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Health and Social Care Committee

Delivering core NHS and care services during the pandemic and beyond

Second Report of Session 2019–21

Report, together with formal minutes relating to the report

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Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

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Committee staff

The current staff of the Committee are Dr Charlie Bell (Clinical Fellow), Matt Case (Committee Specialist), Dr Jasmine Chingono (Clinical Fellow), Laura Daniels (Senior Committee Specialist), James Davies (Clerk), Gina Degtyareva (Media Officer), Previn Desai (Second Clerk), Sandy Gill (Committee Operations Assistant), Bethan Harding (Trainee Assistant Clerk), James McQuade (Committee Operations Manager), Rebecca Owen-Evans (Committee Specialist) and Kandirose Payne-Messias (Committee Support Assistant) and Anne Peacock (Senior Media Officer).

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Summary

The coronavirus pandemic has presented an unprecedented and considerable challenge to the delivery of core NHS and care services. Alongside the British public, the Committee is hugely grateful to all NHS and care staff who have courageously and dutifully continued to meet the needs of patients in these exceptional circumstances. In particular, we remember with humility the frontline health and care workers who have lost their lives to coronavirus and their bereaved families who have paid a price no words can fully do justice to. Less often thanked, but none the less deserving of gratitude, are the efforts of civil servants and officials at the Department of Health and Social Care, NHS England and Improvement and Public Health England for doing their very best to ensure clinical care continued as best it could in such a challenging situation.

Throughout our inquiry, we have investigated a range of important issues relating to the delivery of core NHS and care services during the pandemic. We have sought to address the challenges raised in written and oral evidence from perspectives of NHS and care staff, patients and the healthcare system. This report addresses the following issues:

- communication with patients;
- managing waiting times and the backlog of appointments;
- issues facing NHS and care staff relating to access to Personal Protective Equipment (PPE) and routine testing of staff;
- issues facing NHS and care staff relating to workforce "burnout"; and
- what lessons can be learnt from the pandemic in order to support the NHS in the future.

In Chapter 2, we assess the Government's and NHS England & Improvement's communication strategy with patients. We heard from NHS users, such as Rob Martinez and Daloni Carlisle, who said that their experiences of poor communication about their medical appointments had left them "in limbo". We recommend, as a matter of urgency, that the Government and NHS England and Improvement (NHSE/I) review their and NHS Trusts' communication strategies with patients.

We assess what impact the pandemic has had on demand for NHS services in Chapter 3. During the pandemic, while the NHS prioritised urgent COVID-related care, there has been a substantial increase in the number of missed, delayed and cancelled appointments across critical non-COVID services. This has resulted in an increase in waiting times and the backlog of appointments which has placed further pressure on the NHS. We ask the Government and NHSE/I to clarify what they are doing to identify and manage this demand.

We have also been greatly concerned about the effect of the pandemic on the physical and mental wellbeing of the NHS and social care workforce. In Chapters 4 and 5, we address the problems in the supply of appropriate personal protective equipment (PPE) and the value of routinely testing NHS staff for COVID-19. We are yet to understand why such a testing system cannot be introduced and why the disadvantages currently

outweigh the advantages of doing so. We also consider workforce fatigue and "burnout", and issues around diversity and race in the NHS and the need to support Black, Asian and Minority Ethnic (BAME) NHS staff.

The pandemic has of course also required the NHS to adapt the delivery of its non-COVID services. In Chapter 6, we assess what changes should take place to support the NHS in the long-term. They include introducing an expanded 111 dial service to support A&E departments, investigating how technology ("telemedicine") can be used without digitally excluding those already disadvantaged, and retaining capacity and resources from the independent sector in the long term.

1 Introduction

1. The coronavirus pandemic posed an unprecedented dual challenge to the NHS and social care system. The first part of this was to ensure swift and effective medical treatment to those who had contracted the virus under a potentially disastrous yet very real threat of the NHS becoming overwhelmed, as was seen for example in parts of Italy. The second element was to ensure that in dealing with the pandemic, the NHS and care services did not neglect the ongoing and critical health and care needs of the population not affected by COVID-19.

2. Our work in the weeks and months following the arrival of COVID-19 in the UK has considered the response to both challenges. In evidence sessions on *Management of the Coronavirus Outbreak*,[1] we have heard from the Chief Medical Officer and his deputies, the Government Chief Scientific Adviser, the Secretary of State, the Head of NHS Test and Trace and international scientific experts on the pandemic response, as well as from staff and care users involved at the front line of the response to the pandemic. Meanwhile, in a separate series of evidence sessions held under the title *Delivering core services during the pandemic and beyond*,[2] we have heard from a wide variety of stakeholders including Royal Colleges, NHS Providers, the NHS Confederation, patients and patient groups, health think tanks, and the Chief Executive of the NHS and other senior NHS England and Improvement leaders.

3. During this inquiry, we received over 350 items of written evidence which can be found on our website. We are grateful to all those who have taken the time to contribute to our work since the coronavirus pandemic hit the UK, and particularly to NHS patients Rob Martinez and Daloni Carlisle and third sector organisations Versus Arthritis, MacMillan Cancer and National Voices for championing the patient voice throughout our inquiry. The work we have done has played a key role not only in scrutinising and publicly holding to account those who have been advising and making decisions in Government and the NHS in recent months, but also in giving a public voice to staff, patients and care users on the front line of the pandemic response.

4. We also thank the Government, NHSE/I and Public Health England, who have, despite inevitable controversy, endeavoured to put patients first and ensure clinical care continues in the best way possible. The construction of Nightingale Hospitals in record time alongside rapid securing of capacity from the independent sector through landmark deals meant ultimately that not a single coronavirus patient was denied a hospital bed (IU or otherwise) or a ventilator—a significant achievement that did not happen in a number of other countries and is a tribute to all those who made it possible.

5. This report draws together some key conclusions and recommendations from our work on Delivering core services during the pandemic and beyond.[3] It also follows a letter which we sent to the Secretary of State and the Chief Executive of NHS England and

1 Health & Social Care Committee, Managing the Coronavirus Outbreak inquiry, HC 36 [webpage]
2 Health & Social Care Committee, Delivering core NHS and care services during the pandemic and beyond inquiry, HC 320 [webpage]
3 Health & Social Care Committee, Delivering core NHS and care services during the pandemic and beyond inquiry, HC 320 [webpage]

Improvement in July 2020,[4] which highlighted three key areas which required urgent attention: communication with patients; waiting times and managing the backlog of appointments caused by the pandemic; and the value of routine testing of all NHS staff for COVID-19. We have received replies to that letter,[5] for which we are grateful to both the Secretary of State and the Chief Executive of NHSE/I. Those replies partially address our concerns but we still believe further work needs to be done in order to prepare the NHS for a possible winter spike in the virus, provide much-needed reassurance to NHS and care workers, and ensure that patients receive the care they need in a safe environment.

6. The purpose of this report is to address the key points which have arisen from the substantial amount of written and oral evidence we have taken during this inquiry. We begin with patients: first of all drawing out communication issues which may not necessarily be the top priority in the context of a pandemic, but which our inquiry shows to be deserving of much greater and more focused attention; and then addressing the question of the response of the NHS to managing the backlog of appointments which has built up as services were scaled back to deal with COVID-19. We then turn to issues facing the NHS and care staff, particularly those who have been part of the front-line response to the pandemic: access to personal protective equipment (PPE); regular testing of all staff; and workforce fatigue and burnout, and race and discrimination in the NHS. Finally, we consider some important lessons which can be learnt from the pandemic response for the future of NHS services.

7. Delivering core NHS and care services during the pandemic has been a huge challenge; the task of continuing to deliver them beyond the pandemic—and potentially through a second wave—will be just as arduous. The recommendations of this report are designed to focus the attention of the Government and the management of the NHS on key points which we believe will equip the NHS and care services better to deal with the challenges in the next phase of the pandemic, to the benefit of patients, NHS and care staff, and future reform of the system alike.

4 Letter from Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, to Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, and Sir Simon Stevens, Chief Executive of NHS England and Improvement, Delivering core NHS and care services during the pandemic, 21 July 2020 [letter]

5 Response from Rt Hon Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter] and Response from Sir Simon Stevens, Chief Executive of NHS England and Improvement, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 21 August 2020 [letter] and Response from NHS England and Improvement, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 20 August 2020 [letter]

2 Communication issues with patients

8. The past months have inevitably placed a strain on the NHS and care sector which has in turn hindered the delivery of core NHS and care services in meeting patients' needs. We are impressed by the visible efforts of all those associated with the delivery of healthcare services, from policy makers to front line professionals, to minimise the impact of the pandemic.

9. Throughout the course of the pandemic, the message from Government and NHSE/I has been that "the NHS is open for business". However, despite this reassuring message, for some, the reality of accessing healthcare services has inevitably been mixed which has caused anxiety and stress.

10. As we set out in our letter to the Secretary of State and Chief Executive of NHSE/I on 21 July,[6] during the pandemic, communication to patients about i) delays, cancellations and access to medical services and ii) important medical guidance (such as that relating to "shielding") could have been clearer. We have received personal and heartfelt pleas from individuals whose worries have been accentuated by less than helpful communication from both the Department of Health & Social Care and NHSE/I, as well as individual hospitals. Some patients with critical needs have found themselves unable to find out what medical treatment and advice is available, how to access health services safely and whether their appointments will be going ahead or not. Some individuals have also been confused and worried about what precisely the medical guidance means for them with their condition. Further to this, we have also heard that a combination of the public's perception that the NHS is not functioning normally, plus fears of attending due to risk of catching COVID-19, have added to the difficulties faced by the NHS.[7]

Delays, cancellations and a lack of access to key medical services

11. The quality of communication with patients about delays and cancellations to their referrals and appointments for critical health services has been variable and this has clearly added to the burden on patients.[8] Some patients—even with life threatening conditions such as cancer—have reported the emotional distress that has resulted from them being unclear as to when their medical appointment will take place. For example,

6 Letter from Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, to Rt Hon Matt Hancock MP, Secretary of State for the Department of Health and Social Care, and Sir Simon Stevens, Chief Executive of NHS England and Improvement, Delivering core NHS and care services during the pandemic, 21 July 2020 [letter]

7 See in particualr paragraphs 25, 46–47 and 103–105 of this Report. Also, see, for example: Q1; Q20; Q54; Q70; Q87; Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070); Rory Murray (Public Affairs Manager at Royal College of Physicians) (DEL0160); Mr Paul Alexander (Policy Manager at The Royal College of Radiologists and collaborator at The Society and College of Radiographers) (DEL0030); Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); The Royal College of Pathologists Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists) (DEL0211) and Caitlin Plunkett-Reilly (Public Affairs and Campaigns Lead at Royal College of Paediatrics and Child Health) (DEL0237).

8 See, for example: Q1; Q20; Q47; Q70; Qq119–120; Q123; National Voices (DEL0266); Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070); Rory Murray (Public Affairs Manager at Royal College of Physicians) (DEL0160) and (DEL0319); Jenny Priest (Director of Policy and Public Affairs at Royal College of Obstetricians and Gynaecologists) (DEL0199); Ms Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists Cytopathology Sub-Committee) (DEL0213); Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258); Ms Jessica Reeves (Public Affairs and Campaigns Manager at Sands, stillbirth and neonatal death charity) (DEL0011); Ms Kate Mulley (Director of Research, Education and Policy at Sands - the stillbirth and neonatal death charity) (DEL0092); Rebecca Brione (Research and Partnerships Officer at Birthrights) (DEL0025).

during our inquiry, we heard from Daloni Carlisle, an NHS patient in need of cancer treatment, who told us:

> I fell into a hole where I was absolutely in limbo. I did not know, and I had no communication about, when the chemotherapy might start. For most of the lockdown I have been sitting here at home knowing that all the cancers are growing and knowing that the tumours in my lung, my liver and my spine are all busily growing, and there has been absolutely no word at all from the hospital about when some treatment might start.
>
> I am a single mum with teenagers at home. My absolute priority is to stay alive. I cannot tell you how difficult that limbo period has been.[9]

12. Giving evidence at the same session, Rob Martinez, an NHS patient whose urgent joint replacement surgery was cancelled, told us about his experience:

> [O]n the NHS side of it, with the hospitals, I think they should be in contact with people, to keep them aware that they have not been forgotten and that things will eventually come back again. They could have given a phone call or an update, but it went completely silent. It is almost like, "Is this going to happen? Isn't it going to happen?" You were left in the lurch. They could have helped by being in contact with people.[10]
>
> […] If I had the odd phone call just to say, "Look, we know you are waiting for an operation but you have not been forgotten. This is the latest update," it would have been nice. It went so silent. I was so close to having [surgery], and then it was cancelled. It was absolutely devastating the day it got cancelled. It is a shame that they did not communicate.[11]
>
> […] I would have liked to have some updates from the hospital. There was nothing. There was no offer of pain management. There was nothing whatsoever. I had no updates at all until, as I say, I rang them yesterday.[12]

13. Dr Charlotte Augst (Chief Executive, National Voices) told us that the lack of communication to patients about their appointments "can tip people over into deep despair"[13] and that this is "the common thread through all the stories [National Voices] have heard"[14] as part of its Our Covid Voices project and wider work. Dr Augst explained:

> We are currently interviewing people about their experiences of cancellation and delay. We have yet to meet anyone, before or after COVID, who says that they have ever had a referral acknowledged. Your GP refers you and then you do not hear anything. The anxiety of not knowing whether you are actually on a waiting list, whether you will be seen or whether your referral has been lost adds a whole layer of distress to what is already a distressing situation.[15]

9 Q160
10 Q120
11 Q123
12 Q119
13 Q161
14 Q168
15 Q168

14. Sir Robert Francis (Chair, Healthwatch England) similarly told us that "many [patients] feel that they have been left in the lurch […] they get messages that their so called routine treatment has been cancelled or their screening has not happened, and then they are left in a hole. They do not hear anything".[16] Sir Robert explained:

> People need to know why appointments are being cancelled and what is being done about that for them in their circumstances. It is not just an administrative matter of a duplicated letter saying the same thing to everyone. People have the right to be treated as individuals.[17]

15. We have also heard that communication relating to the operation of services more widely has been ineffective at times. Dr Charlotte Augst illustrated how information she had received about a recent medical appointment had been contradictory and inconsistent:

> [On the] example of cervical screening, I got the letter; I was overdue and I had to go. I was then told, "We haven't got any lab capacity." I got a communication from the NHS saying, "It's really important; you've missed it and you've got to go." Then I was told by my GP, "Even if I did you a smear test, I couldn't send a sample anywhere because all the labs are doing [COVID-19 related] testing." We need to get our ducks in a row, and then we need to communicate what the local deal is.[18]

Communication of medical guidance (including "shielding" information)

16. We are aware that publication of shielding guidance was of clinical importance, and a medical decision was made as to which individuals do and do not belong in the "clinically extremely vulnerable" category.[19] During our inquiry, however, we were told that some patients were left feeling confused by the information they received, and frustrated by the lack of clarity of what practical changes they would need to take in order to adhere to the shielding guidance. Changes to shielding guidance also did not respond to some patients' anxiety or remove confusion.[20] This was made clear to us on 16 June 2020, when Daloni Carlisle, who has been required to "shield", told us:

> I am supposed to be shielding. The advice is completely impossible to follow. It is utterly meaningless and has caused an enormous amount of distress. Personally, I read the top line that says that it is up to you whether you follow it. I make my own judgments about my own safety. I feel reasonably confident in doing so, but I know people for whom it has caused extraordinary distress. It is utterly useless. I cannot tell you how galling it has been for people. Something has to be done about that.[21]

16 Q162
17 Q170
18 Q168
19 Q202
20 Qq176–178; Ms Amelia Chong (Senior Policy and Public Affairs Manager at Anthony Nolan) (DEL0044); Miss Charlotte Wickens (Policy and Public Affairs Officer at Anthony Nolan) (DEL0123); National Voices (DEL0266); Mr Tom Nightingale (Senior Public Affairs Officer at Diabetes UK) (DEL0150); Christopher Walden (Head of Policy and Campaigns at Blood Cancer UK) (DEL0040); and Rory Murray (Public Affairs Manager at Royal College of Physicians) (DEL0160) and (DEL0319).
21 Q178

Daloni's experience is not a "one off". We received a body of written evidence which highlights the difficultly patients have had in understanding shielding guidance and what it means for them.[22]

17. Dr Charlotte Augst told us of her concern that "the shielded" and "organisations that understand shielding" were not involved in drafting the shielding guidance,[23] while Sir Robert Francis told us that the lack of patient involvement was an "overarching theme" and that individuals who are shielding were "not being sufficiently involved in the decisions that are being made about what should happen next".[24]

Communication issues with patients: conclusions

18. Sir Robert Francis underlined to us the need for medical staff to have "an actual conversation with patients about what their needs are in the context of the pandemic and what may follow it"[25] and the need for "much more clearer communication" about what medical services are available to patients and how patients can access such services.[26] Dr Charlotte Augst agreed and she told us:

> You would not approach communication with the most important actor [patients] anywhere else with a mix of saying, "The NHS is open but don't waste our time. Fingers crossed." That seems to me to be the approach we have taken. We are saying, "Do come. Don't come. Fingers crossed that the right people come." That is not how we can resolve this.
>
> […] ideally that communication needs to be led by the clinical team […] we need to get the cardiologist, the endocrinologist, the diabetes nurse and so on to write to the patient and say, "This is how it is going to work around here now. If this happens, this is what you do. If that happens, you've got my number. For everything else you go to the GP." Everyone in that local place must know that that is the deal now.[27]

22 See, for example: National Voices (DEL0266); National Voices (DEL0329); Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070); Jane Lyons (CEO at Cancer52) (DEL0018) and (DEL0158); Mrs Katie Begg (Secretariat at Blood Cancer Alliance) (DEL0039); Christopher Walden (Head of Policy and Campaigns at Blood Cancer UK) (DEL0040); Ms Sally Greenbrook (Policy Manager at British Geriatrics Society) (DEL0114); Rory Murray (Public Affairs Manager at Royal College of Physicians) (DEL0160); Ms Samantha Sharp (Senior Policy Officer at Kidney Care UK) (DEL0042); Fiona Loud (Kidney Care UK at Kidney Care UK) (DEL0278); Ms Amelia Chong (Senior Policy and Public Affairs Manager at Anthony Nolan) (DEL0044); Miss Charlotte Wickens (Policy and Public Affairs Officer at Anthony Nolan) (DEL0123); Ms Josie Anderson (Campaign and Policy Manager at Bliss) (DEL0056); Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066); Laura Cockram (Head of Policy and Campaigns at Parkinson's UK) (DEL0147); Mrs LIz Darlison (Head of Charity at Mesothelioma UK) (DEL0085); Andy Bell (Deputy Chief Executive at Centre for Mental Health) (DEL0130); Roche Products Ltd Emma Pritchard (Roche Products Ltd at Roche Products Ltd) (DEL0141); Ms Lynn Mackay-Thomas (Cheif Executive Officer at British Society for Heart Failure) (DEL0149); Dr Lisa Wilde (Director of Research and External Affairs at Bowel Cancer UK) (DEL0179); Niall Dickson (Chief Executive at NHS Confederation) (DEL0198); Ms Rachel Power (Chief Executive at The Patients Association) (DEL0221); Mr Andy McGuinness (Senior Public Affairs Officer at Macmillan Cancer Support) (DEL0238); Harjit Sandhu (Managing Director at FODO and Managing Director at NCHA) (DEL0270); Samuel Lawes (Policy and Communications Manager at National Rheumatoid Arthritis Society) (DEL0261) and Mr Noah Froud (Coordinator at RAIRDA (Rare Autoimmune Rheumatic Disease Alliance)) (DEL0245).

23 Q176

24 Q162

25 Q162

26 Q162

27 Q168

19. On 30 June 2020, commenting on the oral testimonies of Daloni Carlisle and Rob Martinez, Sir Simon Stevens told us that he thought that there was "a sense that communication on a range of topics has been quite comprehensive".[28] However, he admitted that "there is a question of communication"[29] and that "Quite clearly, hospital teams have a big job of work to do to connect and communicate properly with patients whose care had to be paused".[30]

20. In response to our letter of 21 July 2020,[31] Sir Simon Stevens further explained how NHSE/I are improving communication with patients. Sir Simon wrote:

> We have asked: "Trusts working with GP practices should ensure that between them every patient whose planned care has been disrupted by COVID receives clear communication about how they will be looked after, and who to contact in the event that their clinical circumstances change." We have also drawn colleagues' attention to helpful advice produced by Healthwatch, National Voices, as well as the work of the NHS Assembly.[32]

21. **The pandemic has presented an unprecedented challenge to the NHS and the Government. Whilst we have no doubt that often communication to patients was as effective as could reasonably be expected in the context of a pandemic, this was not always the case. As we set out in our letter to Rt Hon Matt Hancock and Sir Simon Stevens on 21 July 2020,[33] the patient experience for some has been unacceptably poor, leaving them feeling like they have been left in "limbo" or "in the lurch". Unnecessary anxiety and stress has been caused to those patients due to poor communication not just from their local hospital about the scheduling of appointments or access to treatments, but from national bodies, and on key items of guidance such as on shielding. Some sections of the public have been left thinking the NHS is not working on routine non-COVID conditions, this in conjunction with the fear of some patients about going into hospitals where there could be a risk of catching COVID-19, is having a significant impact and needs addressing.**

22. ***Notwithstanding the actions taken to date, we recommend that NHS England & Improvement review, as a matter of priority, the directions given to NHS Trusts about how to communicate with patients about the progress of their treatment and important medical guidance in any future spike or second wave. As part of this review, NHSE/I must ensure that patients are always treated with dignity and compassion. We ask that as part of that review, NHSE/I makes an assessment of its and hospitals' communication with patients—and provide us with an update by the end of October 2020. We also ask, as part of this review, that NHSE/I address how they will communicate to the general population to ensure that the public gets the message that the NHS is open, and that***

28 Q209
29 Q200
30 Q201
31 Letter from Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, to Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, and Sir Simon Stevens, Chief Executive of NHS England and Improvement, Delivering core NHS and care services during the pandemic, 21 July 2020 [letter]
32 Letter from Sir Simon Stevens, Chief Executive of NHS England and Improvement, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 21 August 2020 [letter]
33 Letter from Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Select Committee, to Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, and Sir Simon Stevens, Chief Executive of NHS England and Improvement, Delivering core NHS and care services during the pandemic and beyond, 21 July 2020 [letter]

those who have fears of catching COVID-19 in medical settings are not discouraged from accessing medical treatment.

3 Waiting times and managing the backlog of appointments

23. At the start of the pandemic, NHS England & Improvement and the Government rightly prioritised the treatment of individuals showing COVID-19 symptoms and focused their efforts on supporting the extra pressure put on hospitals—ensuring that everybody who needed coronavirus emergency care was able to get it.[34] However, with many local NHS services having had to suspend, cancel or otherwise alter the delivery of their services and treatments, there has now been a substantial increase in the number of missed, delayed and cancelled appointments across essential non-COVID related services. This has increased waiting times, the backlog of appointments and pent-up demand for core healthcare services. As a result, Dr Charlotte Augst (Chief Executive, National Voices) told us "avoidable harm is now very clearly happening". It is right that the restoration of non-COVID related services is now being prioritised: the NHS cannot act exclusively as a "COVID-only" service.

