which, as Jim said, takes two to three years to deliver—even more in the longer term. We have to do those two things simultaneously and at the same time as continuing to fight covid. That is the huge risk here. It is an enormous agenda, but it is completely essential, for the reasons we have set out here.

The risks are exactly as people have said. I am not a clinician, but from everything I have seen, the risks around cancer and the effect on cancer services should be at the top of everyone's mind. There are other conditions that would be in a similar category. It is those conditions that we ought to worry about most. You made a point about people living in long-term pain. There may not be an immediate risk, as with some of the patients Amanda was describing earlier, but that is a crucial question for us as well.

Q106 **Chair:** Thank you, Ms Osamor. On the point about cancer care standards, it is worth highlighting what figure 13 starkly lays out in graphic form: it was not exactly perfect before the pandemic. We will not go into the detail of every graph at this stage of the session, but we all need to

recognise that it was not going in the right direction before covid hit. While we are interested in hearing the impact of covid, we are also concerned to make sure that this long-term plan is actually delivered.

It seems, Ms Pritchard and Sir Jim, that you are planning on quite an optimistic reading of future demand. Is it realistic, do you think? How much capacity are you building in? There has been some discussion with you and the NAO about the missing patients, but whatever estimate you take is going to be a range. Do you think you are being realistic, Sir Jim?

Sir Jim Mackey: I will always be optimistic on these things. I think we are trying to convey that none of us want to have the waiting time experience and the performance that we have got now. It is very complicated, and we are going to throw absolutely everything at it. There are a lot of uncertainties in it all, but we do not want to talk ourselves out of improvement. There is lots of risk. We cannot really quantify the missing patients and the rate at which they will return. We are really not trying to give an over-optimistic or delusional view, but we are trying to say that we will absolutely throw ourselves at this. The NHS will do its absolute best and recover as quickly as humanly possible.

Q107 **Chair:** Will that be a sustained recovery? You have talked a good talk today about trying to make change, longer term, but it is going to be two or three years until we see a shift. How quickly do you think that could be maintained, so that we actually see waiting lists drop?

Sir Jim Mackey: If the demand thing is at the better end of the spectrum and we do not have disruptions like those we are going to potentially have in the next few weeks, the NHS will get a really good run at it. I am really confident that we will ramp up activity, but we will also fundamentally improve and change some of our systems. That separation is important. The massive increase in diagnostic capacity and our ability to engage and interact with patients are all in train, and I think they will give us a massive chance of really getting on top of things.

Q108 **Chair:** Okay, so we want to get on top of things. We have had the pandemic, which has been an extraordinary shock, but every winter we have a winter crisis. Every winter, we have high rates of flu. There is always something that the NHS can stumble over, because that is partly the nature of the business. Do you think you are building in enough resilience to cope with those regular, expected shocks as well as some of the known unknowns?

Sir Jim Mackey: As I said earlier, running parallel with elective recovery, our planning process will start a process of building resilience into the urgent care system, primary care, mental health and so on, so it is very important that we do not look at this as one thing. The NHS performs a very wide range of functions. One of the biggest risks for us as we try to build an elective care system is that, every winter, it gets disrupted for two or three months. That is absolutely what we are trying to avoid, and we will work very hard in this planning process and build capacity in both parts of the system to avoid that.

Q109 **Chair:** That is all good talk, and you have had a track record before in NHS Improvement of talking honestly about the challenges, which we appreciate. How long are you going to stay in this role, Sir Jim? You have two jobs at the moment. You always seem to have more than one. Everyone has two jobs—not just MPs.

Sir Jim Mackey: I am a public servant and a servant of the NHS, and I will continue as long as I am useful and helpful.

Q110 **Chair:** There you go, Ms Pritchard. You have a promise there, I think. Ms Pritchard, it has been a challenge. You have walked into a job in the middle of a pandemic. It has no doubt been very difficult, but the slight fear of this session, the work that the NAO has done and the work that you know is happening is that there is a danger that you are working to do the best you can do, even though you know that, really, it is not good enough. Is that a harsh judgment on what will actually be the outturn of all these measures to reduce elective and cancer waiting times?

Amanda Pritchard: I share Jim's natural optimism but, again, it is tinged with the realism of where we are today. Right now, we are about vaccination. We are trying to boost the nation in the next three weeks.

Q111 **Chair:** That is my point, partly. We know that, but we are here today specifically to focus on the long-term need. The danger is that you do the best you can but you know that, in the long term, that is not going to deliver the outcome. Is that good enough? Is that where you want to be as chief exec of NHS England?

Amanda Pritchard: That is not where we are, and it is certainly not where I am. We can paint a picture of where we can be over the next two or three years, and Jim has absolutely nailed some of the things that we are doing, that we are planning to do and that were in the long-term plan. We have done some of the things faster in the pandemic, and we have discovered new innovations that we are now building on, which is great. Some of the things are worse—much worse. We have far more people waiting. We have a workforce that has been through a really difficult time over the last two years, and it would be naive not to recognise that and the reality of where we are. We are facing a potentially big wave coming.

Do I believe that, given time and the sort of support that we have had so far from the nation on this, we can do things that are about dealing with the immediate pressures but can also make the sorts of transformational changes that we need in order to do this in a more resilient way? I do, but it will require some things. It will require a workforce, and we have talked about that today. It will require the right estate and capital support. It will require the digital transformation, and it will require social care to have the same kind of reform and transformation. We cannot do it on our own.