24. During our inquiry, we were told that there has been:

- an overall NHS waiting list reduction of over half million people between February and April 2020. Sir Simon Stevens said that he "expects that as referrals return, that [the overall waiting list] will go up quite significantly over the second half of the year".[35] The NHS Confederation has warned that the overall waiting list could grow from 4.2 million to 10 million, or possibly more, as a result of the pandemic;[36]

- a reduction of approximately 40% in pre-COVID capacity in acute hospitals,[37] with Chris Hopson (Chief Executive, NHS Providers) reporting that "the NHS is struggling to keep up with demand" for core health services[38] and that in July "only 7%" of NHS Providers Trusts felt that they are able to "meet the needs of all patients and users";[39]

- significant disruption to referral routes (such as schools, primary care and A&Es) for mental health services, with Claire Murdoch (National Mental Health Director, NHSE/I) telling us that, at the beginning of May, mental health referrals had reduced by between roughly 30% and 40%;[40]

- "a reduction of 62% on the pre-pandemic levels" for urgent cancer referrals in the week commencing 20 April 2020, according to Dame Cally Palmer (National Cancer Director, NHS England),[41] while Richard Murray (Chief Executive, The King's Fund) said referrals had dropped from approximately 40,000 per week to approximately 10,000 per week by the middle of April 2020;[42]

34 Q193
35 Q191
36 NHS Confederation, Public reassurance needed over slow road to recovery for the NHS, 10 June 2020 [webpage]
37 Q74
38 Q179
39 Q179. See also: NHS Providers (DEL0318).
40 Q49
41 Q21
42 Q73

- substantial disruption to chemotherapy appointments with Dame Cally telling us that such appointments were "running at about 70% of normal levels" on 1 May 2020,[43] while the Royal College of Pathologists has reported that 6,000 fewer people than expected are receiving chemotherapy since lockdown began;[44]
- at least eight million courses of dental treatment have been cancelled during the pandemic,[45] with Mick Armstrong (Chair, British Dental Association) describing the availability of dental services during the pandemic as "virtually non-existent"[46] and reporting that there is "likely to be more demand than ever on NHS and for private dentistry in primary care";[47]
- a reduction of 33% (nearly eight million) in GP appointments from March to April 2020;[48]
- a decrease of approximately 60% in A&E attendance[49] with the Royal College of Emergency Medicine describing a reduction in presentations at A&E departments: "worryingly, there is some evidence of seriously ill patients staying at home".[50] The British Heart Foundation has reported a 40% decrease in attendances at emergency departments for symptoms of a possible heart attack;[51]
- 1.16 million fewer referrals for hospital treatments in April 2020 than in April 2019, with the Royal College of Surgeons of England and the Royal College of Emergency Medicine describing "a huge 'hidden waiting list' of patients who will eventually need hospital treatment".[52]

25. Although reductions in the use of health services are likely to have been caused by a combination of factors, throughout our inquiry Presidents of Royal Colleges, senior NHSE/I leaders and others have expressed concern that patients are not accessing NHS services as they fear that in doing so they will be putting themselves at greater risk of catching COVID-19.[53]

43 Q24
44 Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists) (DEL0034) and (DEL0211); and Ms Janine Aldridge (Public Affairs Officer at The Royal College of Pathologistsâ€™ Cytopathology Sub-Committee) (DEL0213).
45 Q130
46 Q130
47 Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252)
48 NHS Digital, Appointments in General Practice - April 2020, 28 May 2020 [webpage]
49 Q75 and Q137
50 Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081) and Mr Theo Chiles (Policy Research Manager at The Royal College of Emergency Medicine) (DEL0288)
51 Mr Richard Phillips (Director, Healthcare Policy at Association of British HealthTech Industries) (DEL0119) and Dr Samual Dick (Policy Manager - Health and Care Systems at British Heart Foundation) (DEL0240)
52 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)
53 See, for example: Q1; Q20; Q54; Q70; Q87; Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070); Rory Murray (Public Affairs Manager at Royal College of Physicians) (DEL0160); Mr Paul Alexander (Policy Manager at The Royal College of Radiologists and collaborator at The Society and College of Radiographers) (DEL0030); Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); The Royal College of Pathologists Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists) (DEL0211); Caitlin Plunkett-Reilly (Public Affairs and Campaigns Lead at Royal College of Paediatrics and Child Health) (DEL0237) and Response from Rt Hon Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter].

Reduction in elective surgery, mental health services cancer services and dental treatments

26. While the delivery of all health and care services have been significantly reduced during the pandemic. This has particularly been the case for elective surgery, mental health services, cancer treatments and dental treatments.

Elective surgery

27. During the pandemic, elective surgery has been mostly postponed with resources being reallocated to other areas in order to help tackle COVID-19. The Royal College of Surgeons of England told us of their concern that patients that do not receive the surgery that they require in a timely fashion will "suffer from worsening symptoms, deterioration in their condition, greater disability and (in some cases) a significant risk of death".[54]

28. The suspension of surgeries has led to many patients living in distress and feeling abandoned. Rob Martinez, an NHS patient who has been unable to receive joint replacement surgery, told us:

> The last I heard from [my local hospital] was in March, when they phoned me with the bad news that my operation was being cancelled. I have been told there is zero chance of my first knee replacement being done this year. I was pretty shocked at that, considering that I had an operation date of 15 April this year.
>
> I have ongoing pain in my knees. I have difficulty climbing stairs at home, and anywhere else. I have pain when walking and sleeping. I basically have pain all the time. No medication that I have been on has helped me at all.
>
> I am frustrated and anxious. My family and social life have been affected as well. It is having an impact on my mental health. It is the not knowing. It is as though my whole life is on hold. I am just getting worse, to be honest. I would like to get my life back again. That is what I want.
>
> There is obviously a massive backlog, let alone the backlog that we had before the pandemic. I had already experienced a massive delay, and it is now going to be far worse. It was absolutely devastating the day it got cancelled.[55]

29. Commenting on Rob Martinez's experience, Professor Derek Alderson (President, the Royal College of Surgeons of England) told us "What he [Rob Martinez] describes is not atypical, and that is the real sadness".[56] Professor Alderson told us of his concern about the growing backlog for surgery:

> The consequence for some patients is the risk of dying if they do not get their new heart valve, or, for a person who has cancer, that it advances in

54 Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258)
55 Q119
56 Q124

> stage so that their chances of being cured are substantially reduced by delay. That is a real issue for us […] We now have a large backlog of patients in that category when you look across the totality of surgery.[57]

30. During our inquiry we heard that:

- Performance against the statutory target of 92% patients starting consultant-led treatment within 18 weeks referral for non-urgent conditions was 83.2% in February 2020, and the target has not been met since February 2016;[58]
- In April 2020, there were 1 million fewer patients having elective surgery than in the corresponding period for 2019, and in April 2020 there were over 1 million people on elective surgery waiting lists for more than 18 weeks. Professor Derek Alderson described this as showing that patients are "waiting unacceptably long times for their surgery";[59]
- The drop in elective admissions was greatest in April 2020, when there were approximately 530,000 fewer elective episodes than might have been expected;[60]
- Elective activity, "at its worst", fell to approximately 25% of the usual level of activity, according to Sir Simon Stevens.[61]

31. On 16 June 2020, Professor Alderson emphasised to us the strain that NHS Trusts are facing in managing the backlog of elective surgery. He told us:

> We believe that at the moment anyway, and for the foreseeable future, the capacity within our NHS resource alone is insufficient for us to be able to get surgery started again and maintain a sustainable and resilient service as we move into the winter.[62]

Recent findings from the Royal College of Surgeons of England's survey of 1,692 surgeons further highlighted a reduction in the pace at which elective surgeries can be resumed. The survey showed that 32.77% of surgeons stated that they are unable to resume elective surgery.[63]

32. Some Trusts have been able to create "COVID-light hubs" to help better manage the backlog of elective surgery. These hubs are typically characterised by repeat testing of NHS staff and patients, enhanced cleaning and separate pathways to allow surgery to continue safely. Professor Alderson told us that COVID-light sites are "ideal" for patients who require elective surgery[64]—noting in that context that it "is absolutely essential to regain public confidence that we are able to test our staff regularly".[65] However, the Royal College of Surgeons of England's survey showed that one quarter (26.2%) of surgeons

57 Q134
58 Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258). See also: Committee of Public Accounts, NHS waiting times for elective and cancer treatment, HC 1750, 12 June 2019 [report].
59 Q124
60 Q188
61 Q189
62 Q125
63 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)
64 Q126
65 Q140

surveyed said that they are unable to access a COVID-light hub for their patients.[66]

33. Professor Alderson also told us that dealing with the backlog would need to be a long-term project for the NHS:

> Dealing with the backlog is not something that is achievable simply in weeks. We have stopped for 12 weeks, but we cannot catch up in 12 weeks. That, to my mind, is completely unrealistic. It will certainly be many months. It may take us a few years to catch up, and we have to be able to sustain that effort. We need a programme for the recovery of surgery and the sustainability of surgery, and we are probably looking at four or five years to have a resilient system and take things forward in the best possible way.[67]

This was reiterated to us by Chris Hopson (Chief Executive, NHS Providers), who estimated that this would take "many months, more likely years, to get through".[68]

Mental health services

34. Since the start of the pandemic there has been significant disruption to referral routes (such as schools, primary care and A&E departments) for mental health services. There has also been a notable decrease in referral rates to, and a reduction in, patient use of mental health services.[69]

35. Throughout our inquiry, we have heard of the disruption caused to mental health services across the country and the impact it has had on patients. Notable evidence we have received includes:

- One-third of 7,500 adult respondents to Mind's survey saying that they have had difficulty in accessing help for their mental health problems which has led to a deterioration in their mental health;[70]
- 80% of 1,434 respondents to Rethink Mental Illness' survey saying that their mental health was "worse" due to the pandemic, and 79% saying that support for their mental health issues had become "worse" or "much worse" since the start of the pandemic;[71]
- 80% of people living with severe mental health problems saying that their mental health support has been "severely cut" and that they "do not feel supported at all" with what is currently offered, as reported to us by Dr Charlotte Augst (Chief Executive, National Voices) on behalf of Rethink Mental Illness;[72]

66 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)
67 Q136
68 Q184. See also: Royal College of Surgeons of Edinburgh (DEL0344)
69 Q47; Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165); Mr Alex Kennedy (Head of Campaigns and Public Affairs at Rethink Mental Illness) (DEL0077); Rethink Mental Illness Jonathan Moore (Head of Social Policy at Rethink Mental Illness) (DEL0194) and Andy Bell (Deputy Chief Executive at Centre for Mental Health) (DEL0130)
70 Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165)
71 Mr Alex Kennedy (Head of Campaigns and Public Affairs at Rethink Mental Illness) (DEL0077; Rethink Mental Illness Jonathan Moore (Head of Social Policy at Rethink Mental Illness) (DEL0194); National Voices (DEL0266) and National Voices (DEL0329)
72 Q171

- Mind's report that Improving Access to Psychological Therapies (IAPT) commissioning leads have "worryingly" noted a decrease of 30% in referral rates with, for example, one Child and Adolescent Mental Health Services (CAMHS) provider having reported a 50% decrease in referrals since the pandemic began. NHS Providers have also raised concern about the "significant fall" in the number of referrals for services such as CAMHS and IATP.[73]

36. The leading mental health charity Mind noted that with "vital mental health services being scaled back and people being unable to get support, [this] is likely to have led to people becoming more unwell and more likely to reach crisis point."[74] Rethink Mental Illness has said that "a common theme" from their recent work has shown that mental health services have "been completely withdrawn in the wake of coronavirus."[75]

37. The Royal College of Psychiatrists has also highlighted the effect of the reduction in child and adolescent mental health services:

> Our members in the front line are reporting significant reductions in patient referrals—especially in child and adolescent services. Those who fail to get the help they need now, will inevitably become more seriously ill. This is particularly concerning for deadly mental health conditions such as eating disorders, which have a higher mortality rate than many cancers. The College is also monitoring early signs that child and adolescent suicide rates may have risen since the lock-down began.[76]

Chris Hopson (Chief Executive, NHS Providers) explained that there is likely to be an increase in demand for mental services particularly for those who have suffered "economic, social and loss of life consequences of COVID-19".[77]

38. On 14 May 2020, Richard Murray (Chief Executive, The King's Fund) told us of the importance of prioritising the restoration of mental health services. Mr Murray said:

> [Mental health services were] not a key priority for the health service and the Government, and that is reflected in deep difficulties in staffing across both adult and children's mental health services. We need to think very carefully about how these services come back together again, so that they do not get pushed into just dealing with emergencies, and we can invest in some of the community services.[78]

39. Throughout the course of the pandemic, various changes have occurred to the provision of mental health services. For example, the reduction in face-to-face contact has been accompanied by the establishment of an all-age 24–7 emergency phone line (and other forms of digital treatment) and there have also been attempts to move the provision

73 Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165)
74 Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165)
75 Mr Alex Kennedy (Head of Campaigns and Public Affairs at Rethink Mental Illness) (DEL0077) and Rethink Mental Illness Jonathan Moore (Head of Social Policy at Rethink Mental Illness) (DEL0194)
76 Mr Jonathan Blay (Public Affairs Manager at Royal College of Psychiatrists) (DEL0038) and (DEL0139)
77 Q74. See also: British Medical Association, The impact of COVID-19 on mental health in England; Supporting services to go beyond parity of esteem, 19 May 2020 [report] and Eve De Marchi (BACP at BACP and BPC at BPC) (DEL0331).
78 Q87

of emergency mental health care away from hospital emergency departments.[79] There has also been a further recruitment of at least 750 mental health support team therapists[80] and an increase in support offered by specialist perinatal mental health services.[81]

40. Nonetheless, more needs to be done to ensure mental health services are delivering at the pace and to the standard required to effectively meet patient demand. Chris Hopson (Chief Executive, NHS Providers) stressed the importance in preparing the NHS for future demand for mental health services, telling us:

> We have already begun to see […] that COVID-19 is going to generate significant amounts of extra mental health demand. We need to be ready for that. We cannot wait until next year to build the capacity to meet that demand.[82]

41. On 30 June 2020, address the provision of mental health services and managing the backlog, Sir Simon Stevens told us:

> The honest answer is that there is a big unknown as to how much of an additional burden of mental ill-health there will be coming out of the last four months. There is some evidence that there will be higher rates of mental distress. […] we believe there will be increased mental health demand, but the precise size and shape of it is yet to be determined and seen.[83]

42. On CAMHS, Sir Simon told us that there is an "unknown around how much the mental health needs of young people can be met through, for example, schools-based programmes as against referrals to the specialist CAMHS service".[84] Sir Simon added that, despite recent innovation in the delivery of mental health services, "we clearly have a long way to go".[85]

43. Chris Hopson also told us that a key problem with mental health services has been "the inability of funding to actually reach the front lines of mental health".[86] Mr Hopson explained:

> At the moment, nobody is talking about money because, effectively, the Government are saying, "Look, whatever the NHS needs, we will ensure gets funded." But when you are talking about the kind of expansion of mental health service that we are going to need, over probably the medium

79 Qq47–51; Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165); Charlotte Watson (Policy and Parliamentary Officer at YoungMinds) (DEL0096); Mr Alex Kennedy (Head of Campaigns and Public Affairs at Rethink Mental Illness) (DEL0077); Rethink Mental Illness Jonathan Moore (Head of Social Policy at Rethink Mental Illness) (DEL0194); and Mr Jonathan Blay (Public Affairs Manager at Royal College of Psychiatrists) (DEL0038) and (Public Affairs Manager at Royal College of Psychiatrists) (DEL0139)

80 Q51

81 Q10; Q13; Q15 and Q207

82 Q182

83 Q205

84 Q207

85 Q207

86 Q89

> term, one of the important questions that our trusts are beginning to ask is, "Okay, we are going to need to fund this beyond the end of COVID-19. How is the funding for that going to work?"[87]

44. Sir Simon emphasised his commitment to financial support for mental health services to us and said that "Mental health services grew faster than the NHS overall last year, and that the mental health investment standard was exceeded by £200 million or thereabouts."[88] In further correspondence to us, on 21 August 2020, Sir Simon wrote:

> We understand the government intends to make decisions in the autumn spending review about the need for any future waiting list 'catch up' and any resulting need for permanent additions to NHS capacity, and the funding consequences arising from that.[89]

Cancer services

45. Cancer referrals, screening, diagnosis and treatment have all been affected by the pandemic. During our inquiry, we have heard about the backlog of appointments, a decrease in referral rates and a reduction in the overall use of cancer services. Some notable concerns raised with us, include the following:

- Cancer Research UK has reported that urgent referrals for diagnostic tests for suspected cancer have dropped by 75% in England, despite national guidelines stating that urgent and essential cancer treatments must continue;[90]
- UCL and DATA-CAN, the Health Care Research Hub (HDR UK) for Cancer, reported that there has been a 76% decrease in urgent referrals from GPs for people with suspected cancers, and a 60% decrease in chemotherapy appointments for cancer patients compared to pre-COVID-19 levels;[91]
- A study conducted by DATA-CAN showed that up to two million routine breast, bowel and cervical cancer screenings may have been missed throughout the pandemic. If delays to cancer services continue, there could be 35,000 avoidable deaths within a year;[92]
- The Royal College of Surgeons of England and Royal College of Emergency Medicine have jointly referred to evidence which suggests around 36,000

87 Q89. See also: Centre for Mental Health, A spending review for wellbeing, July 2020 [briefing], Centre for Mental Health, Our Place: Local authorities and the public's mental health, August 2020 [report] and NHS Confederation, Mental health services and COVID-19: preparing for the rising tide, August 2020 [report]

88 Q206

89 Letter from NHS England and Improvement to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 20 August 2020 [letter]

90 Mr Michael Cousins (Public Affairs Officer at Cancer Research UK) (DEL0063). See also: Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070)

91 UCL Partners, Deaths in people with cancer could rise by at least 20%, 29 April 2020 [blogpost]

92 See, for example: Lai A, Pasea L, Banerjee A, et al., Estimating excess mortality in people with cancer and multimorbidity in the COVID-19 emergency, 28 April 2020; BBC, Coronavirus could cause 35,000 extra UK cancer deaths, experts warn, 6 July 2020 [news article]; and ITV News, UK could experience up to 35,000 excess cancer-related deaths due to COVID-19, 6 July 2020 [news article]

cancer operations had been cancelled by mid-May 2020 in the UK,[93] while the Royal College of Pathologists reported that the number of cancer surgeries taking place had fallen to around 60% of expected levels;[94]

- The Royal College of Radiologists and the Society and College of Radiographers have suggested that, due to the reduction in cancer services during the pandemic, "around 2000 cancer cases across the UK may go undiagnosed per week and these will accumulate over time";[95]
- Dr Charlotte Augst (Chief Executive, National Voices) told us that Cancer Research UK and Macmillan have reported that 2.4 million people are now waiting for screening, tests and treatments for cancer services.[96]

46. The Royal College of Radiologists and the Society and College of Radiographers, in a joint submission to our inquiry, stated that the pandemic has resulted in "a significant decline in patients presenting to primary care with signs and symptoms of cancer".[97] NHS Providers has said that Trusts are "deeply concerned" at the "marked drop in demand for key services" including cancer diagnostics. Trusts are also receiving fewer referrals from general practice for conditions such as suspected cancer.[98]

47. We are aware that cancer services and treatments have been suspended or otherwise altered due to capacity restrictions, reallocation of resources and in order to manage risk to patients (particularly those who are immunocompromised and therefore at a greater risk of catching and then being unable to recover from coronavirus (and other infections)).[99] We have also heard that "cancer hubs" and COVID-light facilities have been introduced to support cancer patients but that they have met limited success.[100]

48. Richard Murray (Chief Executive, The King's Fund) highlighted the critical importance of referral rates for cancer services returning to pre-COVID levels:

> The key to avoiding a spike in cancer mortalities later in the year, next year and the year after is how quickly those referrals pick up again. They definitely declined for a bit, but in most cases of cancer a clinical delay

93 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)

94 Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists) (DEL0034) and (DEL0211); and Ms Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists Cytopathology Sub-Committee) (DEL0213)

95 Mr Paul Alexander (Policy Manager at The Royal College of Radiologists and collaborator at The Society and College of Radiographers) (DEL0030) and Mr Paul Alexander (Policy & Academic Research Manager at The Royal College of Radiologists, Colleague collaborator at The Society and College of Radiographers and Colleague collaborator at The Institute of Physics and Engineering in Medicine) (DEL0121)

96 Q161. See also: National Voices (DEL0329); Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070); Mr Andy McGuinness (Senior Public Affairs Officer at Macmillan Cancer Support) (DEL0079) and (DEL0238); and Mr Michael Cousins (Public Affairs Officer at Cancer Research UK) (DEL0063)

97 Mr Paul Alexander (Policy Manager at The Royal College of Radiologists and collaborator at The Society and College of Radiographers) (DEL0030) and Mr Paul Alexander (Policy & Academic Research Manager at The Royal College of Radiologists, Colleague collaborator at The Society and College of Radiographers and Colleague collaborator at The Institute of Physics and Engineering in Medicine) (DEL0121)

98 Ms Susan Bahl (Head of Policy and Public Affairs at NHS Providers) (DEL0137) and NHS Providers (DEL0318)

99 Qq25–27; Q73; Q194 and Q203

100 Qq125–126; Q184; Mrs Katie Begg (Secretariat at Blood Cancer Alliance) (DEL0039); Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258); Noah Froud (Secretariat at Less Survivable Cancers Taskforce) (DEL0050); Mr Peter De Rosa (Policy and Intelligence Team at Pancreatic Cancer UK) (DEL0058); Mr Michael Cousins (Public Affairs Officer at Cancer Research UK) (DEL0063); and National Voices (DEL0266) and (DEL0329).

> of a couple of weeks is probably not going to be that severe. What matters now is how quickly they go back up again […] as long as referrals pick up again, at least diagnosing them, we may manage to avoid the worst of a big surge in cancer deaths.[101]

49. On 17 March 2020, we asked Sir Simon Stevens if cancer operations and routine care for cancer patients would still go ahead despite the disruption caused by the pandemic. Sir Simon confidently responded with "yes".[102] On 30 June 2020, we therefore questioned NHSE/I leaders on why cancer services have been so severely disrupted during the pandemic despite the assurance given to us at that earlier session. In contrast to much of the written and oral evidence provided to our inquiry, Amanda Pritchard (Chief Operating Officer, NHSE/I) told us "our ability across the NHS to maintain the treatment part of cancer care has been strong throughout the pandemic".[103] Professor Steve Powis (National Medical Director, NHSE/I) added "we did not stand down cancer services at all during the peak of the pandemic" although he acknowledged that there was disruption to the delivery of cancer services "for a variety of reasons".[104] Sir Simon Stevens explained that the reduction in the delivery of cancer services was due to "routine invitations being largely paused by screening providers at the end of March [2020]"[105] and that "there has been a big reduction in the flow of patients through those diagnostic services".[106]

50. On 21 August 2020, Sir Simon wrote to us to explain the steps NHSE/I would be taking to ensure the backlog would be effectively managed. Sir Simon wrote that NHSE/I had proposed several "very challenging 'stretch' objectives".[107] These objectives will aim to ensure that the restoration of core healthcare services happens at pace although, as Sir Simon noted, these objectives will "need to flex depending on local circumstances and any Covid/winter upturn in emergency hospitalisation".[108]

51. Recognising the need to restore cancer services as quickly as possible, Sir Simon said that the delivery of cancer services would have to be done in "new ways",[109] while Professor Powis noted that "imaginative and innovative thinking"[110] will be required. Professor Powis added, "We cannot go back to exactly where we were prior to COVID. We have to do things in a new way."[111] A letter issued by NHSE/I to Chief Executives of all NHS trusts and foundation trusts, CCG Accountable Offices, GP practices and primary care networks and others on 31 July 2020, contained a clear instruction to "restore full operation of all cancer services" and broad plans to "manage the immediate growth in people requiring cancer diagnosis and/or treatment returning".[112]

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101 Q73
102 Q149, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36. See also: Qq180–182.
103 Q198
104 Q195
105 Letter from NHS England and Improvement to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 20 August 2020 [letter]
106 Q194
107 Letter from Sir Simon Stevens, Chief Executive of NHS England and Improvement, to Rt Hon Jeremy Hunt MP, Health and Social Care Committee, 21 August 2020 [letter]
108 *Ibid.*
109 Q194
110 Q195
111 Q195
112 Letter from Sir Simon Stevens, Chief Executive, NHSE/I, and Amanda Pritchard, Chief Operating Officer, NHSE/I, to all commissioners and providers of NHS services, 31 July 2020 [letter]

Dental services in England

52. Dentistry services in England have been severely disrupted by the pandemic. On 25 March 2020, in a joint-letter from Sara Hurley (Chief Dental Officer for England) and Matt Neligan (Director of Primary Care and System Transformation), dental practices in England were instructed to suspend all routine, non-urgent dental care. At the same time, NHS regions were instructed to set up local Urgent Dental Care systems in order to carry out emergency dental treatment for patients.[113] Although the restoration of dental practices in England began from 8 June 2020,[114] concerns have been raised about the backlog of appointments for routine dental care which has, in part, been worsened by financial difficulties some dental practices have faced during the pandemic.

Dentistry and the impact of the pandemic

53. During the course of our inquiry, concerns have been raised about the quality of dental care on offer, particularly at the start of the pandemic, and the impact of pandemic on the population's oral health. For example, the Association of Dentists Groups (ADG) reported that patients have been remotely prescribed with antibiotics for their dental problems but have returned with pain or further swelling as the cause of their dental problem has not been properly addressed. The ADG has described this as contributing to an "overhang of oral healthcare".[115] The British Dental Association (BDA) has also said that the limited availability of dental services during the start of the pandemic has led to "a very substantial burden of untreated dental disease and an overall worsening of the nation's oral health as the UK emerges from the peak of the pandemic".[116] The BDA has argued that:

> There will be a backlog of patients requiring oral surgery that will have been in (sometime intolerable pain from toothache and infection) and with potentially life-threatening infection who will require treatment amidst a growing backlog.

54. In their joint-letter of 28 May 2020, Sara Hurley and Matt Neligan, NHSE/I set out its proposals for the restoration of dental practices in England in a COVID-secure way. Dental practices were asked to commence opening for all face-to-face care and adhere to further COVID-related safety measures.[117]

Financial challenges

55. We have also heard that some dental practices have incurred significant financial costs during the pandemic and have subsequently struggled to re-open. This is because practices are unable to conduct the level of service that they had been able to provide prior to the pandemic but are still incurring substantial overhead costs and other expenses. The

113 Letter Sara Hurley, Chief Dental Officer for England, and Matt Neligan, Director of Primary Care and System Transformation at NHSE/I, to general dental practices and community dental services, from 25 March 2020 [letter]. Urgent Dental Care "hubs" have been designed to provide emergency dental treatment for patients with urgent needs, such as cracked teeth, gum infections and facial swelling.

114 Letter from Sara Hurley, Chief Dental Officer for England, and Matt Neligan, Director of Primary Care and System Transformation at NHSE/I, to dental practices, 28 May 2020 [letter]

115 Lewis Robinson (Policy and Public Affairs Advisor at Association of Dental Groups) (DEL0276)

116 Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252)

117 Letter from Sara Hurley, Chief Dental Officer for England, and Matt Neligan, Director of Primary Care and System Transformation, to dental practices, 28 May 2020 [letter]

BDA have described this as a "dire situation" with private dental practices, in particular, being "left with little or no income in this period, while a range of fixed business costs remain in place."[118] Mick Armstrong (Chair, British Dental Association) warned us that the effect of the pandemic on general practice, NHS and private, "has been devastating and is probably existential".[119] This was, in part, illustrated by a survey conducted by the BDA of 2,860 owners of dental practices in April 2020. Results from the survey showed that:

- 71.5% of respondents said that they could only remain financially sustainable for 3 months or less;
- Less than a third (28.7%) of respondents estimated they will be placed to restore pre-pandemic levels of patient access; and
- 75% of those with low or no NHS commitment to carrying out dental work stated that they will face imminent difficulties from April 2020.[120]

56. In early June 2020, a further BDA survey of more than 2,000 of its members, indicated that only 8% of dental practices would be financially viable to open from 8 June 2020. That figure was based on expected patient numbers and estimated costs.[121] As discussed in Chapter 4, access to and the cost of PPE has remained a particular issue for dentistry because dental treatments typically involve aerosol generating procedures which are considered to be an infection risk and therefore require all dental staff to wear particular types of PPE.[122] Further to this, Mick Armstrong told us:

> Where [dental practices] may have seen 15 patients a day, they will now see five. The only thing I can say is that they have the ability to pass on those increased costs to patients. Whether that makes dentistry unaffordable is an entirely separate matter.[123]

On 30 June 2020, we were told by Amanda Pritchard (Chief Operating Officer, NHSE/I) that NHSE/I are working with the BDA to support NHS dentists in accessing PPE.[124]

Leadership from NHSE/I

57. Some of the submissions to our inquiry have expressed concern about the priority given by NHSE/I to supporting dental services in England throughout the pandemic.[125] On 14 May 2020, Nigel Edwards (Chief Executive, Nuffield Trust) highlighted his concerns relating to the attention on and support for dentistry services during the pandemic:

118 Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252)
119 Q130
120 Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252)
121 British Dental Association, Dentists: Skeleton dental service going back to work at a fraction of pre-COVID-19 capacity, 5 June 2020 [webpage]
122 Dr Martin Skipper (Head of Policy at LDC Confederation) (DEL0248); Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252); and Lewis Robinson (Policy and Public Affairs Advisor at Association of Dental Groups) (DEL0276).
123 Q156
124 Q204
125 See, for example: Qq152–154; Dr Martin Skipper (Head of Policy at LDC Confederation) (DEL0248); Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252); and Lewis Robinson (Policy and Public Affairs Advisor at Association of Dental Groups) (DEL0276).

> [Dentistry] has not received a lot of attention, but it is a real problem because virtually everything that is done in dentistry generates an infection risk, and we have not given dentists a good answer about how on earth they will run their businesses in a safe way in the future.
>
> We are going to have a very major problem of long-term dental morbidity as a consequence unless we can find an answer to that. There is a limit to what hospitals can do on that, but at the moment we are unclear about how to safely run a general dental practice.[126]

58. On 16 June 2020, Mick Armstrong (Chair, British Dental Association) told us that, in his view, the dental sector has been treated as a "Cinderella service" and as a result there had been a failure in accounting for dentistry services in key strategies such as the NHS Long Term Plan.[127] Mr Armstrong explained:

> The profession is ready, willing and very able to deliver whatever you want us to deliver, but we need that plan and we need clear lines of communication and influence. If we ask for something, we expect to be heard.[128]

Mr Armstrong suggested that leadership from NHSE/I had not always been effective because there is a "disconnect" between dental practices and NHSE/I leaders.[129]

Response from NHSE/I

59. In oral evidence to us on 30 June 2020, Amanda Pritchard (Chief Operating Officer, NHSE/I) reiterated NHSE/I's commitment to support dental practices and staff in England. Ms Pritchard said:

> Dentistry is a hugely important service. We are very much aware that the whole of the dental sector has, as has the rest of the NHS, stepped up through the COVID-19 crisis despite considerable pressures on their services. Our particular responsibility is to NHS dental practitioners.[130]

60. However, Amanda Pritchard acknowledged that "in common with the rest of the NHS, there are real constraints around the productivity that dental services are able to operate."[131] Consequently, NHSE/I are focussing on "balancing safety and patient needs" in order to "absolutely support dentists making some local judgments about what the right balance is to make sure they are able to operate safely."[132]

61. Ms Pritchard also acknowledged the financial challenges facing dental practices and outlined the support that NHSE/I is offering:

> What we have done is maintain a roll-over contract model from last year, so that there is stability and a reliable source of income that is separated from the amount of activity that is being done at the moment.[133]

126 Q84
127 Q151
128 Q154
129 Q152
130 Q204
131 Q204
132 Q204
133 Q204

Waiting times and managing the backlog: conclusion

62. **The pandemic has placed an unprecedented burden on the delivery of core NHS and care services. This has resulted in the delay, suspension or cancellation of services which in turn has inevitably led to a significant increase in waiting times, the backlog of appointments and pent-up demand for medical treatments. We are concerned that this has, in part, been created as a result of many individuals being too scared to access the medical treatment they require because they are uncertain as to whether NHS services are safe to use.**

63. **We recognise the commitment of policy makers and the NHS leadership to restoring core NHS services and the ongoing efforts to manage the backlog. We are also grateful for the hard work of all staff and the use of innovative methods to support core NHS services during the pandemic, including: the creation of cancer hubs, Urgent Dental Centres and COVID-light facilities. We are concerned, however, that despite such innovations many core health services have been unable to continue or have continued with very limited capacity. In March 2020, Sir Simon Stevens issued an instruction that cancer services should not be stopped, but it is clear that this instruction was not always adhered to.**

64. **During our session on 30 June 2020, Sir Simon Stevens told us that he "expects" waiting times for and referrals to core health services to "go up quite significantly over the second half of the year."[134] We also heard from Sir Simon,[135] Amanda Pritchard[136] and Professor Steve Powis[137] of the importance of restoring core services for patients. It nevertheless remains unclear to us what practical steps the Government and NHSE/I are taking and are planning to take to reduce waiting times, meet the backlog of appointments and prepare the NHS for addressing pent-up demand. The absence of a public plan to address these issues may be contributing to the inability of local trusts to inform patients when they can expect to receive a long-awaited medical procedure. Nevertheless, we do also recognise the significant difficulty in planning ahead when the risk of a second spike remains unclear.**

65. ***We recommend that the Department of Health & Social Care and NHSE/I provide an update on what steps they have, individually and collectively, taken and are planning to take to quantify and address the overall impact of the pandemic on waiting times, the backlog of appointments and pent-up, and as yet unknown and unmet patient demand for all health services, specifically across cancer treatments, mental health services, dentistry services, GP services and elective surgery. We also ask the Department and NHSE/I to provide a comprehensive update on what steps are being taken and what steps will be taken in the future to manage the overall level of demand across health services. We request this information by the end of October 2020.***

66. ***We also recommend that NHSE/I provides us with a more broader update on what positive innovations or changes have taken place in the NHS during the pandemic, and how it seeks to ensure all the positive changes that have occurred are captured and potentially implemented across the entire NHS. We expect this information by the end of 2020.***

134 Q191
135 Q193
136 Q197
137 Q215

67. **We further conclude that the delivery of dental services in England has been significantly hindered by the pandemic. This has been largely due to the need to protect both patients and staff from COVID-19 which has, in turn, presented financial challenges to both NHS and private dental practices. We welcome NHSE/I's continued efforts to support the restoration of dentistry services in England**.

68. ***We are concerned that there does not appear to be a plan for the restoration of dental services in England. We recommend that Sara Hurley (Chief Dental Officer for England) sets out her assessment of the challenges facing dentistry services in England, and clarifies what steps will be taken to ensure dentistry services are able to continue to be restored to meet patient demand in the safest possible way whilst also remaining financially sustainable.***

4 Issues facing NHS and care staff: PPE and testing

69. NHS and social care staff have worked courageously and tirelessly to deliver for patients and care users throughout the course of the pandemic, and a number have sadly lost their lives to COVID-19. There have been consistent calls, from across all core health and care services, for the Government and NHS England & Improvement to take all necessary action to protect these essential front-line NHS and care workers. We have heard that some NHS and care staff were frustrated by a lack of, or in some cases perceived lack of, access to appropriate personal protective equipment (PPE) during the early stages of the pandemic. Some members of staff have also expressed a desire to be routinely tested for COVID-19. Without adequate access to PPE and a sensible testing regime, there is a significant risk that core NHS and care services cannot be provided safely and effectively during the next phase of the pandemic.

70. We also heard about problems relating to the fatigue and "burnout" of the NHS and care workforce with some members of staff expressing concern that more support may be required. Recent events in this country and elsewhere have, of course, also placed a spotlight on problems facing Black and Ethnic Minority (BAME) individuals. We have consequently reviewed some of the important issues relating to discrimination and racism within the NHS. We have also launched a separate inquiry into *Workforce burnout and resilience in the NHS and social care* to ensure that these issues are voiced and addressed in more detail than has been possible in this report.[138]

Personal protective equipment (PPE)

71. There is a clear imperative to protect NHS and care staff who are dutifully providing treatments to patients and are by definition putting themselves at risk of catching COVID-19. As Claire Murdoch (National Mental Health Director, NHSE/I) told us on 1 May 2020:

> [NHS staff] are heroes; they are courageous because they are coming to work when they are frightened. […] One of the best things we [NHSE/I] can do […] is to have our staff going home from work saying that they felt well supported, they had good access to things like PPE and they felt safe and listened to. That is incredibly important.[139]

72. Reliable access to appropriately fitting PPE is critical for NHS and care staff and therefore to the resumption of healthcare services. As Dr Katherine Henderson (President, Royal College of Emergency Medicine) put it: "We know PPE works".[140] However, during the early stages of the pandemic, there were numerous reports of significant problems in the Government's and NHSE/I's attempts to procure and supply PPE. These problems have been documented in the work of the Science and Technology Select Committee, the Committee of Public Accounts and the National Audit Office, as well as through our own

138 Health & Social Care Committee, Workforce burnout and resilience in the NHS and social care inquiry, HC 320 [webpage]
139 Q54
140 Q140

inquiry into *Management of the Coronavirus Outbreak*.[141]

73. Difficulty in accessing sufficient levels of appropriately fitting PPE has left a significant minority of NHS and care staff feeling unprepared and anxious as they were put at unnecessary risk of catching COVID-19. On 1 May 2020, three months after the first case of COVID-19 was identified in the UK, and five weeks after lockdown, Gill Walton (Chief Executive, Royal College of Midwives) raised concerns around PPE provision, particularly in a community setting.[142] Two weeks later, Nigel Edwards (Chief Executive, Nuffield Trust), Dr Jennifer Dixon (Chief Executive, The Health Foundation) Richard Murray (Chief Executive, The King's Fund) each told us that PPE was still not being provided to adequate levels.[143]

74. On 14 May 2020, Chris Hopson (Chief Executive, NHS Providers) also explained that "If everything [PPE] had arrived that had been ordered, and if everything had arrived on time and to quality, we would not have the problems that we have",[144] adding that there has not been a "sufficiently reliable and consistent flow" of PPE for NHS staff.[145] He referred to a NHS Trust Chief Executive telling him: "'I can't really restart services until I have more than two days' supply of PPE [...]. I am not there yet.'"[146] These concerns were recently reiterated by a survey conducted by NHS Providers of its membership at the end of June 2020, which reported that 53% of respondents said that "PPE remains a concern".[147] The Royal College of Surgeons of England and Royal College of Emergency Medicine have stated that "The NHS workforce has responded brilliantly to the crisis, but morale has been damaged by the system failure on PPE."[148]

Staff access to the most appropriate type of PPE

75. During the start of the pandemic, concerns were also raised about staff access to the right type and quality of PPE. For example, Chris Hopson explained that an inconsistent supply of the same type of PPE has reduced productivity for NHS Trusts, with Trusts forced to restart the "fit-testing process" for staff which "can take up to 30 or 40 minutes per person per mask".[149] Mr Hopson explained that:

> There were six different mask types sitting in that stock reserve, and NHS Trusts found that one day they were getting one type of mask delivered, the next day another type of mask and the next day another type of mask. […] each different mask required a different fit test. There were other problems along the line—for example, insufficient fit-testing liquid.
>
> You asked, "What would be the answer?" The answer would be to get to a stable distribution system in which there was sufficient stock of all the

141 Health & Social Care Committee, Managing the Coronavirus Outbreak inquiry, HC 36 [webpage]; Science & Technology Committee, UK Science, Research and Technology Capability and Influence in Global Disease Outbreaks, HC 136 [webpage]; Public Accounts Committee, Readying the NHS and social care for the COVID-19 peak, HC 405; National Audit Office, Readying the NHS and adult social care in England for COVID-19, HC367, 12 June 2020.

142 Q19

143 Q72; Q98 and Q117. See, also: The Health Foundation, The King's Fund and Nuffield Trust (DEL0292)

144 Q92

145 Q92

146 Q80

147 NHS Providers (DEL0318)

148 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)

149 Q95

> different types of masks, so that Trusts could say, "Okay, I just want to have type A because that is what we are used to using, and that is what all our staff have been fit-tested in." […] we are reliant either on what sits in the pandemic stock reserve or on what we can bring in from abroad. It is an imperfect situation.[150]

76. Dr Katherine Henderson (President, Royal College of Emergency Medicine) told us that some types of PPE had caused problems for staff productivity across emergency services. Dr Henderson said that "The productivity of everything drops in this situation. Putting on and taking off PPE takes time. It adds time to every single encounter."[151] Dr Henderson also highlighted the problems that PPE can have for staff, telling us: "Wearing a face mask all day is tiring. It dehydrates you. You feel tired by the end of the day. People get skin problems from wearing a mask. It is very uncomfortable. All of that adds up to a productivity issue, so the workforce are a real concern."[152]

77. Dr Henderson further explained that PPE can also cause "problems with communication" between staff and patients.[153] She explained that the Royal College of Emergency Medicine conducted a survey of its members and fellows and "97% of [respondents] said that it is more difficult to communicate wearing PPE. Even doing simple things like having a conversation takes longer when you are wearing PPE."[154]

78. The need for a consistent supply of the correct type of PPE has been a particularly pronounced challenge for dentistry services because most dental operations involve aerosol generating procedures which are considered to be an infection risk and therefore require dental staff to wear particular types of PPE. Mick Armstrong (Chair, British Dental Association) told us that the dentistry industry is "still bedevilled by having the correct PPE consistently and widely available".[155] The Local Dental Committees Federation, the Association of Dentists Groups and British Dental Association have all said that the lack of adequate PPE has significantly limited the number of patients that can be seen.[156]

79. In response to these concerns, Amanda Pritchard (Chief Operating Officer, NHSE/I) explained that "We [NHSE/I] are conscious that both the demand for PPE and the price of PPE has risen, so we are very keen to continue working with the BDA [British Dental Association] to make sure that we support NHS dentists through that".[157]

PPE and BAME NHS staff

80. We were told that problems with the supply of PPE to NHS staff, as outlined above, have been especially severe for Black, Asian and Minority Ethnic (BAME) staff. In the

150 Q95
151 Q140
152 Q140. See also: Jenny Priest (Director of Policy and Public Affairs at Royal College of Obstetricians and Gynaecologists) (DEL0199); Stuart Bonar (Public Affairs Advisor at Royal College of Midwives) (DEL0255); Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284) and Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308); Royal College of Physicians (DEL0319).
153 Q140
154 Q140
155 Q131
156 Dr Martin Skipper (Head of Policy at LDC Confederation) (DEL0248); Ms Penny Whitehead (Head of Policy and Research at British Dental Association) (DEL0252); and Lewis Robinson (Policy and Public Affairs Advisor at Association of Dental Groups) (DEL0276).
157 Q204

context of the heightened risk that COVID-19 poses to people from BAME communities, the need for BAME staff to have appropriately fitting PPE has been consistently raised with us. Chris Hopson told us that:

> [O]ne of the consistent issues that is raised with our Trust Chief Executives is that some of the different types of mask do not fit particular types of face. You are right to identify that that has been raised as an issue particularly for certain groups of Black and ethnic minority staff. I had heard that east Asian nurses in particular were finding that some brands of mask did not fit in the right way. I have heard variants of your anecdote about some of it being built for 6-foot-3 rugby players.[158]

81. Richard Murray (Chief Executive, The King's Fund) noted the disproportionate impact COVID-19 is having on BAME staff and told us that this "ratchets up the requirement for PPE" for BAME staff.[159] The Royal College of Nursing has similarly called for "A comprehensive and continuous equality impact assessment on staffing issues relating to COVID-19, including reviewing […] access to PPE and to fit testing for BAME workers to be carried out across all settings."[160]

82. Professor Steve Powis told us that: "It is absolutely the case that faces are different and not every single type of mask fits as perfectly as we would like on to every individual face" and it is "absolutely critical" that NHSE/I supports "staff who are at greater risk of COVID-19, [including] our BAME colleagues [who] are a particular risk group".[161]

Response from the Government and NHSE/I

83. On 3 June 2020, we heard from Lord (Paul) Deighton (Adviser on PPE to the Secretary of State for Health and Social Care), who outlined the challenges to procuring and supplying of PPE to NHS and care staff, and the steps that were being taken to improve it. Lord Deighton emphasised the importance of building resilience into the PPE supply chain by diversifying where PPE is procured from. He also highlighted his and the Government's ambition and plan to ensure that a range of PPE is made available to meet the needs of all healthcare staff.[162]

84. On 30 June 2020, we questioned NHSE/I leaders on the security of the PPE supply chain particularly as winter approaches and the possibility of a second wave of coronavirus remains present. Professor Steve Powis (National Medical Director, NHSE/I) said "It is absolutely the case that the supply lines are more secure now and the distribution network […] is in a much more secure and robust place".[163] He explained that:

> We are doing work with Government and colleagues in NHSE to ensure, now that supply is much more stable, that organisations get a range of different masks in different sizes and of different makes where they need them, so that there is more flexibility in ensuring that individuals have a

158 Q95
159 Q98
160 Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284)
161 Q225
162 See, for example: Qq553–562, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
163 Q225

> choice of the masks that fit best. [This is] a very important point, and it is work that we are doing as we speak.[164]

85. Sir Simon Stevens added:

> The Department of Health team have increasing confidence that supply will be available on a predictable forward basis rather than some of the more just-in-time approaches that were in place while there was a huge worldwide crunch on PPE supply and a massive spike in worldwide demand.[165]

86. **We recognise the unprecedented scale of the challenge facing the Government and NHSE/I to keep NHS and care staff safe during the pandemic. As in other countries facing the pandemic there were, however, persistent failures with the procurement and supply of appropriate personal protective equipment (PPE) to some NHS and care staff, particularly during the early stages of the pandemic. It is important to recognise that different staff will require different types of PPE and there is a need to make sure that the PPE available is suitable for a diverse work force. We welcome the appointment of Lord Deighton as adviser on PPE to the Secretary of State for Health and Social Care. Lord Deighton's evidence gave us confidence that the issues relating to PPE which have been raised with us will be prioritised and addressed.**

87. ***We request an update from the Department of Health & Social Care by the end of November 2020 on what steps are being taken to ensure that there is a consistent and reliable supply of appropriately fitting PPE to all NHS staff in advance of the onset of winter and a potential second wave.***

Routine testing of all NHS and care staff

88. All front-line NHS and care staff are placing themselves at a heightened risk of catching COVID-19. But despite repeated public and private pleas from NHS and care staff and representative organisations, from eminent scientists such as Professor Sir John Bell, Professor Sir Paul Nurse, and Professor Sir Jeremy Farrar, and from other House of Commons select committees,[166] the Government and NHSE/I have not yet introduced routine asymptomatic testing for all NHS staff. Around 70% of COVID-19 carriers are asymptomatic,[167] and only the routine testing all healthcare staff will ensure core health and care services are returned to normal levels.

89. Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, announced the Government's plans for testing NHS staff to the House of Commons on 24 June 2020. He promised:

> […] to prioritise testing of all NHS staff with symptoms, asymptomatic regular testing of staff in situations where there is an incident, outbreak or high prevalence and regular surveillance testing across all staff.[168]

164 Q225
165 Q225
166 See, for example: NHS Providers, Testing questions in testing times, 30 April 2020 [webpage]; Q568–571, Q586, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36; Public Accounts Committee, Readying the NHS and social care for the COVID-19 peak, HC 405, 29 July 2020 [report]
167 See, for example: Office for National Statistics, Coronavirus Infection Survey, 18 August 2020 [webpage]
168 Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, Written Statement: COVID-19, Statement UIN HCWS312, 24 June 2020. See also: Letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Committee, 06 August 2020 [letter].

90. Throughout our inquiry, we have heard that the Government's and NHSE/I's testing strategy has arguably moved too slowly and put patients, care home residents, and NHS and care staff at avoidable risk. We have also heard that, in the early stages of the pandemic, where testing was on offer to staff, access was limited, turnaround time for results were too often long and staff morale and confidence were consequently damaged.[169] We are also aware that there are some limitations to testing for COVID-19, including results which provide "false positives".