Q112 **Chair:** You are new to this Committee, but your predecessor was a frequent flyer. He would also refer to social care, and I once said to him, "Didn't you just use that as your 'get out of jail free' card?" When things cannot work in the NHS, it is always possible and realistic—partly—to say there is an element of social care in this. You have both used the word

"optimistic". We love optimists on this Committee, but we really prefer realists. There is always an excuse about problems today that can prevent the long-term change that the NHS needs to deliver, and not just on pandemic backlogs. As the Report highlights, these are long-standing, systemic backlogs. We are slipping backwards in this country. Under your watch, Ms Pritchard, can you tell us that you really will have that plan and deliver, so that patients are not waiting a year or two years for their treatment?

Amanda Pritchard: You were right to say it is not just about plans. But I would say we have a long-term plan, and no one has lost sight of that. We are about to publish an elective recovery plan. To Jim's point, I think we might be the first country in the world to do that. We have also just published a winter plan, talking about some of the things we are going to do to try to build resilience over winter. It is not about passing the buck at all on social care, but it is about recognising that we need to do this in an integrated way, and that that really matters.

Q113 **Chair:** In your new elective plan you will presumably have milestones that will be the proof of what you are putting in, in terms of buildings, staff, training and resources. You will have the metrics about what you input and, crucially, what the outputs will be. Will that be part of that plan?

Amanda Pritchard: With the caveat that we have made all the way through this hearing, which is where we can control some of the supply side. That ability to control the demand side is not the same. Therefore, our ability to be clear about outputs we can do in some ways, absolutely, and Jim has set out some of those. We will have to recognise that we are still operating with a high level of uncertainty about what that demand will look like. Certainly, that is the intention of putting a plan in place—to give greater clarity to some of the things that we have discussed today.

Q114 **Chair:** One could say, "'Twas ever thus," from the inception of the NHS: the supply side was always going to go up. Hence, Sir Jim's 4% increase effectively in demand, which is reflected in the money. We will have you back again and challenge you on these plans, on the elective recovery plan particularly, because we are absolutely committed, of course, to looking at the costs of the pandemic. One of the biggest costs of the pandemic is to patients, as Ms Osamor very graphically highlighted, who are suffering as a result.

Finally, while we have been meeting I have been informed that we have had the highest number of daily cases of coronavirus since the beginning of the pandemic. I believe it has hit 78,610. That's today's figure. Ms Pritchard, would you like a final word about what you think that will mean for the NHS this winter, and any requests you have of the British public to help protect our NHS, while also ensuring that they get the healthcare that they need?

Amanda Pritchard: Thank you. That is a stark reminder of why the current national mission to get covid vaccination is the right one. My final word would be to say thank you to all those amazing people who are already working on the booster programme within the NHS, within our

volunteer group, the public who have come forward, but please keep doing it, because we need all the help we can collectively get to ensure that we achieve that national mission, and do our best to protect the health of the nation once again.

Q115 **Chair:** Does that figure worry you for what we have been talking about today, and the capacity of the NHS to cope this winter?

Amanda Pritchard: I think that figure should worry all of us. That's why the booster programme is so important. It is also why we have already taken the steps we have to prepare for what was still, and still is, a potential wave of hospitalisation over the winter It is also why this conversation has been really timely, in recognising some of the uncertainties around the elective recovery programme. But we will do again what we did last time. We will make very clear—we already have—the importance of maintaining as much elective work as possible, focusing on those high clinical priorities, those longest-wait patients.

In the first wave, as Steve has already said, we said we were going to stop. We saw only 40% of elective work continue through that first phase, and that was just the urgent work. Last time, we said, "Don't stop; do as much as you can." We saw 70% of our elective work maintained, despite that extraordinary peak through January. We will be seeking to do the same again. I guess the assurance we can give the Committee is that the NHS will once again pull out all the stops, because like you, nobody I speak to in the NHS thinks this is anything other than a really important priority.

Q116 **Chair:** Perhaps rather meanly, because I feel you have got a challenge ahead and we recognise you have all got to work very hard, I have just been tipped off that you were actually not the first country in the world to have a covid recovery plan. Sorry, Sir Jim—Scotland has apparently beaten you to it.

Sir Jim Mackey: Scotland, yes.

Chair: Sir Jim knew that.

Sir Jim Mackey: I knew that. I still count them as part of Great Britain.

Chair: You are very lucky that our Scottish National party colleague isn't here. We could have a long argument about that. As a Geordie, you are probably used to having arguments about who's who in the UK. Thank you very much for your time. I called you a Geordie, but you are probably the wrong side of the river.

Sir Jim Mackey: No, I am.

Chair: My husband would never forgive me. I'm probably going to go home to an argument now about that. I thank you very much indeed for your time. The transcript of the session will be up on the website, we hope, in the next few days. Our good colleagues at *Hansard* are still beavering away, even though Parliament goes into recess tomorrow.

We will produce a report on this in January or early February. We wish you, all NHS staff, volunteers and everybody who is working in the national effort to manage this latest covid-19 outbreak, all the very best. Our thoughts are with them, but we will continue to hold you to account for spending the money of our taxpayers, patients and citizens, to ensure that they get the best service and the best value for money. Thank you very much.