Testing and social care

91. From as early as March 2020, we have raised the matter of regular testing for all health and care staff throughout this inquiry and our other work on the Government's response to the pandemic.[170] For example, on 26 March 2020, we asked Professor Yvonne Doyle (Director for Health Protection and Medical Director at Public Health England) whether social care workers would be treated as a priority for testing. In response, Professor Doyle told us "Yes […] [individuals who are] dealing with people in the community and in hospital, are very much part of the worker priority [for testing]".[171]

92. On 19 May 2020, Vic Rayner (Executive Director, National Care Forum) told us that it is "absolutely critical" that all social care workers (including agency staff or those directly employed by care homes) are regularly tested for coronavirus and that results are received in a timely fashion. Ms Rayner added that this will be crucial to ensuring that "care homes can make proper decisions" about who can be in care settings and what further support is required.[172] Ms Rayner stressed to us that, if this does not happen, then:

> We [will] end up in a position where staff who have done a most extraordinary and incredible job of supporting people in this very difficult climate end up feeling like they are the people who are responsible for the spread [of COVID-19], which is the last possible thing they would want to do, whether they are agency or employed.[173]

169 See, for example: Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308); Mr Paul Alexander (Policy Manager at The Royal College of Radiologists and collaborator at The Society and College of Radiographers) (DEL0030); Sean O'Sullivan (Head of Health and Social Policy at Royal College of Midwives) (DEL0027); Mr Jonathan Blay (Public Affairs Manager at Royal College of Psychiatrists) (DEL0038); Mr Jordan Clark (Public Affairs Officer at Alzheimer's Society) (DEL0049); Head of Patient Advocacy Shelagh McKinlay (Myeloma UK) (DEL0060); Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); Mr Jonathan Blay (Public Affairs Manager at Royal College of Psychiatrists) (DEL0139); The Royal College of Pathologists Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists) (DEL0211); Stuart Bonar (Public Affairs Advisor at Royal College of Midwives) (DEL0255); Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258); Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284); Niall Dickson (Chief Executive at NHS Confederation) (DEL0198); and Ms Susan Bahl (Head of Policy and Public Affairs at NHS Providers) (DEL0137) and NHS Providers (DEL0318).

170 See, for example: Qq199–204; Q469, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

171 Q234, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

172 Q475, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36. See, also: Qq468–475.

173 Q475; Qq468–474, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36.

93. However, subsequently, we have heard about the inequitable treatment of the social care sector which has inevitably affected care workers and patients.[174] For example, the announcement made by NHSE/I on 17 March 2020, stated that there would be an «Urgent discharge of all hospital inpatients who are medically fit to leave" without these patients or care staff being tested at all[175] and subsequent announcements, have failed to ensure the necessary safety of patients and care staff. Commenting on this announcement, Sir Robert Francis (Chair, Healthwatch England) told us that:

> When I first saw the initial guidance that patients were to be discharged within two hours of being declared medically fit, I wondered how that could possibly happen safely. We heard stories that rather confirmed that, sadly.[176]
>
> The idea that people might be discharged into that care home without anyone knowing whether they have COVID-19 or not seems very concerning. […] It is very important that there are properly run facilities, with the ability and capacity to look after people well and safely.[177]

94. During our inquiry, Richard Murray (Chief Executive, The King's Fund) similarly questioned the Government's and NHSE/I's handling of the spread of coronavirus in care settings. Mr Murray told us:

> Despite the fact that we saw evidence in Italy, Spain, France and others that social care was going to be the second problem for coronavirus after the hits on intensive care, we did not seem to take that on board. […] There is a question about how we were so slow given that we had seen what happened in Europe.[178]

95. There have been frequent and long-standing calls for more investment and support to be provided to the social care sector during the pandemic and beyond. Richard Murray emphasised the long-term need to support the care sector, telling us that "The social care workforce needs just as much attention as the health workforce".[179] This was reiterated by Dr Jennifer Dixon (Chief Executive, The Health Foundation) who told us that the Government should focus on supporting the care sector "without delay".[180] Nigel Edwards (Chief Executive, The Nuffield Trust) similarly echoed these comments when he told us that "Jennifer's point, and indeed everyone else's, about where we should put our effort is that getting the social care problem sorted out, which has been festering for a couple of decades, is absolutely the key priority".[181]

174 See, for example: Q78; Qq92–94; Q98; Qq102–103; Qq106–108; Qq117–118 and Qq165–167. Fazilet Hadi (Policy Manager at Disability Rights UK) (DEL0124); Mrs Anna Bailey-Bearfield (Policy and Public Affairs Manager at Care and Support Alliance) (DEL0142); Mr Sam Dalton (Policy & External Affairs Executive at ARCO (Associated Retirement Community Operators)) (DEL0164); Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284); Mr Matthew Rose (Senior Parliamentary and Stakeholder Engagement Adviser at Care Quality Commission) (DEL0299); Erika Schmidt (Senior Associate at Equality and Human Rights Commission) (DEL0190) and Mr Joseph Brunwin (External Relations Officer at MS Society and N/A at MS Trust) (DEL0208).

175 Letter from Sir Simon Stevens (Chief Executive, NHSE/I) and Amanda Pritchard (Chief Operating Officer, NHSE/I), to Chief executive of all NHS trusts and foundation trusts et al., Important and Urgent Next Steps on NHS Response to COVID-19, 17 March 2020 [letter]

176 Q166

177 Q167

178 Q117

179 Q94

180 Q106

181 Q108

96. In his oral evidence to us, Sir Simon Stevens acknowledged that "There is a general point, which is that the coronavirus pandemic has shone a very sharp spotlight on some longstanding weaknesses and lack of investment and resilience in the social care sector."[182]

97. We questioned Professor Steve Powis (National Medical Director, NHSE/I) about what has been learnt since NHSE/I's communication from the start of March 2020. In particular, we asked Professor Powis whether, knowing what he does now, he would change the guidance set out in the announcement issued on 17 March 2020 to ensure patients are tested or quarantined for 14 days prior to being discharged into care settings. We also questioned Professor Powis about subsequent delays in amending critical infection control and prevention guidance for healthcare settings. For example, we sought clarification as to why updates to the guidance (such as that relating to the 2-metre socially distancing measure) were introduced towards the end of May 2020, despite SAGE minutes from April 2020 showing that nosocomial infections (infections originating in hospitals) had been rising significantly.[183]

98. In response, Professor Powis acknowledged that:

> It is always difficult going back in hindsight to a particular point in time, but clearly in April we moved to testing people coming out of care homes. As our knowledge of the virus has changed over the months, so the various guidance and advice has changed.[184]

However, he defended the NHSE/I's early approach to the discharge of patients to care homes and its approach to updating infection prevention and control guidance for healthcare settings. Professor Powis told us:

> No, I would not accept that we have taken our eye off infection prevention and control [in care homes]. I think people have been focused on it throughout.[185]

99. Professor Powis also drew specific attention to the matter of testing capacity. He explained that "testing capacity was very constrained at that time in early March. There were many fewer daily tests available than there are now."[186] Following consistent calls for routine testing of all healthcare staff including during our oral evidence sessions, on 3 July 2020, the Government announced a commitment to weekly tests for care home staff and monthly tests for residents in care homes in England.[187] This routine testing has taken longer than was originally planned but appears now to be in place, although issues remain around the time taken to receive results.

182 Q245
183 Qq214–218. See also: SAGE, Dynamic CO-CIN report to SAGE and NERVTAG [OFFICIAL-SENSITIVE PROTECT] 1 April 2020 [report] and SAGE, Twenty-ninth SAGE meeting on COVID-19, 28th April 2020 Held via Zoom, 28 April 2020.
184 Q213
185 Q216
186 Q213
187 Gov.uk, Regular retesting rolled out for care home staff and residents: Press Release, 3 July 2020 [webpage]

Testing and NHS staff

The benefits of routinely testing NHS staff

100. Regular testing of NHS staff will also help to reassure the public that NHS services are safe to use. The Royal College of Nursing has stated that the lack of testing is a "key barrier" to providing "effective and safe care" and that there should be a "rapid expansion" and "a sustained rise in the number of tests being conducted."[188] The Royal College of Surgeons of England has similarly called for the Government to "ensure that the rollout of asymptomatic testing is swift".[189] In their joint submission, the Royal College of Surgeons of England and the Royal College of Emergency Medicine have stated that the "weekly testing of staff will help lower the risk of nosocomial infections [that is, infections originating in hospitals]".[190]

101. The question of routine testing for NHS staff has been raised throughout our inquiry. On 14 May Nigel Edwards (Chief Executive, The Nuffield Trust) told us that "We are way behind where we need to be" in terms of testing[191] and Chris Hopson (Chief Executive, NHS Providers) told us that regular testing of NHS staff was "something we know we need to do"[192] and an "obvious next step".[193] The importance of routinely testing NHS staff was further emphasised to by Chris Hopson when he came before us again on 30 June 2020. Mr Hopson told us:

> Our Trusts are telling us at the moment that they cannot guarantee sufficient reliable and consistent access in a timely way to the tests that they need. If, for example, you want to restart emergency services, you absolutely need to know that all the staff involved in that process will be able to get a test, and have it done and turned around sufficiently quickly to guarantee restarting services. What actually counts on testing is whether everybody who needs access to a test can get it reliably and consistently.
>
> [...] we are still a long way from where we need to be to have a testing regime that is reliable and consistent, which enables us to restart services in the way we need to.[194]

102. This concern has been particularly stressed to us by results from a recent survey conducted by NHS Providers of its membership. The survey showed that 57% of respondents agree or strongly agree with the statement: "There is insufficient testing capacity to safely

188 Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284)
189 Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258)
190 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308). See also: Mr Paul Alexander (Policy Manager at The Royal College of Radiologists and collaborator at The Society and College of Radiographers) (DEL0030); Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); Mr Jonathan Blay (Public Affairs Manager at Royal College of Psychiatrists) (DEL0139); The Royal College of Pathologists Janine Aldridge (Public Affairs Officer at The Royal College of Pathologists) (DEL0211); Stuart Bonar (Public Affairs Advisor at Royal College of Midwives) (DEL0255); Tamora Langley (Head of Policy Media and Public Affairs at Royal College of Surgeons of England) (DEL0258); Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284); Niall Dickson (Chief Executive at NHS Confederation) (DEL0198); and Ms Susan Bahl (Head of Policy and Public Affairs at NHS Providers) (DEL0137) and NHS Providers (DEL0318).
191 Q96
192 Q93
193 Q181
194 Q93

resume all services".[195] On 30 June 2020, despite announcements from NHSE/I on 29 April[196] and 24 June,[197] Chris Hopson told us that "Trusts felt that two months ago there was a commitment that we would get to regular staff testing as quickly as possible, but two months later we still do not have a clear plan for doing that".[198]

103. We have also heard that routine testing of NHS staff will be key to restoring public confidence that NHS services are safe to use. Professor Derek Alderson told us that routine testing of staff will be "absolutely essential to regaining public confidence" that medical services are safe to use.[199] Similarly, Dr Katherine Henderson (President, Royal College of Emergency Medicine) told us:

> We cannot build confidence for patients coming into hospitals if we cannot be sure that we can protect everybody. We must make sure [through regular testing] that staff are not carrying the virus, because asymptomatic spread is a worry, and staff-on-staff infection is a worry.[200]

104. Concern about asymptomatic transmission has also been raised by others. For example, Professor Sir Paul Nurse (Chief Executive and Director of the Francis Crick Institute, whose work has been at the forefront of the efforts to understand and tackle COVID-19) told us that research conducted by the Francis Crick Institute and others during March and April 2020 showed that, at the height of the pandemic, 40% of healthcare workers were infected and asymptomatic carriers of COVID-19.[201] SAGE minutes from mid-April 2020 suggested that up to 20% of coronavirus patients may have been infected in hospitals.[202] Whilst more recent estimates of nosocomial infections suggest that the actual figure was probably closer to 15%,[203] that still remains a significant figure and the fact that SAGE saw those figures in mid-April makes it even more regrettable that faster progress has not been made on asymptomatic testing.

The importance of routinely testing all NHS staff

105. It is of course not just clinical staff who need testing. Professor Sir Paul Nurse told us that "regular, systematic testing of all healthcare workers, including not only frontline doctors and nurses but support staff, ambulance drivers, and other healthcare providers such as care homes, GP surgeries, community nurses and the like" is essential.[204] Sir Paul explained that testing all NHS staff routinely:

> […] is important because it protects our healthcare workers. They deserve to work in a safe environment. Some of them are dying because of what they do. Frankly, they deserve better. They need to be protected and we need testing.[205]

195 NHS Providers (DEL0318)
196 Letter from Sir Simon Stevens (Chief Executive, NHSEI) and Amanda Pritchard (Chief Operating Officer, NHSE/I), to Chief executives of all NHS trusts and foundation trusts et al, Second Phase of NHS Response to COVID19, 29 April 2020 [letter]
197 Letter from Ruth May (Chief Nursing Officer for England), Steve Powis (National Medical Director) et al, to Chief Executives, Chief Nurses and Medical Directors and HR Directors of all NHS Trusts and Foundation Trusts, Healthcare associated COVID-19 infections - further action, 24 June 2020 [letter]
198 https://committees.parliament.uk/oralevidence/607/html/Qq180–181
199 Q140
200 Q140
201 Q569, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
202 Scientific Advisory Group for Emergencies, Social Distancing Review - Sage Advice, 14 April 2020 [report]
203 SAGE, Dynamic CO-CIN report to SAGE and NERVTAG [OFFICIAL-SENSITIVE PROTECT] 1 April 2020 [report]
204 Q568, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
205 Q568, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

106. Richard Murray (Chief Executive, The King's Fund) similarly told us that routine testing should be expanded beyond clinical staff to, for example, porters and cleaners because they "move in and around wards" and into "people's homes".[206] Mr Murray explained that: "You cannot run a hospital without them. […] they are providing essential services. They are at risk and, equally, they can transfer the virus themselves".[207]

Response from the Government and NHSE/I

107. We have questioned Rt Hon Matt Hancock, Professor Chris Whitty and Sir Simon Stevens on the progress being made to test all NHS staff. We were told that decisions relating to how NHS staff should be tested and at what frequency has been medically led. We also heard that capacity constraints continue to influence those decisions.[208]

108. On 30 June 2020, Sir Simon told us that capacity to conduct routine testing remains a problem. Sir Simon explained that this was not, however, "the end of the story" and that NHSE/I "want to see a significant further increase in testing capacity".[209] Sir Simon further explained:

> The aim, clearly, by the end of September or October [2020] is to have significant extra lab capacity so that, were the Chief Medical Officer then to recommend a change in the asymptomatic staff testing policy, that would be something that could be delivered.[210]

109. During our session on 21 July 2020, Professor Chris Whitty (Chief Medical Officer) similarly told us that from the start of the pandemic, the Government had been "starting from a standing start" as capacity for testing had not been sufficiently built up.[211] Professor Whitty explained:

> Initially, we did not have the capacity. Even now, we would be at the margins of capacity were we to do routine testing for all healthcare staff on a more than very occasional basis, but it is improving. The capacity constraints are being eased.[212]

110. We wrote to Rt Hon Matt Hancock and Sir Simon Stevens on 21 July 2020 to raise our concerns across three areas which required urgent action, including the matter of routine testing of all NHS staff.[213] In his response, on 6 August 2020, Rt Hon Matt Hancock wrote:

> We know that winter will bring new challenges, including a likely increase in cases of individuals showing symptoms that are consistent with those linked to COVID-19. So it is critical that we continue to scale up our testing

206 Q98
207 Q98
208 Q221; Qq621–622; Q653 Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36; and Letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter].
209 Q221
210 Q223
211 Q619, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
212 Q621, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
213 Letter from Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, to Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, and Sir Simon Stevens, Chief Executive of NHS England and Improvement, Delivering core services during the pandemic, 21 July 2020 [letter]

> programme. As the Prime Minister announced on 17 July, we will further increase our testing capacity to at least half a million antigen tests a day by the end of October.[214]

111. On 21 August 2020, Sir Simon wrote to us and set out his position on the future of testing all NHS staff. Sir Simon wrote:

> I am […] pleased to confirm that NHS England and Improvement would be fully supportive of the introduction of regular asymptomatic NHS staff antigen testing in the Autumn (presuming of course that the chief medical officer/DHSC decide that it is scientifically and clinically appropriate, and the Test and Trace programme secures the requisite testing capacity as they are planning). To that end, my letter of 31 July asks frontline NHS organisations to gear up to be ready to do so.[215]

Testing and scientific advice

112. Despite being informed that capacity constraints have inhibited the routine testing of all NHS staff, we have also been told consistently that decisions about testing staff have been medically led and based on scientific research. Since the start of the pandemic, we have investigated what scientific research has been conducted, in the UK and internationally, on the role of testing in managing and preventing the further spread of COVID-19.

113. On 21 July 2020, we spoke to several eminent scientists who described the importance of routine testing of all NHS staff—especially for those that may be asymptomatic carriers of COVID-19. During this session, Professor Sir Jeremy Farrar (Director, Wellcome Trust) told us:

> It has to be blanket testing. We know that a significant number of people are asymptomatic. Therefore, just testing those who are symptomatic will leave a whole pile of transmission going on that we will not get on top of. It needs to be random and frequent.[216]

114. Professor Devi Sridhar (Chair of Global Public Health, Edinburgh University) reiterated the concern that there was still no mass, routine testing of NHS staff when she told us "We knew about the issue of asymptomatic infections from the New England Journal in February 2020".[217] Professor Sir John Bell (Regius Chair of Medicine, University of Oxford), commenting on the lack of routine testing, similarly told us "It was not a novelty to think, "Oh gosh, we should test healthcare workers." It was in fact something that we knew about from other places."[218]

115. During our session on 21 July and also in further correspondence with us, Sir Paul Nurse (Chief Executive and Director, Francis Crick Institute) explained that, as part of the SAFER study, researchers at University College London Hospitals (UCLH) NHS Foundation Trust, in partnership with the Francis Crick Institute, have been collecting

214 Letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter]

215 Letter from Sir Simon Stevens, Chief Executive of NHS England and Improvement, to Rt Hon Jeremy Hunt MP, Health and Social Care Committee, 21 August 2020 [letter]

216 Q586; Q607, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

217 Q573, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

218 Q571, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

twice-weekly self-administered nose and throat swabs and monthly blood samples from 200 healthcare staff. These staff are caring for patients in a variety of roles within, for example A&E, intensive care, and COVID-19 wards at UCLH. Sir Paul concluded, from initial analysis of samples taken between 26 March and 8 April 2020, that all healthcare staff should be tested for COVID-19, including those who are not showing any symptoms of the virus. This is because there is a significant risk that coronavirus is being and will continue to be spread between staff, and between staff and patients, at a high rate.[219] Sir Paul explained:

> My colleagues at the Francis Crick Institute contacted Downing Street in March and wrote to Matt Hancock in April, emphasising[…] [that] at the height of the pandemic, our own research, which only backs up what has been done elsewhere, showed that up to 45% of healthcare workers were infected. They were infecting their colleagues and patients, yet they were not being tested systematically.
>
> […] it was quite clear that those without symptoms were likely to be transmitting the disease. Again, our own research has shown that nearly 40% of healthcare workers at that time were infected but had no symptoms. That was a major failure. In the healthcare environment, we were not providing proper protection.[220]

116. In contrast to the expert evidence we have received, on 21 July 2020, Professor Chris Whitty (Chief Medical Officer) told us that there is currently not a need to test all NHS staff on a routine basis. In later correspondence, Professor Whitty acknowledged that current research shows that "67% of UK infections are asymptomatic" but argued that "the percentage of people who are infected asymptomatic remains uncertain and is between 30–80%".[221] This uncertainty means, according to Professor Whitty, that the need to routinely test all NHS staff "is therefore not a settled question".[222] The Chief Medical Officer emphasised the importance of the on-going SIREN study which aims to provide clearer data on the "frequency and under what circumstances" the testing of all staff should take place.[223]

117. Public Health England, with advice from the Chief Medical Officer, is running the SIREN study, which is designed to monitor the prevalence of COVID-19 in NHS staff. The Secretary of State for Health and Social Care has told us that the study will help to determine where, and how frequently, wider asymptomatic staff testing is needed by identifying areas or settings in the NHS where there is a high prevalence of coronavirus.[224] Professor Whitty explained that this study will "allow for systematic data capture, which

219 Q569, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36 and Letter from Sir Paul Nurse, Chief Executive and Director of the Francis Crick Institute, Management of the Coronavirus Outbreak inquiry (session on 21 July 2020) - follow-up, 22 July 2020 [letter]

220 Q569, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

221 Letter from Professor Chris Whitty, Chief Medical Adviser for England and Department of Health and Social Care Scientific Adviser, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, Management of the Coronavirus Outbreak inquiry (session 21 July 2020) - follow-up, 18 August 2020 [letter]

222 *Ibid.*

223 Q621, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

224 Letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter]. See also: Qq621–622; Q653 Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36.

tells us more than a large amount of unconnected data would"[225] and that this will provide "a much better idea about the right way to do [testing]".[226]

118. Although Professor Whitty has stressed that the Government's attention should currently be on determining the frequency at which staff should be tested through the SIREN study, Professor Whitty has told us that, in the longer-term, he "does not disagree that asymptomatic testing is going to be needed".[227] During our session on 21 July 2020, Professor Whitty further explained:

> If there is a surge in winter, which is a really serious concern looking forward—where I spend most of my thinking time—and is what I am really worried about, we certainly will need asymptomatic testing among healthcare staff.[228]
>
> If there was a big surge I would be absolutely in favour of going for regular testing [of all NHS staff], even in advance of knowing the optimal frequency.[229]

119. During the same session, Professor Sir Paul Nurse emphasised to us that, throughout a pandemic "knowledge is uncertain, and we cannot always rely on clinical trials to come to decisions". Sir Paul described this as being "uncomfortable for scientists because they are giving advice in an uncertain situation", and suggested that the best way to deal with such situations is through transparency and openness.[230]

120. **We are grateful to Professor Chris Whitty (Chief Medical Officer) and his expert colleagues for their continued and constructive engagement with our work. We also recognise that the Government, following the advice of the Chief Medical Officer and others, has taken a considered approach to implementing the SIREN study. We note that the Government aims to utilise the SIREN study to better inform the frequency at which, and under what circumstances, the testing of NHS staff for coronavirus ought to take place.**

121. ***We accept the advice we have received from many eminent scientists that there is a significant risk that not testing NHS staff routinely could lead to higher levels of nosocomial infections in any second spike. We therefore urge the Government to set out clearly why it is yet to implement weekly testing of all NHS staff.***

122. **We note that Professor Chris Whitty has said that the testing of asymptomatic staff may be necessary in the future and that if there is a "surge in winter" of coronavirus cases then he would be likely to advise that routine testing of NHS staff should take place.[231] However, we are concerned that contrary to this advice, routine testing of asymptomatic NHS staff appears not to have been introduced where the virus is already surging in the North East and the North West, perhaps due to capacity constraints.**

225 Letter from Professor Chris Whitty, Chief Medical Adviser for England and Department of Health and Social Care Scientific Adviser, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, Management of the Coronavirus Outbreak inquiry (session 21 July 2020) - follow-up, 18 August 2020 [letter]
226 Q621, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
227 Q621, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
228 Q621, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
229 Q622, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
230 Q567, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36
231 Q622, Health & Social Care Committee, Management of the Coronavirus Outbreak, HC 36

123. ***We ask that Professor Whitty sets out to what extent testing capacity has impacted the advice he and his colleagues have provided to the Government on routine testing of NHS staff. We further ask Professor Whitty to clarify whether he has advised the Government to introduce routine testing of all NHS staff in the current virus hotspots and if not why.***

124. **We conclude that the case for routine testing of all NHS staff in all parts of the country (including clinical staff as well as cleaners, porters and so forth) is compelling and should be introduced as quickly as capacity allows and before the winter-flu season begins. Those who—either directly or indirectly—provide treatment to patients should not be put at any further unnecessary risk of catching or spreading COVID-19. We urge that steps be taken to expand capacity rapidly to make this possible.**

125. ***We recommend that, by the end of October 2020, the Government and NHSE/I set out: i) what current capacity there is for testing all NHS staff, ii) what further capacity (if any) will be required and iii) how long it is likely to take to secure sufficient capacity to offer routine tests to all NHS staff.***

5 Issues facing NHS and care staff: fatigue and "burnout"

126. NHS and care employees have worked valiantly and tirelessly to rise to the unprecedented challenges brought about by the pandemic. We are, however, aware that this additional pressure has led to workforce fatigue and "burnout" with a significant cost being imposed on staff members' mental and physical wellbeing. We have also heard that pre-existing issues relating to staff recruitment, training and retention have been exacerbated by the pandemic. In light of recent international events, we have heard many concerns about discrimination and racism against Black, Asian and Minority Ethnic (BAME) NHS and care staff. No member of NHS staff or social care worker should face bullying, harassment or discrimination and in particular, we have received urgent calls for greater steps to be taken to ensure BAME staff are protected and to ensure racism—in whatever form—is eradicated from the NHS and care system.

127. Although the People Plan: *We are the NHS: People Plan 2020/21 - Action for us all* (July 2020)[232] makes good progress in addressing these issues for the period of 2020–21, the pandemic has illustrated that further, more substantive and longer-term action is required if the NHS and care workforce is to be adequately supported. We will continue to champion these matters and solutions to them through our inquiries into *Workforce burnout and resilience in the NHS and social care*[233] and *Social care: funding and workforce*.[234]

NHS and care workforce wellbeing during the pandemic

128. The pandemic has required the NHS and care workforce to rise to new, unprecedented and sustained challenges. However, the cost of tackling the consequences of the pandemic must not be underestimated, particularly in terms of staff mental and physical wellbeing. The evidence provided to our inquiry has shown that much of the NHS and care workforce is fatigued, exhausted and otherwise "burnt out" with no obvious let up or plan to relieve the pressure in sight. This has damaged staff morale.[235] Professor Andrew Goddard (President, Royal College of Physicians) told us:

> The workforce is really tired at the moment. [...]That is all parts of the workforce, not just doctors; it is nurses and other healthcare professionals, who are all part of the hospital team. There is a mountain that people know they have to climb; they are willing to climb it and willing to pull together to do it, but it seems quite a large mountain at the moment. The worry that the peak is going to get higher in winter is a big one.[236]

232 NHSE/I, We are the NHS: People Plan for 2020/21 – action for us all, 30 July 2020

233 Health & Social Care Committee, Workforce burnout and resilience in the NHS and social care inquiry, HC 320 [webpage]

234 Health & Social Care Committee, Social care: funding and workforce inquiry, HC 206 [webpage]

235 Q165; Emma Paveley (Policy Manager at Mental Health Network, NHS Confederation) (DEL0064); Niall Dickson (Chief Executive at NHS Confederation) (DEL0198); Dr Agnes Arnold-Forster and Dr Caitjan Gainty (DEL0103); Jenny Gowen (Advocacy and Campaigns Manager at Association of Anaesthetists) (DEL0140); Mr Richard Stubbs (Chief Executive Officer, Yorkshire and Humber Academic Health Science Network at AHSN Network) (DEL0178); NHS Providers (DEL0318); Ms Susan Bahl (Head of Policy and Public Affairs at NHS Providers) (DEL0137); Helen Hughes (Chief Executive Officer at Patient Safety Learning) (DEL0250). See also: Health & Social Care Committee, Workforce burnout and resilience in the NHS and social care inquiry, HC 320 [webpage].

236 Q183

129. A survey carried out by NHS Providers of its membership, at the end of June 2020, showed that 92% of Trusts agreed with the statement "I am concerned about staff wellbeing, stress and burnout following the pandemic".[237] NHS Providers has told us that:

> Trust leaders are concerned that it is unrealistic and unfair to expect healthcare workers to go from coping with one crisis to working flat out to manage the backlog of care that has arisen during the pandemic. Steps must be taken to ensure, protect, and maintain staff resilience.[238]

130. Those points are reinforced by the evidence we heard from Professor Derek Alderson (President, the Royal College of Surgeons of England) and Dr Katherine Henderson (President, the Royal College of Emergency Medicine) who drew our attention to the implications for workforce numbers in the context of the pandemic. Professor Alderson told us:

> Our bed base and our total workforce were short. I am not just talking about surgeons but everybody who contributes to care in a hospital. We need expanded facilities. […] We still need to retain as much of our expanded workforce as we possibly can, bearing in mind that people have worked very hard for some months and are getting tired.[239]

Dr Henderson referred to the longer-term implications:

> When we get to February, we may lose a lot of staff. The other thing is people towards the end of their career and near retirement. Will it be, "I've had enough. I can't be doing with this. This is not how I thought I was going to be spending my day and I am now going to retire earlier"? We have a real worry at that end that very experienced people may feel that it has been great to deal with the crisis but the aftermath is just a bit too much to take forward.[240]

Mental health support

131. Concerns have also been raised with us relating specifically to the mental health support for the NHS and care workforce. It is understood that long-term exposure to high-pressured situations, particularly where staff have lost colleagues and experienced other work-related traumas, puts staff at an even greater risk of post-traumatic stress disorder and other forms of severe mental ill-health.[241]

132. The NHS Confederation has highlighted the importance of providing adequate mental health support for NHS staff. The NHS Confederation have said:

> The impact of COVID-19 on the dedicated staff providing health and care and wider public services will be significant, with personal sacrifice and loss coupled with the unrelenting and unprecedented demands made

237 NHS Providers (DEL0318)
238 Ms Susan Bahl (Head of Policy and Public Affairs at NHS Providers) (DEL0137) and NHS Providers (DEL0318)
239 Q135
240 Q140
241 See, for example: Professor Ben Hannigan (Chair at Mental Health Nurse Academics UK, Catherine Gamble, Professional Lead for Mental Health, is a signatory at Royal College of Nursing and David Munday, Lead Professional Officer for Mental Health, Unite the Union, is a signatory at Unite the Union) (DEL0036)

> of them. We do not yet know what the long-term impact will be on staff mental health and wellbeing.[242]

133. The NHS Confederation's Mental Health Network has said that, while local, targeted support offerings to NHS staff is appropriate, "there is a need for national, evidence-based guidance on how to best support staff wellbeing following the emergency period".[243] The People Plan: *We are the NHS: People Plan 2020/21 - Action for us all* (July 2020), similarly notes:

> The pandemic has already had a significant physical, mental and psychological impact on our people—and this will continue for some time to come. Many people are tired and in need of rest and respite.[244] […] It is our moral imperative to make sure our people have the practical and emotional support they need to do their jobs.[245]

134. During our session on 30 June 2020, Amanda Pritchard (Chief Operating Officer, NHSE/I) said that "We [NHSE/I] are absolutely committed" to supporting staff[246] but noted that "we have a real task ahead of us to make sure that we support our workforce. That is critical".[247] Similarly, the Department of Health and Social Care, in its written evidence, noted the risk that current work poses to staff members' mental health and that it aims to "gather evidence and assess the potential longer-term mental health impacts of COVID-19".[248]

135. Giving evidence earlier in our inquiry, Claire Murdoch (National Mental Health Director, NHSE/I) told us that "we [NHSE/I] are planning for wellbeing, resilience and mental health support for staff right now. In fact, we are delivering a lot more right now".[249] Claire Murdoch explained that "all Trusts and organisations across the country" are investing more in occupational health support, mental health support and national 24/7 helplines.[250] She further explained that:

> All the evidence shows that the best thing you can do for staff mental health right now resides within teams and how teams operate, with good supervision, good debriefs at the end of every shift, remembering to think about what went well and remembering to help staff go home at the end of a shift having talked about anything they are concerned about. It is about making sure they are getting sleep, rest and down-time. We are trying to reinforce good team behaviours.[251]

136. The People Plan provides a comprehensive and vital list of actions that are being taken and will be taken to support the mental health of NHS staff in the 2020–2021 period. It states that "Further action for 2021/22 and beyond is expected to be set out later in the year, once funding arrangements for future years have been confirmed by the Government."[252]

242 Niall Dickson (Chief Executive at NHS Confederation) (DEL0198)
243 Emma Paveley (Policy Manager at Mental Health Network, NHS Confederation) (DEL0064)
244 NHSE/I, We are the NHS: People Plan for 2020/21 – action for us all, p.14, 30 July 2020
245 NHSE/I, We are the NHS: People Plan for 2020/21 – action for us all, p.17, 30 July 2020
246 Q208
247 Q228
248 Q294
249 Q52
250 *Ibid.*
251 *Ibid.*
252 NHSE/I, We are the NHS: People Plan for 2020/21 – action for us all, p.51, 30 July 2020

Initiatives currently being rolled out to support the workforce's mental wellbeing include:

- access to a confidential support service (through phone or text);
- free access to wellbeing apps and webinars, safe spaces and discussion groups;
- guidance to team leaders including the introduction of wellbeing conversations between managers and reportees;
- the piloting of resilience hubs in partnership with occupational health programmes; and
- an increase in staff working remotely and flexibly.[253]

137. **We are extremely grateful to all NHS and care staff for their hard work and dedication in trying to meet patient needs in such exceptional circumstances. This includes those who have returned to the NHS (such as clinicians returning from academia, retirement and other industries); students who have left their training early to do so, and staff that have been redeployed to manage capacity constraints in other areas of the NHS. We share concerns that some NHS and care staff are suffering from fatigue, exhaustion and a general feeling of being "burnt out" and that the wellbeing of staff (particularly their mental health) is at significant risk.**

138. **We are grateful for NHSE/I's continued support of NHS staff and welcome the further measures set out in the People Plan (July 2020) for the 2020–21 period. In particular, we welcome the important and ambitious measures set out in the People Plan which show a clear desire to address workforce fatigue and provide mental health support to NHS staff. However, given the pressures on recruitment and retention of staff, we are concerned that the People Plan does not set out future workforce recruitment objectives, therefore failing to address one of the biggest concerns that many staff have, namely whether there will be enough of them to give high quality care to patients. We also believe more must be done to support the mental wellbeing of staff. Helplines, apps, webinars and managerial training will all be of value but with many members of staff facing much more severe and sustained pressures on their mental health, more substantive action will need to be taken to support the wellbeing of staff, particularly before the busy winter period. We note that the People Plan states further announcements will be made once the Government has confirmed funding arrangements for the NHS.**

139. ***We recommend that NHSE/I set out in detail what further specific steps it would like to take over the coming years to support the mental and physical wellbeing of all staff and a plan to deal with the specific issue of sustained workplace pressure due to the current pandemic and backlog associated with the coronavirus. This information should be made available to us in advance of any forthcoming Government spending announcements or by the end of October 2020 (whichever is earlier) in order for us to clarify what NHSE/I's priorities for NHS staff are, and to judge how far the Government's eventual spending commitments enable their implementation.***

140. ***We further recommend that NHSE/I should develop a full and comprehensive***

253 NHSE/I, We are the NHS: People Plan for 2020/21 – action for us all, pp.9–10; 15; 17–19, 30 July 2020

definition of "workforce burnout", and set out how the wellbeing of all NHS staff is being monitored and assessed. This information should be made available to us by the middle of October 2020, to enable us to scrutinise it in the course of our inquiry into Workforce Burnout and Resilience in the NHS and social care.

141. **We note, meanwhile, that there is no equivalent of the NHS People Plan for the social care workforce. We will have more to say about support for those working in social care in our forthcoming report on** *Social care: workforce and funding***.**

Support for BAME NHS staff members

Impact of COVID-19

142. The delivery of core health and care services during the pandemic has posed an unprecedented risk to Black, Asian and Minority Ethnic (BAME) NHS staff. Coronavirus has and continues to disproportionately harm those from BAME communities with recent data showing a significant excess deaths amongst BAME communities when compared with other groups. For example, Public Health England statistics (August 2020) stated that:

> [Coronavirus-related] deaths in Black males were 3.9 times higher than expected in this period (20 March to 7 May 2020), compared with 2.9 times higher in Asian males and 1.7 times higher in White males. Among females, deaths were between 2.7–2.8 times higher in Black, Mixed and Other ethnic groups in this period, compared with 2.4 in Asian and 1.6 in White females.[254]

143. NHSE/I have similarly noted the disproportionate impact coronavirus has had on BAME individuals in society, as well on frontline BAME NHS workers. A recent statement from NHSE/I noted:

> We know there is evidence of disproportionate mortality and morbidity amongst black, Asian and minority ethnic (BAME) people, including our NHS staff, who have contracted COVID-19. It is critical that we understand which groups are most at risk, so we can take concerted action to protect them.[255]

254 Public Health England, Disparities in the risk and outcomes of COVID-19, p.48, 11 August 2020. See also: Melanie Coombes (Chairman at National Mental Health & Learning Disability Nurse Directors Forum) (DEL0024); Rebecca Brione (Research and Partnerships Officer at Birthrights) (DEL0025); Robert Henderson (Senior Public Affairs Manager at Age UK) (DEL0028); Professor Ben Hannigan (Chair at Mental Health Nurse Academics UK, Catherine Gamble, Professional Lead for Mental Health, is a signatory at Royal College of Nursing and David Munday, Lead Professional Officer for Mental Health, Unite the Union, is a signatory at Unite the Union) (DEL0036); Ms Samantha Sharp (Senior Policy Officer at Kidney Care UK) (DEL0042); Hannah Lynes (administrator at National Maternity Voices) (DEL0043); Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); Ms Kate Mulley (Director of Research, Education and Policy at Sands - the stillbirth and neonatal death charity) (DEL0092); Sarah Whitehead (External Relations and Public Affairs Manager at Novo Nordisk) (DEL0187); Nil Guzelgun (Senior Health Policy and Influencing Officer at British Red Cross) (DEL0196); Mrs Alison Whitford (Healthcare Access Manager at Astellas Pharma Ltd) (DEL0200); Dr Samual Dick (Policy Manager - Health and Care Systems at British Heart Foundation) (DEL0240); Simon Whalley (Secretariat at British Association for Sexual Health and HIV (BASHH) and Comms liaison with BASHH at British HIV Association (BHIVA)) (DEL0241); National Voices (DEL0266); Mr James Byrne (Executive Treasurer at British Obesity and Metabolic Surgery Society) (DEL0272); and Knight-Yamamoto (Public Affairs Manager at Royal College of Nursing) (DEL0284).

255 NHS England and NHS Improvement, Addressing the impact of COVID-19 on BAME staff in the NHS [webpage]

144. On 30 June 2020, Professor Steve Powis (National Medical Director, NHSE/I) told us that NHSE/I had been working, throughout the pandemic and as evidence emerged, to support individuals—including BAME NHS staff—"who are most at risk of complications and harm from COVID-19."[256] Professor Powis explained:

> We worked with independent experts and NHS employers to formulate a risk assessment and a risk framework. Risk assessment tools were distributed to organisations, and we have been asking organisations, where they have not completed those risk assessments, to complete them in the next few weeks.
>
> […] Where adjustments need to be made, which could be redeployment to another work setting, working from home or a variety of measures, we have asked organisations to go through that process and ensure that all staff who have increased risk have that conversation and the opportunity to adjust their working environment to minimise risk.[257]

Issues facing BAME staff in the NHS

145. During the pandemic, recent international events have also put a much-needed spotlight on the issues facing BAME NHS staff. We are conscious of the wider debate about racism in society and the forms of discrimination BAME staff encounter in all workplaces. We recognise this extends even to organisations like the NHS which are rightly recognised for their inclusiveness. Such discrimination ranges from unconscious bias to fully-fledged racism.[258] As The King's Fund noted in its recent report *Workforce race inequalities and inclusion in NHS Providers* (July 2020), "addressing race inequalities in the NHS workforce is critical on multiple levels".[259] The report highlighted the following recent findings:

- 15.3% of ethnic minority staff report experiencing discrimination at work from a manager, team leader or other colleague—more than double the proportion of white staff reporting discrimination (6.4%);[260]
- 29.0% of ethnic minority staff have experienced harassment, bullying or abuse from staff in the past 12 months, compared with 24.2% of white staff;[261] and
- people from an ethnic minority background make up only 8.4% of boards in NHS trusts across England,[262] and "as the pay bands increase, the

256 Q229
257 *Ibid.*
258 See, for example: Dr Klearchos A. Kyriakides (DEL0037); Dr Agnes Arnold-Forster and Dr Caitjan Gainty (DEL0103); Mr Richard Stubbs (Chief Executive Officer, Yorkshire and Humber Academic Health Science Network at AHSN Network) (DEL0178); The King's Fund, 'A long way to go': ethnic minority NHS staff share their stories, July 2020 [blogpost]; The King's Fund, It's no longer enough to know, we must act: workforce race inequality in the NHS, 15 July 2020 [blogpost]; The King's Fund, Workforce race inequalities and inclusion in NHS Providers, July 2020 [report]; Victor Adebowale and Mala Rao, Racism in medicine: why equality matters to everyone, British Medical Journal, 12 February 2020 [article]; Gemma Mitchell, Yvonne Coghill: 'Racial inequality cannot be denied any more', Nursing Times, 1 July 2020 [interview]; and Saroo Sharda, We need to talk about racism, the BMJ Opinion, 5 March 2020 [article].
259 The King's Fund, Workforce race inequalities and inclusion in NHS Providers, p.9, July 2020 [report]
260 *Ibid.*
261 *Ibid.*
262 *Ibid.*

proportion of ethnic minority staff within those bands decreases".[263]

146. The NHS Workforce Race Equality Standard's report *2019 Data Analysis Report for NHS Trusts* (February 2020) also presented key findings, including:

- 19.7% of staff working for the NHS were from a BAME background in 2019;
- Only 8.4% of board members were from a BAME background (up from 7% in 2017 and 7.4% in 2018);
- The number of BAME staff at very senior manager level has risen by 30% since 2016, but the total proportion is only 6.5%; and
- 29.8% of BAME staff compared to 27.8% of white staff reported experiencing harassment in 2018, a worse disparity than in 2017.[264]

147. Commenting on the issue of racism and diversity in the NHS, Richard Murray (Chief Executive, The King's Fund) told us:

> There is a whole series of very practical issues about trying to make sure that the leadership of the NHS reflects the communities it serves and to make sure that we are not wasting the incredible talents that all the staff can deliver.
>
> What is a bit of a worry is that in the crisis of COVID-19 some of those long-standing issues are getting overlooked. We can see by the way the virus has moved through the country that they are just played out all over again. If anything, it should make us more determined and more resourceful in trying to overcome some of those long-standing race inequalities.[265]

148. During the same session, Dr Jennifer Dixon (Chief Executive, The Health Foundation) said:

> COVID-19 has exacerbated existing inequalities that we know exist in the population. Maybe now it is time for an inequalities strategy, off the back of COVID-19, to try to address some of those issues more purposefully than we have been able to do over the last 10 years.[266]

149. On 30 June 2020, we questioned Sir Simon Stevens on the challenges facing BAME staff. Sir Simon told us "I think there are systemic features to discrimination and racism, and the NHS is both part of the problem and part of the solution" and that "The reality is that the NHS has always relied on a diverse workforce and we have to become a better employer".[267]

150. Sir Simon also outlined the steps that had been taken to support BAME staff in the NHS. This included the Workforce Race Equality Standard, which has begun to track

263 The King's Fund, Workforce race inequalities and inclusion in NHS Providers, p.12, July 2020 [report]
264 NHS England and NHS Improvement, NHS Workforce Race Quality Standard 2019 Data Analysis Report, pp.6–7, February 2020 [report]
265 Q99
266 Q99
267 Q231

the experiences of BAME at every Trust,[268] a greater focus on the Freedom to Speak Up guardians network[269] and the funding of the independent NHS Race and Health observatory with the NHS Confederation which will, in part, aim to support BAME staff.[270] Sir Simon said that he hoped that these initiatives would "help shine a light on whether there are particular practices in particular organisations that need to change."[271]

151. The People Plan: *We are the NHS: People Plan 2020/21 - Action for us all* (July 2020) provides further detail on the initiatives that Sir Simon outlined to us. The People Plan also commits to tackling discrimination and racism in the NHS and states that there "has never been more urgent need for our leaders to take action and create an organisational culture where everyone feels they belong – in particular to improve the experience of our people from Black, Asian and Minority Ethnic (BAME) backgrounds."[272]

152. **The NHS is founded on the principle of equality and is one of the most diverse and inclusive organisations in the UK. It hugely benefits from the diversity of its staff as in turn so does the nation. In recent months, there has been a much-needed focus on supporting NHS staff from a Black, Asian and Minority Ethnic background (BAME). COVID-19 has, regrettably, disproportionately harmed and resulted in excess BAME deaths. We welcome the introduction of risk assessments and other initiatives, as set out by Professor Steve Powis, which are being implemented to protect BAME NHS staff from the risk of catching coronavirus.**

153. **We have also heard that some BAME NHS staff face discrimination and racism in the NHS and that, across the NHS, the levels of diversity must be improved. We accept Sir Simon Stevens' comments that "there are systemic features to discrimination and racism, and the NHS is both part of the problem and part of the solution".[273] Nonetheless, it is unacceptable that any BAME NHS employee should face discrimination, harassment or racism when working for the NHS. It is clear that more must be done to ensure that all NHS staff—regardless of their race, ethnicity or cultural heritage—feel safe, confident and proud to work for the NHS.**

154. ***The NHS must increase its efforts to eradicate all forms of discrimination and racism from in its organisation. We therefore recommend that NHSE/I provide a full and comprehensive definition of the "racism and discrimination" that it seeks to eradicate from the NHS. We invite NHSE/I and the Department for Health & Social Care to set out in detail its strategy to tackle racism and discrimination and to promote diversity in the NHS, including information on targets and deadlines by the end of 2020. We expect full and constructive engagement with NHSE/I and the Department as we further investigate matters relating to diversity and race in the NHS as part of our future work, including our Workforce burnout and resilience in the NHS and social care inquiry, in which we will review the root causes of these matters (including the difference between correlation and causation relating to coronavirus and excess deaths amongst BAME communities) and potential solutions.***

268 Q230
269 Q231
270 Q230
271 Q231
272 NHSE/I, We are the NHS: People Plan for 2020/21 – action for us all, p.23, 30 July 2020. See also pp.24–26.
273 Q231

6 The NHS: Lessons learnt and building for the future

155. The pandemic has required the NHS to make fundamental changes to the way it delivers services to patients. It is crucial to assess these changes in order to build for the future and support the NHS in the long-term. As part of our inquiry, we have assessed the use of:

- a "beefed-up" 111 dial service to prevent overcrowding at accident and emergency departments;
- technology and digital alternatives ("telemedicine") in the delivery of core medical services; and
- independent sector capacity (such as beds, facilities and staff) in supporting the delivery of core healthcare services.

Although no change comes without risk, there are lessons to be learnt from the pandemic which have the potential to substantially benefit the future of the NHS and build-upon the positive work already being undertaken by NHS Trusts, NHSE/I and the Government.

Long-term support for accident and emergency departments

156. In recent years, pressure on accident and emergency departments has been an ongoing source of concern.[274] The Royal College of Emergency Medicine (RCEM) has explained that the overcrowding of A&E departments has resulted in "corridor care" becoming commonplace in hospitals with most emergency departments being "stretched beyond the capacity they were designed and resourced to manage at any one time."[275] During our session on 16 June 2020, Dr Katherine Henderson (President, Royal College of Emergency Medicine) referred to emergency departments as having "elastic walls" with teams never able to say "We are full. We are at capacity."[276]

157. The RCEM told us that patients have attended A&E Departments less as a result of the pandemic and in consequence A&E Departments have "no longer been forced to pick up the pieces where community or specialist care fails to cope, especially out of hours."[277] Dr Henderson told us that the pandemic had effectively "cured" the issue of crowding in A&E departments for now.[278]

158. Recent data shows that admissions to emergency departments are increasing.[279] Consequently, as patient presentations for emergency care begin to rise, there is a concern

274 For example, on 25 March 2020, The King's Fund reported that the national four-hour waiting time standard has missed every month since July 2015. The Royal College of Emergency Medicine has stated that 18 million people attended Emergency Departments during 2018 with over 100,000 waiting 12 hours or more from arrival to departure which has been described as "crowding on a record scale" by the Royal College of Surgeons of England and the Royal College of Emergency Medicine.

275 Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081)

276 Q128

277 Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081) and Mr Theo Chiles (Policy Research Manager at The Royal College of Emergency Medicine) (DEL0288)

278 Q137

279 See, for example: Letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter]

about how A&E departments will be able to meet patient demand while sufficiently mitigating the risk of spreading COVID-19. Chris Hopson (Chief Executive, NHS Providers) highlighted that Trusts have been "particularly concerned" about emergency departments as the winter period approaches and that "restarting the full range of emergency services is going to be complicated and difficult."[280]

159. Dr Henderson explained this was a significant worry because those in need of emergency treatment are also likely to be the most vulnerable, so they tend to be at greater risk of dying from nosocomial (hospital-acquired) infections including COVID-19.[281] She added that the real "risk is that [overcrowding] comes back and we do people harm."[282] Dr Henderson explained that:

> The idea that you could have a vulnerable 80-year-old with a hip fracture in a corridor next to someone who might have COVID-19 is just impossible. We cannot let that happen. We need to find a way of making it possible for people to get the care they need where they need it, which does not always necessarily require going to the emergency department.[283]

160. The RCEM believes that there is now a "moral imperative to ensure that we never see a return to crowding or corridor care",[284] and to ensure emergency departments continue to operate with "an absolute focus on minimising nosocomial infections."[285]

161. In a joint written submission, the Royal College of Surgeons of England and the Royal College of Emergency Medicine's argue that overcrowded A&E departments are "fundamentally incompatible" with social distancing and infection control measures. This is because existing emergency departments are "too small, run down and in need of repair," since the physical size of hospitals and departments had not increased along with demand for their services.[286]

A "beefed-up" 111 dial service

162. Dr Katherine Henderson suggested that the problem of overcrowded A&E departments could be resolved by ensuring further steps are taken to triage patients prior to them presenting at A&E departments. She explained that this would "make sure that the right patients come to the emergency department and that there are other routes of access to care for urgent patients who do not need emergency care".[287]

163. The Royal College of Surgeons of England and the Royal College of Emergency

280 Q75
281 Q128. See, also: Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); Mr Theo Chiles (Policy Research Manager at The Royal College of Emergency Medicine) (DEL0288) and Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308).
282 Q137
283 Q129
284 Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081)
285 R Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)
286 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308). Chris Hopson (Chief Executive, NHS Providers) similarly told us about the risks of not supporting A&E Departments and said that Trusts have been "particularly concerned" about Emergency Departments as the Winter period approaches and that "restarting the full range of emergency services is going to be complicated and difficult." (Q75). Nigel Edwards (Chief Executive, The Nuffield Trust) also told us that Emergency Departments "before the crisis, were running at well above their design capacity, so we need to manage that activity in a very different way" (Q72).
287 Q128

Medicine have said that evidence shows that patients with less acute needs are already willing to use telephone services rather than attend emergency departments:

> Calls to NHS 111 in March reached nearly 3 million, over twice the number recorded the previous March. While this figure fell substantially in subsequent months, the 1.62m calls offered in May 2020 was 11% higher than May 2019, indicating that NHS 111 is being more widely used.[288]

164. Dr Henderson consequently endorsed a "call first" approach whereby a "beefed-up" 111 dial service could be used to ensure that patients are able to use the most appropriate pathway to meet their needs, rather than patients presenting at Emergency Departments by default.[289] Dr Henderson told us:

> We have not focused on getting 111 as robust as it needs to be, and appreciating the need for clinical input—having clinicians available to give advice to the people who are answering the phones, so that you get a robust disposal decision, as it is called. That is a realisation that COVID-19 has given us. There are huge advantages in there being people who can give good, sensible advice to somebody who understandably is worried about risk and has defaulted to the safest option, which is to go to A&E.[290]

165. Dr Henderson further explained how the 111 dial service would work:

> There is going to be no change in the provision of 999 access to emergency departments, nor would there be a scenario that we could envisage whereby we would be turning away people who are in desperate need of care. Some people do not have access to smartphones. They are not going to be able to ring 111. They are homeless; they are in domestic violence; or they are very vulnerable.[291]

166. Nigel Edwards (Chief Executive, The Nuffield Trust) agreed that A&E Departments could be supported by "bolstering the 111 service".[292] Mr Edwards explained:

> […] we should probably consider the type of approach that is used in Norway, Denmark and the Netherlands where you do not go to the ED unless you have had a referral from the equivalent of a 111 service or a GP, or the ambulance service has decided to take you. There are ways of dealing with the homeless and people who do not have telephones.[293]

Dr Charlotte Augst (Chief Executive, National Voices) also agreed that "whether we call 111 before we go to A&E will determine whether we weather the storm."[294]

167. On 30 June 2020, Sir Simon Stevens told us that "The evidence you heard from Dr Katherine Henderson, President of the Royal College of Emergency Medicine, makes a lot of sense to us".[295] Professor Steve Powis (National Medical Director, NHSE/I) also told

288 Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308))
289 Q142
290 Q144
291 Q129
292 Q77
293 Q77
294 Q186
295 Q237

us that an important long-term aim for NHSE/I, prior to the pandemic, was to ensure that the 111 dial service was used "to signpost people and to help people […] get their treatment in the most appropriate place".[296] Professor Powis explained that:

> We [NHSE/I] want to move increasingly to a 111 first model […] We are piloting various forms of Call First in London, Portsmouth and other areas, because we want to make sure that we get the exact model right and that we get the data back that will tell us what the right model is.[297]

168. Amanda Pritchard (Chief Operating Office, NHSE/I) further explained:

> One of the things that we are trying to do in the pilot is to use 111 as a way of directing people to the appropriate next-step service. Getting the range of bookable services as wide as possible is part of the pilot. Portsmouth is particularly focusing on that as a critical part of testing the model.[298]

169. **Historically, accident and emergency departments have been over-stretched, over-burdened and running over capacity. We have heard that the initial decline in patient attendances at A&E departments during the pandemic to some extent "cured" the problem of "corridor care".[299] However, as presentations at A&E begin to increase, the Government and NHSE/I need to ensure emergency departments do not become overwhelmed by patient demand and remain able to provide high-quality and safe treatment for all patients.**

170. **We welcome the news that the Government and NHSE/I are piloting a '111 dial first' scheme to support the triaging of patients before they attend A&E departments.[300] The introduction of an expectation that a patient will call first before walking into an A&E department is a sensible change to support A&E departments during the pandemic, and has much to commend it as a long-term reform. *We recommend that the Department and NHSE/I provide us with an update by the end of November 2020 on the progress of these pilots and other steps that are being taken, in both the short and long-term, to support A&E departments.***

Technology and digital alternatives ("telemedicine")

171. Technology and digital alternatives have been rolled out across a range of core healthcare services to ensure treatments and appointments can continue and that updated information can be provided to patients. Such "telemedicine" has largely been welcomed as a positive innovation in circumstances where many medical services would otherwise be unable to meet the needs of patients. The pandemic has also encouraged greater innovation and the wider deployment of technology to support the productivity of healthcare services. The Secretary of State, along with other NHS leaders, has shown significant leadership on technological innovation across the NHS which we have heard has provided a much-needed boost to the delivery of core healthcare services during the pandemic.

296 Q237
297 Q237
298 Qq240–241
299 Q137; Dr Katherine Henderson (President at Royal College of Emergency Medicine) (DEL0081); Mr Theo Chiles (Policy Research Manager at The Royal College of Emergency Medicine) (DEL0288) and Royal College of Surgeons of England and Royal College of Emergency Medicine (DEL0308)
300 Q142

172. During our session on 1 May 2020, Claire Murdoch (National Mental Health Director, NHSE/I) told us that NHS Trusts across the country have been organising online groups. These groups provide support to people "recovering from addiction, older people or people with serious mental illness."[301] She noted that this has been achieved in a series of "days and weeks" despite these online groups originally being planned to be rolled out over a three to four year period.[302]

173. During the same session, Gill Walton (Chief Executive, Royal College of Midwives) told us about how important technology has been to the delivery of maternity services during the pandemic. She explained:

> One of the positives from the pandemic is the use of technology; there has been more virtual contact and follow-up with women through midwives and maternity services than before. That is important, and we need to keep stepping it up. While some face-to-face contacts have been reduced, virtual contact and telephone contact have been increased. That is a good thing and something to hold on to for the future.[303]

174. Throughout our inquiry, we have heard about the wide-reaching and beneficial use of technology - particularly telephone and digital consultations - across a range of settings during the pandemic. Examples include:

- Professor Martin Marshall (Chair of Council, Royal College of General Practitioners) told us that only 23% of consultations in general practice are currently being conducted face to face, compared to 70% prior to the pandemic[304] and that the "use of remote technologies, particularly online technologies, and even the basic telephone, will improve access [to healthcare services] for young people."[305]

- Nigel Edwards (Chief Executive, The Nuffield Trust) noted that "We have seen an upswing in the use of digital for communication between GPs and consultants. That offers some very major opportunities to build on."[306]

- Claire Murdoch (National Mental Health Director, NHSE/I) said that, in order to combat the reduction in referrals to mental health services, NHSE/I have brought forward an "all-age, 24/7 crisis services"[307] and consequently patient "access [to mental health services] has happened a lot more quickly because we are able to see more people through digital routes."[308]

- Roche Diabetes Care has said that the use of apps in supporting diabetic individuals has been "effective" and "needs to continue beyond the pandemic, to empower each individual living with diabetes to manage their condition".[309]

301 Q55
302 Q56
303 Q2
304 Q65
305 Q68
306 Q109
307 Q47
308 Q56
309 Mr Conn O'Neill (Public Affairs Lead at Roche Diabetes Care) (DEL0095) and (DEL0295)

- Asthma UK and the British Lung Foundation have welcomed the use of technology "with 71% of routine consultations being delivered remotely during this crisis compared to just 25% the same time last year." They have said that "We now have a golden opportunity to build on all this innovation" and to "make improvements" for the long-term.[310]

175. However, although much of the evidence we have received has praised the greater use of telemedicine in the healthcare system, we have also heard that the use of remote consultations and other forms of technology has not been appropriate in all circumstances. This is because, in some cases, there are inequalities that result from differing levels of digital access and literacy amongst patients which can prevent some of the most vulnerable patients from accessing the medical services they require. Concerns have also been raised as to whether the use of telemedicine is an effective means of treatment even for those who are not digitally excluded. Sir Robert Francis (Chair, Healthwatch England) broadly described the benefits and risks of the continued use of telemedicine:

> Clearly, an enormous amount could be done by way of digital appointments, and we should bottle that and keep it. There has been a notorious reluctance—not necessarily willing reluctance but institutional reluctance by the NHS—to do what everyone else is doing and to communicate in a way that most of the rest of society has been doing for a long time. You can reach people in a digital way as you could not possibly do otherwise. By the way, we are only at the threshold of exploiting the benefits of that.[311]
>
> […] But, as I mentioned, there are people who are socially isolated or elderly people who may be living on their own. There are people who still do not have internet access. There are people in communities where access is difficult, even if they have a computer in their house, because there are privacy issues and the like. We have to cater for them.[312]
>
> Digital communications are great because a lot of people—maybe the majority—can benefit from them, but they cannot be the only solution. We have to remember the other people whose needs cannot be met that way.[313]

176. During the same session, Daloni Carlisle, an NHS patient, told us about her own experiences of using telemedicine. Daloni explained:

> It was much easier for me not to have to go out to a waiting-room and sit in a waiting-room at a point when I had shingles and was feeling very unwell. It was great to be able to make that diagnosis on the telephone. I felt quite safe in that diagnosis, but ideally a doctor should have had a look at that. As a way of dealing with things in a crisis, it was totally acceptable and had advantages, but I am not sure that it would be good long term. It also depended on me having the internet.[314]

310 Sarah MacFadyen (Head of Policy and Public Affairs at Asthma UK and British Lung Foundation Partnership) (DEL0026) and Jessica Eagelton (Policy and Public Affairs Officer at Asthma UK and the British Lung Foundation) (DEL0155)
311 Q170
312 Q171
313 Q170
314 Q158

> […] A successful telephone consultation requires quite a lot of confidence from the patient's side. You have to be quite confident in your ability to talk about what you are experiencing and your symptoms. […] I do not think patients are pushing for telephone consultations. I am not convinced that doctors are either.[315]

177. We have heard that the increased use of technology and digital alternatives to deliver medical services has negatively impacted already marginalised groups. Consequently, there has been a clear message, as the Royal College of Psychiatrists has stated, that "Those with lack of digital literacy, lacking in confidence using technology or with little or no access to digital platforms must not be disadvantaged."[316]

178. Rethink Mental Illness has claimed that clinical appointments and community services which are now taking place online have become less helpful to patients. This is because individuals are finding such digital services "impossible to engage with" and it has left them "feeling abandoned".[317] Mind has highlighted that not all patients will have access to the necessary technology or have the right skills to enable them to receive support via digital channels. Mind has drawn attention to those with mental health problems and those with disabilities as being disproportionately excluded by telemedicine.[318] Mind has also suggested that individuals may not feel comfortable talking about their mental health online or may not be in an environment where they are safe to talk about their mental health.[319]

179. Blood Cancer Alliance has suggested individuals whose first language is not English have found it harder to follow online guidance and videos.[320] Meanwhile, Healthwatch England has said that "People affected by homelessness and those on low incomes are two groups that may be particularly affected" by the use of telemedicine.[321] Age UK has also outlined the potential challenges that the increased use of telemedicine will have on older patients. For example, Age UK has claimed that 36% of people aged 65 and over are "not online" but should still be able to access health and care in the way that suits them best.[322] Dr Jennifer Dixon (Chief Executive, The Health Foundation) also told us about the risks telemedicine posed to "patients, particularly those with chronic disease and those in socioeconomic groups who may not be so used to using technology.[323]

Assessing the future of telemedicine

180. Dr Jennifer Dixon (Chief Executive, The Health Foundation) highlighted the need "to think very carefully about the [need for] longer-term assessments of the impact of technology".[324] Similarly Richard Murray (Chief Executive, The King's Fund) called for the "evaluation" of the use of technology to be conducted in order "to make sure that it

315 Q160
316 Mr Jonathan Blay (Public Affairs Manager at Royal College of Psychiatrists) (DEL0139)
317 Mr Alex Kennedy (Head of Campaigns and Public Affairs at Rethink Mental Illness) (DEL0077) and Rethink Mental Illness Jonathan Moore (Head of Social Policy at Rethink Mental Illness) (DEL0194)
318 Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165)
319 Rhea Newman (Senior Parliamentary Officer at Mind) (DEL0066) and (DEL0165)
320 Mrs Katie Begg (Secretariat at Blood Cancer Alliance) (DEL0039)
321 Mr Shueb Ansar (Public Affairs Officer at HealthWatch England) (DEL0070)
322 Robert Henderson (Senior Public Affairs Manager at Age UK) (DEL0028)
323 Q112
324 *Ibid.*

has worked exactly and as well as we think it has done."[325] Richard Murray explained that the rapid, and potentially longer-term, switch to virtual consultations could have several negative consequences and many of which have not yet been fully explored. This includes exacerbating potential inequalities and issues relating digital exclusion, in addition to potential unintended patient safety consequences.[326] Mr Murray told us:

> There is some evidence that GPs doing telephone and video consultations become more risk averse, order more tests and are more likely to prescribe antibiotics. They may well make mistakes.[327] […] We also need to make sure that [telemedicine] has not altered inequalities.[328]

181. Dr Charlotte Augst (Chief Executive, National Voices) also emphasised the need to assess the use of telemedicine and ensure that technology is effectively deployed to meet patient need. Dr Augst suggested that:

> We need to move from a perspective that, "This works for a lot of people. Let's hope it doesn't exclude people," to "Because there is a real risk that we will exclude people, we will tailor our technology responses and our face-to-face responses to pick up people with the biggest need and who find it the hardest to access services anyway." We must focus on meeting the needs of people who have the most complexities going on and might find it the hardest to get solutions.[329]

182. Concerns relating to patients being digitally excluded or constrained from accessing core health services has been further assessed by Healthwatch England, National Voices and Traverse in their joint report *The Dr Will Zoom You Now* (July 2020). The report noted that:

> The reality is that for many, remote and virtual consultations are the only options at the moment so it is important we continue to hear from people about whether it is actually working for them or not and what support is needed to ensure people feel confident to receive healthcare in this way.[330]

183. On 30 June 2020, Amanda Pritchard (Chief Operating Office, NHSE/I) told us that the use of technology and digital alternatives in the long-term is important. Amanda Pritchard claimed that NHSE/I is considering: "How do we use technology most effectively to find different ways of accessing services? How do we make sure that the people who need face-to-face care can access it safely? At the moment, all the effort is going into really trying to push that restoration journey but recognising that it is not straightforward."[331]

184. **We welcome the support of the Secretary of State and the Chief Executive of NHSE/I for technological innovation in the NHS. The use of technology and digital alternatives ("telemedicine"), although it has had a mixed response from some patients and medical practitioners, shows that the NHS is innovating. We also welcome the**

325 Qq109–110
326 Q109
327 Q102
328 Q109
329 Q171
330 Healthwatch England, National Voices, Traverse, The Doctor will Zoom you now: getting the most out of the virtual health and care experience, July 2020 [report]
331 Q228

wider deployment of technology which has helped to improve productivity across the healthcare system. Although the use of technology has been much-needed and largely worked in supporting the delivery of health and care services, there is nevertheless a risk that many individuals in need of medical advice or treatment will be digitally excluded. Therefore, in order to ensure telemedicine benefits all patients equally, a clearer and more comprehensive assessment is required to ensure that technology does not replace key elements of health services (such as face-to-face consultations) or disadvantage other groups, and to also ensure the benefits of telemedicine can be maintained and built-upon. Parts of the NHS have also explored new options for the delivery of care, trialling new pathways for treatment. These hold real promise for future NHS productivity. It is vital that successful examples of innovation in models of service delivery during the pandemic are brought forward, alongside technological and digital innovation.

185. ***We recommend that NHSE/I and the Department for Health & Social Care set out their assessment of how effective the use of technology and digital alternatives ("telemedicine") has been across all health and care services. As part of this assessment, we ask that both NHSE/I and the Department to clearly set out how they plan to ensure patients' wellbeing is not jeopardised by the risk of being digitally excluded from accessing medical treatment and advice. We also ask that NHSE/I and the Department set out what aspects of telemedicine have worked well, including which new models of service delivery have worked particularly well, and what plans there are (if any) to invest in and support the further use of such technology and new pathways in the health and care system. We request an update on these matters by the end of 2020. We will investigate the use of technology and new pathways in the health and care system more extensively as part of our work in the new year.***

The independent sector

186. The independent sector's provision of additional bed capacity has played a significant role in supporting the NHS in responding to the pandemic. The Government's and NHSE/I's agreements with the independent sector, in this respect, has provided a much-needed boost to facilities, staff and capacity available for the delivery of core healthcare services. Consequently, we have received calls for longer-term agreements to be made with the independent sector in relation to bed capacity and other facilities.

187. Throughout our inquiry we have heard that, due to social distancing and infection control measures, there is currently not enough capacity in the healthcare system to meet the growing patient demand. On 16 June 2020, Dr Layla McCay (Director, NHS Confederation) emphasised to us that there is "anxiety" about how much capacity will be required in the coming months, and that "capacity will be needed not just in the acute sector but in primary care, in community services and in social care".[332] This was also echoed by NHS Providers in its written submission:

> Extra staff, equipment and beds have been made available following a blanket contract agreed between the NHS and the independent hospital sector. We believe there is a strong argument to contract this capacity for a further period and Trusts recognise their responsibility to ensure this

332 Q165

> capacity, if it is contracted for a further period, is used to best effect.[333]

188. Concerns about capacity have been further reflected in a survey conducted at the end of June 2020 by NHS Providers of its member Trusts. The survey showed that only 7% of respondents said that their Trust will be able to return to "meeting the needs of all patients and services users that require services immediately". Trusts told NHS Providers that, although overall the provider sector would open more capacity over the coming months, currently capacity is nearly half (53%) of what it was before COVID-19.[334] Commenting on the survey during our session on 30 June 2020, Chris Hopson (Chief Executive, NHS Providers) told us of the importance of retaining capacity from the independent sector. Mr Hopson explained:

> We have demand up there and we have dropped capacity down there; and the key thing we need the Government to do is to help us get capacity back up. The Government has promised that the NHS will have everything that it needs, but […] they need to ensure that we carry on using independent sector capacity.[335]

189. Similarly, on 16 June 2020, Professor Derek Alderson (President, the Royal College of Surgeons of England) was clear in his testimony to us that "the Government needs to commit to maintaining [access to the independent sector's] facilities".[336] Professor Alderson told us that "for the foreseeable future, the capacity within our NHS resource alone is insufficient for us to be able to get surgery started again and maintain a sustainable and resilient service as we move into the winter" and consequently retaining access to the independent sector will be "essential".[337]

190. On 30 June 2020, Amanda Pritchard (Chief Operating Office, NHSE/I) reiterated what we have heard throughout our inquiry: «The independent sector has been critical» to supporting the NHS.[338] She explained that "What that means in the short term is that we [NHSE/I] are very keen to continue the partnership arrangements with the independent sector because that provides some much-needed additional capacity on top of normal NHS facilities."[339]

191. During the same session, we questioned Sir Simon Stevens about what long-term arrangements should be made with the independent sector in order to sufficiently support NHS services. He told us that:

> Going into July [2020], we hope that we will, on the back of some decisions that we want to be able to take around access to independent sector hospital capacity and other capacity that we will need, set a clear trajectory for the rest of the year. At that point, when hospitals know what resources and beds they have available, they will be able to provide the kind of guidance that you mention[340]

333 Ms Susan Bahl (Head of Policy and Public Affairs at NHS Providers) (DEL0137)
334 NHS Providers (DEL0318)
335 Q182 and Q184
336 Q127
337 Q125; Q127; Q135
338 Q197
339 Q228
340 Q193

192. We have sought to clarify the position of the Department of Health & Social Care and NHSE/I on securing capacity from the independent sector in the longer term. On 21 August 2020, Sir Simon wrote to us and explained that "The government has confirmed funding for the remainder of this year to cover some continuing use of independent hospitals, nightingale reserve capacity and community health discharge services".[341] On 6 August 2020, Rt Hon Matt Hancock also wrote us and explained:

> Looking ahead to winter, the Prime Minister has announced £3bn of extra NHS funding to ensure the retention of the Nightingale hospital surge capacity and continued access to independent hospitals capacity to help meet patient demand.
>
> […] Continued access to independent sector capacity will be in place to further support the recovery and restoration of elective services.[342]

193. **We commend the efforts of the Government, NHSE/I and the independent sector for stepping up and securing independent sector capacity (i.e. beds, staff and facilities) which has been crucial to supporting the NHS during the pandemic. It is clear that such independent sector capacity will be needed over the coming months as the restoration of core healthcare services is prioritised, particularly over the winter period.**

194. ***We recommend, in addition to our recommendations in Chapter 2, that the Government and NHSE/I clarify what plans there are to continue to use independent bed capacity and other independent resources as the winter period approaches. We further recommend that the Government and NHSE/I set out i) what the current level of capacity is across all NHS services, ii) what assessment it has made of what additional capacity will be required, in the medium and long term, to ensure the restoration of non-COVID NHS services and iii) what level of capacity it is expecting and planning to retain from the independent sector in the medium and long term. We expect this information by the end of October 2020.***

341 Letter from NHS England and Improvement to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 20 August 2020 [letter]

342 Letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, to Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Committee, 6 August 2020 [letter]

Conclusions and recommendations

Communication issues with patients

1. The pandemic has presented an unprecedented challenge to the NHS and the Government. Whilst we have no doubt that often communication to patients was as effective as could reasonably be expected in the context of a pandemic, this was not always the case. As we set out in our letter to Rt Hon Matt Hancock and Sir Simon Stevens on 21 July 2020, the patient experience for some has been unacceptably poor, leaving them feeling like they have been left in "limbo" or "in the lurch". Unnecessary anxiety and stress has been caused to those patients due to poor communication not just from their local hospital about the scheduling of appointments or access to treatments, but from national bodies, and on key items of guidance such as on shielding. Some sections of the public have been left thinking the NHS is not working on routine non-COVID conditions, this in conjunction with the fear of some patients about going into hospitals where there could be a risk of catching COVID-19, is having a significant impact and needs addressing. (Paragraph 21)

2. *Notwithstanding the actions taken to date, we recommend that NHS England & Improvement review, as a matter of priority, the directions given to NHS Trusts about how to communicate with patients about the progress of their treatment and important medical guidance in any future spike or second wave. As part of this review, NHSE/I must ensure that patients are always treated with dignity and compassion. We ask that as part of that review, NHSE/I makes an assessment of its and hospitals' communication with patients—and provide us with an update by the end of October 2020. We also ask, as part of this review, that NHSE/I address how they will communicate to the general population to ensure that the public gets the message that the NHS is open, and that those who have fears of catching COVID-19 in medical settings are not discouraged from accessing medical treatment.* (Paragraph 22)

Waiting times and managing the backlog of appointments

3. The pandemic has placed an unprecedented burden on the delivery of core NHS and care services. This has resulted in the delay, suspension or cancellation of services which in turn has inevitably led to a significant increase in waiting times, the backlog of appointments and pent-up demand for medical treatments. We are concerned that this has, in part, been created as a result of many individuals being too scared to access the medical treatment they require because they are uncertain as to whether NHS services are safe to use. (Paragraph 62)

4. We recognise the commitment of policy makers and the NHS leadership to restoring core NHS services and the ongoing efforts to manage the backlog. We are also grateful for the hard work of all staff and the use of innovative methods to support core NHS services during the pandemic, including: the creation of cancer hubs, Urgent Dental Centres and COVID-light facilities. We are concerned, however, that despite such innovations many core health services have been unable to continue or

have continued with very limited capacity. In March 2020, Sir Simon Stevens issued an instruction that cancer services should not be stopped, but it is clear that this instruction was not always adhered to. (Paragraph 63)

5. During our session on 30 June 2020, Sir Simon Stevens told us that he "expects" waiting times for and referrals to core health services to "go up quite significantly over the second half of the year." We also heard from Sir Simon, Amanda Pritchard and Professor Steve Powis of the importance of restoring core services for patients. It nevertheless remains unclear to us what practical steps the Government and NHSE/I are taking and are planning to take to reduce waiting times, meet the backlog of appointments and prepare the NHS for addressing pent-up demand. The absence of a public plan to address these issues may be contributing to the inability of local trusts to inform patients when they can expect to receive a long-awaited medical procedure. Nevertheless, we do also recognise the significant difficulty in planning ahead when the risk of a second spike remains unclear. (Paragraph 64)

6. *We recommend that the Department of Health & Social Care and NHSE/I provide an update on what steps they have, individually and collectively, taken and are planning to take to quantify and address the overall impact of the pandemic on waiting times, the backlog of appointments and pent-up, and as yet unknown and unmet patient demand for all health services, specifically across cancer treatments, mental health services, dentistry services, GP services and elective surgery. We also ask the Department and NHSE/I to provide a comprehensive update on what steps are being taken and what steps will be taken in the future to manage the overall level of demand across health services. We request this information by the end of October 2020.* (Paragraph 65)

7. *We also recommend that NHSE/I provides us with a more broader update on what positive innovations or changes have taken place in the NHS during the pandemic, and how it seeks to ensure all the positive changes that have occurred are captured and potentially implemented across the entire NHS. We expect this information by the end of 2020.* (Paragraph 66)

8. We further conclude that the delivery of dental services in England has been significantly hindered by the pandemic. This has been largely due to the need to protect both patients and staff from COVID-19 which has, in turn, presented financial challenges to both NHS and private dental practices. We welcome NHSE/I's continued efforts to support the restoration of dentistry services in England. (Paragraph 67)

9. *We are concerned that there does not appear to be a plan for the restoration of dental services in England. We recommend that Sara Hurley (Chief Dental Officer for England) sets out her assessment of the challenges facing dentistry services in England, and clarifies what steps will be taken to ensure dentistry services are able to continue to be restored to meet patient demand in the safest possible way whilst also remaining financially sustainable.* (Paragraph 68)

Issues facing NHS and care staff: PPE and testing

Personal Protective Equipment (PPE)

10. We recognise the unprecedented scale of the challenge facing the Government and NHSE/I to keep NHS and care staff safe during the pandemic. As in other countries facing the pandemic there were, however, persistent failures with the procurement and supply of appropriate personal protective equipment (PPE) to some NHS and care staff, particularly during the early stages of the pandemic. It is important to recognise that different staff will require different types of PPE and there is a need to make sure that the PPE available is suitable for a diverse work force. We welcome the appointment of Lord Deighton as adviser on PPE to the Secretary of State for Health and Social Care. Lord Deighton's evidence gave us confidence that the issues relating to PPE which have been raised with us will be prioritised and addressed. (Paragraph 86)

11. *We request an update from the Department of Health & Social Care by the end of November 2020 on what steps are being taken to ensure that there is a consistent and reliable supply of appropriately fitting PPE to all NHS staff in advance of the onset of winter and a potential second wave.* (Paragraph 87)

Routine testing of all NHS and care staff

12. We are grateful to Professor Chris Whitty (Chief Medical Officer) and his expert colleagues for their continued and constructive engagement with our work. We also recognise that the Government, following the advice of the Chief Medical Officer and others, has taken a considered approach to implementing the SIREN study. We note that the Government aims to utilise the SIREN study to better inform the frequency at which, and under what circumstances, the testing of NHS staff for coronavirus ought to take place. (Paragraph 120)

13. *We accept the advice we have received from many eminent scientists that there is a significant risk that not testing NHS staff routinely could lead to higher levels of nosocomial infections in any second spike. We therefore urge the Government to set out clearly why it is yet to implement weekly testing of all NHS staff.* (Paragraph 121)

14. We note that Professor Chris Whitty has said that the testing of asymptomatic staff may be necessary in the future and that if there is a "surge in winter" of coronavirus cases then he would be likely to advise that routine testing of NHS staff should take place. However, we are concerned that contrary to this advice, routine testing of asymptomatic NHS staff appears not to have been introduced where the virus is already surging in the North East and the North West, perhaps due to capacity constraints. (Paragraph 122)

15. *We ask that Professor Whitty sets out to what extent testing capacity has impacted the advice he and his colleagues have provided to the Government on routine testing of NHS staff. We further ask Professor Whitty to clarify whether he has advised the Government to introduce routine testing of all NHS staff in the current virus hotspots and if not why.* (Paragraph 123)

16. We conclude that the case for routine testing of all NHS staff in all parts of the country (including clinical staff as well as cleaners, porters and so forth) is compelling and should be introduced as quickly as capacity allows and before the winter-flu season begins. Those who—either directly or indirectly—provide treatment to patients should not be put at any further unnecessary risk of catching or spreading COVID-19. We urge that steps be taken to expand capacity rapidly to make this possible. (Paragraph 124)

17. *We recommend that, by the end of October 2020, the Government and NHSE/I set out: i) what current capacity there is for testing all NHS staff, ii) what further capacity (if any) will be required and iii) how long it is likely to take to secure sufficient capacity to offer routine tests to all NHS staff.* (Paragraph 125)

Issues facing NHS and care staff: fatigue and "burnout"

NHS and care workforce wellbeing during the pandemic

18. We are extremely grateful to all NHS and care staff for their hard work and dedication in trying to meet patient needs in such exceptional circumstances. This includes those who have returned to the NHS (such as clinicians returning from academia, retirement and other industries); students who have left their training early to do so, and staff that have been redeployed to manage capacity constraints in other areas of the NHS. We share concerns that some NHS and care staff are suffering from fatigue, exhaustion and a general feeling of being "burnt out" and that the wellbeing of staff (particularly their mental health) is at significant risk. (Paragraph 137)

19. We are grateful for NHSE/I's continued support of NHS staff and welcome the further measures set out in the People Plan (July 2020) for the 2020–21 period. In particular, we welcome the important and ambitious measures set out in the People Plan which show a clear desire to address workforce fatigue and provide mental health support to NHS staff. However, given the pressures on recruitment and retention of staff, we are concerned that the People Plan does not set out future workforce recruitment objectives, therefore failing to address one of the biggest concerns that many staff have, namely whether there will be enough of them to give high quality care to patients. We also believe more must be done to support the mental wellbeing of staff. Helplines, apps, webinars and managerial training will all be of value but with many members of staff facing much more severe and sustained pressures on their mental health, more substantive action will need to be taken to support the wellbeing of staff, particularly before the busy winter period. We note that the People Plan states further announcements will be made once the Government has confirmed funding arrangements for the NHS. (Paragraph 138)

20. *We recommend that NHSE/I set out in detail what further specific steps it would like to take over the coming years to support the mental and physical wellbeing of all staff and a plan to deal with the specific issue of sustained workplace pressure due to the current pandemic and backlog associated with the coronavirus. This information should be made available to us in advance of any forthcoming Government spending announcements or by the end of October 2020 (whichever is earlier) in order for*

us to clarify what NHSE/I's priorities for NHS staff are, and to judge how far the Government's eventual spending commitments enable their implementation. (Paragraph 139)

21. *We further recommend that NHSE/I should develop a full and comprehensive definition of "workforce burnout", and set out how the wellbeing of all NHS staff is being monitored and assessed. This information should be made available to us by the middle of October 2020, to enable us to scrutinise it in the course of our inquiry into Workforce Burnout and Resilience in the NHS and social care.* (Paragraph 140)

22. We note, meanwhile, that there is no equivalent of the NHS People Plan for the social care workforce. We will have more to say about support for those working in social care in our forthcoming report on Social care: workforce and funding. (Paragraph 141)

Support for BAME NHS staff members

23. The NHS is founded on the principle of equality and is one of the most diverse and inclusive organisations in the UK. It hugely benefits from the diversity of its staff as in turn so does the nation. In recent months, there has been a much-needed focus on supporting NHS staff from a Black, Asian and Minority Ethnic background (BAME). COVID-19 has, regrettably, disproportionately harmed and resulted in excess BAME deaths. We welcome the introduction of risk assessments and other initiatives, as set out by Professor Steve Powis, which are being implemented to protect BAME NHS staff from the risk of catching coronavirus. (Paragraph 152)

24. We have also heard that some BAME NHS staff face discrimination and racism in the NHS and that, across the NHS, the levels of diversity must be improved. We accept Sir Simon Stevens' comments that "there are systemic features to discrimination and racism, and the NHS is both part of the problem and part of the solution". Nonetheless, it is unacceptable that any BAME NHS employee should face discrimination, harassment or racism when working for the NHS. It is clear that more must be done to ensure that all NHS staff—regardless of their race, ethnicity or cultural heritage—feel safe, confident and proud to work for the NHS. (Paragraph 153)

25. *The NHS must increase its efforts to eradicate all forms of discrimination and racism from in its organisation. We therefore recommend that NHSE/I provide a full and comprehensive definition of the "racism and discrimination" that it seeks to eradicate from the NHS. We invite NHSE/I and the Department for Health & Social Care to set out in detail its strategy to tackle racism and discrimination and to promote diversity in the NHS, including information on targets and deadlines by the end of 2020. We expect full and constructive engagement with NHSE/I and the Department as we further investigate matters relating to diversity and race in the NHS as part of our future work, including our Workforce burnout and resilience in the NHS and social care inquiry, in which we will review the root causes of these matters (including the difference between correlation and causation relating to coronavirus and excess deaths amongst BAME communities) and potential solutions.* (Paragraph 154)

The NHS: Lessons learnt and building for the future

Long-term support for accident and emergency departments

26. Historically, accident and emergency departments have been over-stretched, over-burdened and running over capacity. We have heard that the initial decline in patient attendances at A&E departments during the pandemic to some extent "cured" the problem of "corridor care". However, as presentations at A&E begin to increase, the Government and NHSE/I need to ensure emergency departments do not become overwhelmed by patient demand and remain able to provide high-quality and safe treatment for all patients. (Paragraph 169)

27. We welcome the news that the Government and NHSE/I are piloting a '111 dial first' scheme to support the triaging of patients before they attend A&E departments. The introduction of an expectation that a patient will call first before walking into an A&E department is a sensible change to support A&E departments during the pandemic, and has much to commend it as a long-term reform. *We recommend that the Department and NHSE/I provide us with an update by the end of November 2020 on the progress of these pilots and other steps that are being taken, in both the short and long-term, to support A&E departments.* (Paragraph 170)

Technology and digital alternatives ("telemedicine")

28. We welcome the support of the Secretary of State and the Chief Executive of NHSE/I for technological innovation in the NHS. The use of technology and digital alternatives ("telemedicine"), although it has had a mixed response from some patients and medical practitioners, shows that the NHS is innovating. We also welcome the wider deployment of technology which has helped to improve productivity across the healthcare system. Although the use of technology has been much-needed and largely worked in supporting the delivery of health and care services, there is nevertheless a risk that many individuals in need of medical advice or treatment will be digitally excluded. Therefore, in order to ensure telemedicine benefits all patients equally, a clearer and more comprehensive assessment is required to ensure that technology does not replace key elements of health services (such as face-to-face consultations) or disadvantage other groups, and to also ensure the benefits of telemedicine can be maintained and built-upon. Parts of the NHS have also explored new options for the delivery of care, trialling new pathways for treatment. These hold real promise for future NHS productivity. It is vital that successful examples of innovation in models of service delivery during the pandemic are brought forward, alongside technological and digital innovation. (Paragraph 184)

29. *We recommend that NHSE/I and the Department for Health & Social Care set out their assessment of how effective the use of technology and digital alternatives ("telemedicine") has been across all health and care services. As part of this assessment, we ask that both NHSE/I and the Department to clearly set out how they plan to ensure patients' wellbeing is not jeopardised by the risk of being digitally excluded from accessing medical treatment and advice. We also ask that NHSE/I and the Department set out what aspects of telemedicine have worked well, including which new models of service delivery have worked particularly well, and what plans there are*

(if any) to invest in and support the further use of such technology and new pathways in the health and care system. We request an update on these matters by the end of 2020. We will investigate the use of technology and new pathways in the health and care system more extensively as part of our work in the new year. (Paragraph 185)

The independent sector

30. We commend the efforts of the Government, NHSE/I and the independent sector for stepping up and securing independent sector capacity (i.e. beds, staff and facilities) which has been crucial to supporting the NHS during the pandemic. It is clear that such independent sector capacity will be needed over the coming months as the restoration of core healthcare services is prioritised, particularly over the winter period. (Paragraph 193)

31. *We recommend, in addition to our recommendations in Chapter 2, that the Government and NHSE/I clarify what plans there are to continue to use independent bed capacity and other independent resources as the winter period approaches. We further recommend that the Government and NHSE/I set out i) what the current level of capacity is across all NHS services, ii) what assessment it has made of what additional capacity will be required, in the medium and long term, to ensure the restoration of non-COVID NHS services and iii) what level of capacity it is expecting and planning to retain from the independent sector in the medium and long term. We expect this information by the end of October 2020.* (Paragraph 194)

Formal minutes

Thursday 24 September 2020

Members present:

Rt. Hon Jeremy Hunt, in the Chair

Paul Bristow	Barbara Keeley
Rosie Cooper	Taiwo Owatemi
Dr James Davies	Sarah Owen
Dr Luke Evans	Dean Russell
Neale Hanvey	Laura Trott

Draft Report (*Delivering core NHS and care services during the pandemic and beyond*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 194 read and agreed to.

Summary agreed to.

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

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

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 29 September at 9.00am

Witnesses

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

Friday 01 May 2020

Gill Walton, CEO, Royal College of Midwives; **Professor Martin Marshall**, Chair of Council, Royal College of General Practitioners; **Claire Murdoch**, National Mental Health Director, NHS England; **Dame Cally Palmer**, National Cancer Director, NHS England — Q1–70

Thursday 14 May 2020

Chris Hopson, Chief Executive Officer, NHS Providers; **Richard Murray**, Chief Executive Officer, The King's Fund; **Nigel Edwards**, Chief Executive Officer, Nuffield Trust; **Jennifer Dixon**, Chief Executive Officer, Health Foundation — Q71–118

Tuesday 16 June 2020

Dr Katherine Henderson, President, Royal College of Emergency Medicine; **Professor Derek Alderson**, President, Royal College of Surgeons; **Mick Armstrong**, Chair, British Dental Association; **Rob Martinez**, NHS patient — Q119–156

Daloni Carlisle, NHS patient; **Charlotte Augst**, Chief Executive, National Voices; **Sir Robert Francis**, Chair, Healthwatch England; **Dr Layla McCay**, Director, NHS Confederation — Q157–178

Tuesday 30 June 2020

Chris Hopson, Chief Executive, NHS Providers; **Professor Andrew Goddard**, President, Royal College of Physicians — Q179–187

Sir Simon Stevens, Chief Executive, NHS England and NHS Improvement; **Professor Stephen Powis**, National Medical Director, NHS England and NHS Improvement; **Amanda Pritchard**, Chief Operating Officer, NHS England and NHS Improvement — Q188–257

Tribute to Daloni Carlisle

Committee members were saddened to learn of the death of Daloni Carlisle shortly before the publication of this report. Her powerful and brave testimony to the inquiry on 16 June 2020 helped shape our conclusions and recommendations. We wish to record our gratitude for the honesty and integrity Daloni demonstrated in sharing her experiences with us and send our condolences to her friends and family.

Published written evidence

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

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

1 AbbVie (Ms Laura Wetherly, Government Affairs Manager) (DEL0280)

2 AbbVie UK Ltd (Dr Deborah Roebuck, Government Affairs Manager, Oncology) (DEL0072)

3 Academy of Medical Royal Colleges (DEL0315)

4 Action for Pulmonary Fibrosis (Mr Steve Jones, Chair of Trustees) (DEL0263)

5 Action on Hearing Loss (Ms Ayla Ozmen, Head of Research and Policy) (DEL0193)

6 Adams, Harriet (Associate Director, Policy and Communications at MSD) (DEL0339)

7 Advanced Accelerator Applications (Mr Jeevan Virk, General Manager) (DEL0174)

8 Advanced Accellerator Applications (Vivienne Beckett, Advocacy and Communications Lead) (DEL0059)

9 Age UK (Robert Henderson, Senior Public Affairs Manager) (DEL0028)

10 AHSN Network (Mr Richard Stubbs, Chief Executive Officer, Yorkshire and Humber Academic Health Science Network) (DEL0178)

11 The Air Ambulance Service (Miss Georgia Greaves, Public Affairs Consultant) (DEL0185)

12 Alcohol and Health Alliance UK (Dr Kieran Bunn, Policy and Advocacy Officer) (DEL0332)

13 All Party Parliamentary Group for Radiotherapy (Daniel Laing, Supporting the APPG as a member of the Radiotherapy4Life campaign) (DEL0067)

14 All-Party Parliamentary Group on Axial Spondyloarthritis (Simon Whalley, Secretariat) (DEL0217)

15 The All-Party Parliamentary Group on Obesity (Mr Tom Doughty, Secretariat) (DEL0242)

16 All.Can UK (Ms Natasha Silkin, Secretariat) (DEL0132)

17 Alliance for Heart Failure, and16 Member organisations: https://allianceforheartfailure.org/about-alliance-for-heart-failure (Mr Colin Hallmark) (DEL0262)

18 Allied Health Professions Federation (AHPF Co-ordinator NIcolette Divecha, Chair) (DEL0209)

19 Alzheimer's Society (Mr Jordan Clark, Public Affairs Officer) (DEL0049)

20 Alzheimer's Society (Tom Redfearn, Public Affairs Manager) (DEL0115)

21 Ambler, Mr Tim (DEL0307)

22 Anthony Nolan (Miss Charlotte Wickens, Policy and Public Affairs Officer) (DEL0123)

23 Anthony Nolan (Ms Amelia Chong, Senior Policy and Public Affairs Manager) (DEL0044)

24 ARCO (Associated Retirement Community Operators) (Mr Sam Dalton, Policy & External Affairs Executive) (DEL0164)

25 Arnold-Forster, Dr Agnes (DEL0103)

26 Arthritis and Musculoskeletal Alliance (Sue Brown, Chief Executive) (DEL0106)

27 Association for Improvements in the Maternity Services (AIMS) (Jo Dagustun, Volunteer) (DEL0230)

28 Association of Anaesthetists (Jenny Gowen, Advocacy and Campaigns Manager) (DEL0140)

29 Association of British Clinical Diabetologists (ABCD) (Dr Dinesh Nagi, Chairman of the Association) (DEL0254)

30 Association of British HealthTech Industries (Mr Richard Phillips, Director, Healthcare Policy) (DEL0119)

31 Association of Child Psychotherapists (Nick Waggett, Chief Executive) (DEL0014)

32 Association of Clinical Psychologists U.K. C.I.C. (Mr Bernard Kat, Director of Governance) (DEL0246)

33 Association of Dental Groups (Lewis Robinson, Policy and Public Affairs Advisor) (DEL0276)

34 The Association of the British Pharmaceutical Industry (ABPI) (Miss Vicky Whitehead, Public Affairs Manager) (DEL0052)

35 Association of the British Pharmaceutical Industry (Ms Vicky Whitehead, Public Affairs Manager) (DEL0192)

36 Astellas Pharma Ltd (Mrs Alison Whitford, Healthcare Access Manager) (DEL0200)

37 Asthma UK and British Lung Foundation Partnership (Sarah MacFadyen, Head of Policy and Public Affairs) (DEL0026)

38 Asthma UK and the British Lung Foundation (Jessica Eagelton, Policy and Public Affairs Officer) (DEL0155)

39 AstraZeneca (Ms Naima Khondkar, Policy Lead - Government Affairs and Policy) (DEL0235)

40 BACP, andB (Eve De Marchi) (DEL0331)

41 Baldwin, Professor David R (DEL0291)

42 BAPEN (Dr Trevor Smith, President) (DEL0227)

43 Bayer (Kalata, Senior Government Affairs Manager) (DEL0210)

44 Birthrights (Rebecca Brione, Research and Partnerships Officer) (DEL0025)

45 The Black Stork Charity (Ms Janet Morrison, Chief Executive) (DEL0283)

46 Black, Dr Benjamin (DEL0218)

47 Blind Veterans UK (Ms Helen Wheatley, Manager) (DEL0177)

48 Bliss (Ms Josie Anderson, Campaign and Policy Manager) (DEL0247)

49 Bliss (Ms Josie Anderson, Campaign and Policy Manager) (DEL0056)

50 Blood Cancer Alliance (Mrs Katie Begg, Secretariat) (DEL0039)

51 Blood Cancer UK (Christopher Walden, Head of Policy and Campaigns) (DEL0040)

52 Boland, Samuel T. (DEL0218)

53 Bowel Cancer UK (Dr Lisa Wilde, Director of Research and External Affairs) (DEL0179)

54 Brake, the road safety charity (Brake, the road safety charity mary williams, chief executive) (DEL0289)

55 Breast Cancer Now (Georgina Smerald, Senior Policy Officer) (DEL0144)

56 Breast Cancer Now (Melanie Sturtevant, Policy Manager) (DEL0051)

57 Bristol Myers Squibb (Fiona Campbell, Consultant at Hanover Communications contracted to BMS) (DEL0117)

58 British and Irish Orthoptic Society (Rich Huzzey, Policy Officer) (DEL0112)

59 British Association for Music Therapy (Mr Andrew Langford, Chief Executive) (DEL0016)

60 British Association for Nursing in Cardiovascular Care (Ms Tootie (Teofila) Bueser, President) (DEL0094)

61 British Association for Sexual Health and HIV (BASHH), and British HIV Association (BHIV (Simon Whalley) (DEL0241)

62 British Association of Social Workers (Liz Howard, Professional Officer) (DEL0274)

63 British Dental Association (Ms Penny Whitehead, Head of Policy and Research) (DEL0252)

64 British Dietetic Association (Mr Tom Embury, Public Affairs Manager) (DEL0154)

65 British Geriatrics Society (Ms Sally Greenbrook, Policy Manager) (DEL0114)

66 British Geriatrics Society (Ms Sally Greenbrook, Policy Manager) (DEL0021)

67 British Heart Foundation (Dr Samual Dick, Policy Manager - Health and Care Systems) (DEL0240)

68 British Medical Association (BMA) (Gemma Hopkins, Senior Public Affairs Officer) (DEL0205)

69 British Obesity and Metabolic Surgery Society (Mr James Byrne, Executive Treasurer) (DEL0272)

70 British Pregnancy Advisory Service (Ms Rachael Clarke, Public Affairs and Advocacy Manager) (DEL0239)

71 British Red Cross (Nil Guzelgun, Senior Health Policy and Influencing Officer) (DEL0196)

72 British Society for Antimicrobial Chemotherapy (BSAC) (Michael Corley, Head of Policy and Public Affairs) (DEL0298)

73 British Society for Heart Failure (Ms Lynn Mackay-Thomas, Cheif Executive Officer) (DEL0149)

74 British Society for Rheumatology (Mr John Hopgood, Head of Policy and Public Affairs) (DEL0180)

75 British Society of Abortion Care Providers (Professor Sam Rowlands, Secretary) (DEL0216)

76 British Specialist Nutrition Association (Mr Declan O'Brien, Director General) (DEL0265)

77 The British Thoracic Society (Ms Ruth Ellenby, Head of Policy and Communications) (DEL0109)

78 C the Signs (Dr Bhavagaya Bakshi, GP & Co-founder) (DEL0082)

79 C the Signs (Dr Bhavagaya Bakshi, GP & co-founder) (DEL0047)

80 Camurus (Yasmin Sheikh, Consultant) (DEL0189)

81 Cancer Research UK (Mr Michael Cousins, Public Affairs Officer) (DEL0063)

82 Cancer52 (Jane Lyons, CEO) (DEL0158)

83 Cancer52 (Jane Lyons, CEO) (DEL0018)

84 Care and Support Alliance (Mrs Anna Bailey-Bearfield, Policy and Public Affairs Manager) (DEL0142)

85 Care England (Mrs Louisa Collyer-Hamlin, External Affairs) (DEL0195)

86 Care Quality Commission (Mr Matthew Rose, Senior Parliamentary and Stakeholder Engagement Adviser) (DEL0299)

87 Carlisle, cancer treatment patient, Daloni (DEL0322)

88 Centre for Mental Health (Andy Bell, Deputy Chief Executive) (DEL0130)

89 Chan, Dr Otto (DEL0301)

90 Change Grow Live (Mr Tahmid Chowdhury, Spokesperson) (DEL0260)

91 Chartered Insititute of Public Finance and Accountancy (CIPFA) (Dr Eleanor Roy, Policy Manager - Health and Social Care) (DEL0134)

92 Chartered Society of Physiotherapy (Ms Rachel Newton, Head of Policy) (DEL0229)

93 Chartered Society of Physiotherapy (Robert Yeldham, Director - Strategy, Policy & Engagement) (DEL0048)

94 Checkland, Professor Kath (DEL0279)

95 Checkland, Professor Kath (DEL0244)

96 The Children's Society (Charlotte Rainer, Policy Officer) (DEL0086)

97 CLIC Sargent (Mrs Helen Gravestock, Associate Director - Policy, Influencing and Voice) (DEL0080)

98 Clinks (Zahra Wynne, Health and Justice Policy and Development Officer) (DEL0297)

99 Collaborative Mental Health Taskforce, and Positive Practice in Mental Health Collaborati (Mrs Angie Russell) (DEL0128)

100 Collective Voice (Oliver Standing, Director) (DEL0197)

101 The College of Optometrists (Olivier Deneve, Head of Policy and Public Affairs) (DEL0133)

102 The College of Podiatry (Mr Lawrence Ambrose, Head of Policy and Public Affairs) (DEL0143)

103 Compassion in Dying (Ms Davina Hehir, Director of Policy) (DEL0223)

104 Connolly, Dr Anne (DEL0157)

105 The Contact Group (Mrs Anna Owen, Project Officer) (DEL0169)

106 Crohn's & Colitis UK (Ruth Wakeman, Director of Information and Support Services) (DEL0251)

107 Crossman, Dr Sue (DEL0305)

108 The Cystic Fibrosis Trust (Michaela Regan, Clinical Affairs and Commissioning Adviser) (DEL0201)

109 Daiichi-Sankyo UK (Laura Tantum, Public affairs agency) (DEL0088)

110 Davies, Mr Luke John (DEL0342)

111 Dawson, Dr Sarah (DEL0008)

112 Department for Health and Social Care (DEL0294)

113 Diabetes UK (Mr Tom Nightingale, Senior Public Affairs Officer) (DEL0150)

114 Dignity in Dying (Ms Davina Hehir, Director of Policy and Legal Strategy) (DEL0253)

115 Disability Rights UK (Fazilet Hadi, Policy Manager) (DEL0124)

116 Disabled People Against Cuts (Ms Ellen Clifford, National steering group member) (DEL0275)

117 Embracing Complexity (Ms Georgia Harper, Embracing Complexity Lead) (DEL0090)

118 Epilepsy Action (Mr Samuel Mountney, Senior Policy & Campaigns Officer) (DEL0156)

119 Equality and Human Rights Commission (Erika Schmidt, Senior Associate) (DEL0190)

120 Equality and Human Rights Commission (Erika Schmidt, Senior Associate) (DEL0078)

121 Esmail, Professor Aneez (DEL0222)

122 Essex County Council (Mrs Francesca Day, Public Affairs Manager) (DEL0183)

123 Faculty of Sexual and Reproductive Healthcare (FSRH) (Camila Azevedo, External Affairs Manager) (DEL0175)

124 Farrar, James (DEL0326)

125 FODO, and NC (Harjit Sandhu) (DEL0270)

126 Forces in Mind Trust (Caroline Cooke, Head of Policy) (DEL0101)

127 Foundation for Liver Research (Professor Roger Williams, Director) (DEL0091)

128 Frontline Collaboration against COVID-19 (DEL0285)

129 Gainty, Dr Caitjan (DEL0103)

130 GAMA Healthcare (DEL0328)

131 General Osteopathic Council (Mr Matthew Redford, Acting Chief Executive and Registrar) (DEL0204)

132 Glaukos UK Ltd (DEL0320)

133 Goodman, Helen (DEL0333)

134 Gray, Mr David (DEL0113)

135 The Guinness Partnership (Head of External Affairs Alistair Smyth, Head of External Affairs) (DEL0172)

136 Hallett, MBE, Mr Richard (DEL0031)

137 Hannington, Amy (DEL0006)

138 The Health Foundation, The King's Fund and Nuffield Trust (DEL0292)

139 Health Tech Alliance (Mr Neeraj Shah, Public Affairs Manager) (DEL0181)

140 HealthWatch England (Mr Shueb Ansar, Public Affairs Officer) (DEL0070)

141 Healthwatch Islington (Miss Emma Whitby, Chief Executive) (DEL0120)

142 HealthWatch UK (Dr Roger Fisken, Executive Committee member) (DEL0009)

143 Healthy.io (Ms Katherine Ward, Policy and Communications agency) (DEL0013)

144 HEART UK- The Cholesterol Charity (Mr Simon Williams, Head of Communications and Policy) (DEL0105)

145 Help for Heroes (Ted Arnold, Senior Public Affairs and Policy Manager) (DEL0296)

146 The Hepatitis C Trust (DEL0317)

147 HomeLink Healthcare (DEL0325)

148 Hospice UK (Mr Dominic Carter, Head of Advocacy) (DEL0259)

149 Housing Learning and Improvement Network (Mr Jeremy Porteus, Chief Executive) (DEL0089)

150 Imperial College, and Haldenby Woodfo (Professor Nick Bosanquet and Andrew Haldenby) (DEL0330)

151 Independent Healthcare Providers Network (Megan Cleaver, Senior External Affairs Manager) (DEL0159)

152 The Industry Vision Group (Mr Lloyd Tingley, Secretariat) (DEL0161)

153 Institute of Health Visiting (Dr Robert Nettleton, Education Lead) (DEL0249)

154 Ipsen (Chris Rowland, Policy Lead England & Wales) (DEL0162)

155 Janes, Professor Samuel (DEL0291)

156 Jarrett, Mrs Suzanne (DEL0031)

157 Jo's Cervical Cancer Trust (Miss Kate Sanger, Head of Communications and Public Affairs) (DEL0102)

158 Jo's Cervical Cancer Trust (Miss Kate Sanger, Head of Communications and Public Affairs) (DEL0023)

159 Johnson & Johnson Family of Companies (Lavinia Trehane, Government Affairs and Policy) (DEL0131)

160 Johnson, Ms Emma (DEL0031)

161 Kami, Kim (DEL0316)

162 Keep Up With Cancer (KUWC), and Keep Up With Cancer (KUW (Mr Stephen Kiely) (DEL0055)

163 Keep Up With Cancer, and Keep Up With Cancer (Mr Stephen Kiely) (DEL0184)

164 Kidney Care UK (Fiona Loud, Kidney Care UK) (DEL0278)

165 Kidney Care UK (Ms Samantha Sharp, Senior Policy Officer) (DEL0042)

166 Kyriakides, Dr Klearchos A. (DEL0037)

167 Lambert, Dr Michael (DEL0071)

168 Langford, Andrew (Chief Executive at British Association for Music Therapy) (DEL0340)

169 LDC Confederation (Dr Martin Skipper, Head of Policy) (DEL0248)

170 Leary, Professor Alison (DEL0001)

171 Less Survivable Cancers Taskforce (Noah Froud, Secretariat) (DEL0050)

172 Less Survivable Cancers Taskforce, Pancreatic Cancer UK, The Brain Tumour Charity, Roy Castle Lung Cancer Foundation, British Liver Trust, Guts UK, and Action Against Heartbu (Ms Jane Cox) (DEL0286)

173 LIVI (Mr Declan Mullaney, Public Affairs Lead) (DEL0243)

174 Local Government Association (Miss Jade Hall, Public Affairs and Campaigns Adviser) (DEL0111)

175 Loeffler, Dr Renato Thomas (DEL0093)

176 MacCarthy, Prof Philip (DEL0257)

177 Macmillan Cancer Support (Mr Andy McGuinness, Senior Public Affairs Officer) (DEL0238)

178 Macmillan Cancer Support (Mr Andy McGuinness, Senior Public Affairs Officer) (DEL0079)

179 Marie Curie (Mr Scott Sinclair, Head of Policy & Public Affairs) (DEL0163)

180 Marie Stopes UK (Ms Franki Appleton, Advocacy and Public Affairs Advisor) (DEL0125)

181 Marriott, Dr Mike (DEL0007)

182 Martin, Dr Faith (DEL0008)

183 Martinez, Rob, joint replacement patient (DEL0323)

184 Mayhew, Professor Susannah Harding (DEL0218)

185 McKay, Gillian (DEL0218)

186 Medical and Dental Defence Union of Scotland (MDDUS) (Ms Alison Hardie, Head of Public Affairs and Strategic Communication) (DEL0234)

187 The Medical Technology Group (Mr Toby Bevan, The Secretariat) (DEL0138)

188 Mencap (Mr Matthew Harrison, Public Affairs & Parliamentary Manager) (DEL0219)

189 Mental Health Network, NHS Confederation (Emma Paveley, Policy Manager) (DEL0064)

190 Mental Health Nurse Academics UK, Royal College of Nursing, and Unite the Uni (Professor Ben Hannigan) (DEL0036)

191 Mesothelioma UK (Mrs LIz Darlison, Head of Charity) (DEL0085)

192 Midwifery Unit Network Ltd (C Winstanley, Director and Lead for Midwifery Unit Academy) (DEL0019)

193 Mind (Rhea Newman, Senior Parliamentary Officer) (DEL0165)

194 Mind (Rhea Newman, Senior Parliamentary Officer) (DEL0066)

195 Moore, Ms Jane (DEL0311)

196 Moran, Professor Paul (DEL0008)

197 Morgan, Dr Sally (DEL0061)

198 MS Society, and MS Tru (Mr Joseph Brunwin) (DEL0208)

199 MSD (Mr James Hargrave, Associate Director - Policy and Communications - Oncology) (DEL0074)

200 Mughal, Rosie (DEL0157)

201 Murphy, Professor Peter (DEL0104)

202 Murray, John (Director at Federation of Specialist Hospitals) (DEL0343)

203 Myeloma UK (Head of Patient Advocacy Shelagh McKinlay, Making sure that the voice of myeloma patients, families and carers counts with decision makers.) (DEL0060)

204 NAT (National AIDS Trust) (Kat Smithson, Director of Policy) (DEL0228)

205 The National Autistic Society (Mrs Anna Bailey-Bearfield, Policy and Public Affairs Manager) (DEL0075)

206 National Axial Spondyloarthritis Society (NASS) (Jill Hamilton, Head of Policy and Health Services) (DEL0108)

207 National Maternity Voices (Hannah Lynes, administrator) (DEL0043)

208 National Mental Health & Learning Disability Nurse Directors Forum (Melanie Coombes, Chairman) (DEL0024)

209 National Network of Designated Healthcare Professionals for Children (NNDHP) (Dr Peter Green, Chair) (DEL0277)

210 National Physical Laboratory (Sarah Dalmedo, Policy Manager) (DEL0100)

211 National Rheumatoid Arthritis Society (Samuel Lawes, Policy and Communications Manager) (DEL0261)

212 National Voices (DEL0329)

213 National Voices (DEL0266)

214 Neurological Alliance (Judith Abel, Policy and External Affairs Manager) (DEL0186)

215 Newburn, Ms Mary (DEL0045)

216 Newman, Mrs Pamela (DEL0310)

217 NHS Confederation (Niall Dickson, Chief Executive) (DEL0198)

218 NHS Providers (DEL0318)

219 NHS Providers (Ms Susan Bahl, Head of Policy and Public Affairs) (DEL0137)

220 NICE (National Institute for Health and Care Excellence) (Mr Neil Drake, External Communications Manager (Public Affairs)) (DEL0188)

221 Nobles, Dr James (DEL0008)

222 Northern Health Science Alliance (Ms Hannah Davies, Head of External and Public Affairs) (DEL0127)

223 Novo Nordisk (Sarah Whitehead, External Relations and Public Affairs Manager) (DEL0187)

224 Obesity UK (Ms Sarah Le Brocq, Director) (DEL0268)

225 Olympus Medical (Mr Graham Popham, Head of Market Access) (DEL0062)

226 Oncimmune (Mrs Jessica Mann, Government Relations) (DEL0084)

227 OSOBA, Dr David Oyewole (DEL0264)

228 PAGB, the consumer healthcare association (Donna Castle, Senior Director of Public Affairs and Communications) (DEL0148)

229 Palutikof, Matt (Senior Account Officer at Philips UKI) (DEL0334)

230 Pancreatic Cancer UK (Mr Peter De Rosa, Policy and Intelligence Team) (DEL0058)

231 Pancreatic Cancer UK (Ms Emily Waller, Public Affairs and Policy Manager) (DEL0118)

232 Pape, Dr Sarah (DEL0300)

233 Parent-Infant Foundation, and First 1001 Days Movement (over 110 charities and professional bodies (Mrs Sally Hogg) (DEL0224)

234 Parkinson's UK (Laura Cockram, Head of Policy and Campaigns) (DEL0147)

235 Patient Safety Learning (Helen Hughes, Chief Executive Officer) (DEL0250)

236 Patient Safety Learning, and CECO (Helen Hughes) (DEL0110)

237 Patient Transport Action Group (Ms. Anna Wolffe, Adviser.) (DEL0293)

238 The Patients Association (Ms Rachel Power, Chief Executive) (DEL0221)

239 Pfizer (Cristina Sarb, Policy and Public Affairs Manager) (DEL0073)

240 Pfizer (Miss Cristina Sarb, Policy and Public Affairs Manager) (DEL0146)

241 Pharmacy2U (Laura Tantum, Public Affairs) (DEL0099)

242 Primary Health Properties PLC (Mr Mark Leftly, Public affairs consultant to Primary Health Properties) (DEL0107)

243 Prostate Cancer UK (Mr Tim Windle, Policy Manager) (DEL0281)

244 Prostate Cancer UK (Mr Tim Windle, Policy Manager) (DEL0225)

245 Pumping Marvellous Foundation (Mr Nick Hartshorne-Evans, CEO) (DEL0182)

246 Quanta Dialysis Technologies (Mr Michael Latham, This evidence is submitted on behalf of John Milad, Chief Executive Officer, Quanta Dialysis Technologies) (DEL0097)

247 The Queen's Nursing Institute (The Queen's Nursing Institute Matthew Bradby, Head of Communications) (DEL0152)

248 RAIRDA (Rare Autoimmune Rheumatic Disease Alliance) (Mr Noah Froud, Coordinator) (DEL0245)

249 RBR Active Limited (Mr Paul Westerman, Director) (DEL0002)

250 Rethink Mental Illness (Mr Alex Kennedy, Head of Campaigns and Public Affairs) (DEL0077)

251 Rethink Mental Illness (Rethink Mental Illness Jonathan Moore, Head of Social Policy) (DEL0194)

252 The Richmond Group of Charities (Mr Neil Tester, Director) (DEL0135)

253 Roche Diabetes Care (Mr Conn O'Neill, Public Affairs Lead) (DEL0095)

254 Roche Diabetes Care Limited (Mr Conn O'Neill, Public Affairs Lead, UK & Ireland) (DEL0295)

255 Roche Products Ltd (Roche Products Ltd Emma Pritchard, Public Affairs) (DEL0029)

256 Roche Products Ltd (Roche Products Ltd Emma Pritchard, Roche Products Ltd) (DEL0141)

257 The Royal British Legion (Elizabeth Colliety, Policy Officer (Health & Care)) (DEL0168)

258 Royal College of Emergency Medicine (Dr Katherine Henderson, President) (DEL0081)

259 The Royal College of Emergency Medicine (Mr Theo Chiles, Policy Research Manager) (DEL0288)

260 Royal College of General Practitioners (DEL0327)

261 Royal College of Midwives (Sean O'Sullivan, Head of Health and Social Policy) (DEL0027)

262 Royal College of Midwives (Stuart Bonar, Public Affairs Advisor) (DEL0255)

263 Royal College of Nursing (Knight-Yamamoto, Public Affairs Manager) (DEL0284)

264 Royal College of Obstetricians and Gynaecologists (Jenny Priest, Director of Policy and Public Affairs) (DEL0199)

265 Royal College of Obstetricians and Gynaecologists (Mr Stephen Hall, Political Adviser to the President and Chief Executive) (DEL0041)

266 Royal College of Paediatrics and Child Health (Caitlin Plunkett-Reilly, Public Affairs and Campaigns Lead) (DEL0237)

267 The Royal College of Pathologists (Janine Aldridge, Public Affairs Officer) (DEL0034)

268 The Royal College of Pathologists (The Royal College of Pathologists Janine Aldridge, Public Affairs Officer) (DEL0211)

269 The Royal College of Pathologists' Cytopathology Sub-Committee (Ms Janine Aldridge, Public Affairs Officer) (DEL0213)

270 Royal College of Physicians (DEL0319)

271 Royal College of Physicians (Rory Murray, Public Affairs Manager) (DEL0160)

272 Royal College of Psychiatrists (Mr Jonathan Blay, Public Affairs Manager) (DEL0139)

273 Royal College of Psychiatrists (Mr Jonathan Blay, Public Affairs Manager) (DEL0038)

274 The Royal College of Radiologists, and The Society and College of Radiographers (Mr Paul Alexander) (DEL0030)

275 The Royal College of Radiologists, The Society and College of Radiographers, andThe Institute of Physics and Engineering in Medici (Mr Paul Alexander) (DEL0121)

276 Royal College of Speech and Language Therapists (Ms Claire Moser, Policy Adviser) (DEL0215)

277 Royal College of Surgeons of England (Tamora Langley, Head of Policy Media and Public Affairs) (DEL0258)

278 Royal College of Surgeons of England, and Royal College of Emergency Medicine (DEL0308)

279 Royal National Institute of Blind People (RNIB) (Ms Helen Lee, Policy and Campaigns Manager) (DEL0236)

280 Royal Osteoporosis Society (Mr Craig Jones, CEO) (DEL0233)

281 Royal Pharmaceutical Society (Mr John Lunny, Public Affairs Manager) (DEL0282)

282 Sandbach, Mr David (DEL0306)

283 Sandbach, Mr David (DEL0303)

284 Sands - the stillbirth and neonatal death charity (Ms Kate Mulley, Director of Research, Education and Policy) (DEL0092)

285 Sands, stillbirth and neonatal death charity (Ms Jessica Reeves, Public Affairs and Campaigns Manager) (DEL0011)

286 Sarcoma UK (Mr Bradley Price, Policy and Public Affairs Manager) (DEL0020)

287 Savovic, Dr Jelena (DEL0008)

288 Schafheutle, Professor Ellen (DEL0212)

289 Scottish Veteran Care Network, National Services Scotland, and Veterans First Point Lothi (Dr Lucy Abraham) (DEL0256)

290 SEED Health Alliance (Dr Liz Mear, Chief Executive, Innovation Agency) (DEL0126)

291 Shared Lives Plus (Dr Rebecca Viney-Wood, Policy Officer) (DEL0122)

292 Sheard, Professor Sally (DEL0267)

293 Sheffield Care Association (DEL0314)

294 Shull, Ms Jessica (DEL0207)

295 Society for Acute Medicine (Dr Scriven, Immediate Past President) (DEL0309)

296 The Society of Sports Therapists (Professor Graham Smith, Chairman) (DEL0136)

297 Spire Healthcare (Paul Lehmann, Head of External Communications) (DEL0151)

298 St John Ambulance (Martin Houghton-Brown, Chief Executive) (DEL0176)

299 Statica Research Ltd t/a PEP Health (Dr Mark Lomax, CEO) (DEL0191)

300 SUDEP Action (Sammy Ashby, Deputy Chief Executive) (DEL0098)

301 Sue Ryder (DEL0324)

302 Sue Ryder (Elinor Jayne, Head of Influencing) (DEL0012)

303 Sue Ryder (Ms Elinor Jayne, Head of Influencing) (DEL0171)

304 Target Ovarian Cancer (Rachel Downing, Head of Policy and Campaigns) (DEL0226)

305 Taskforce for Lung Health (Rachael Hodges, Secretariat) (DEL0145)

306 Tata, Mrs Jenny (DEL0031)

307 Teenage Cancer Trust (Louise Soanes, Director of Services) (DEL0065)

308 Terrence Higgins Trust (Debbie Laycock, Head of Policy and Public Affairs) (DEL0116)

309 Trusler, Julia (British Orthopaedic Association) (DEL0338)

310 Turning Point (Mr Peter Lloyd, External Affairs Advisor) (DEL0167)

311 UNISON (Guy Collis, Policy Officer) (DEL0046)

312 Urology Trade Association (DEL0321)

313 Versus Arthritis (Jonathan Canty, Policy Officer) (DEL0173)

314 Veterans First Point (Dr Lucy Abraham, Clinical Lead, Veterans First Point Lothian) (DEL0206)

315 Wise, Mrs Patricia (DEL0220)

316 Wood, Sarah (DEL0232)

317 Young Minds (Charlotte Watson, Policy and Parliamentary Officer) (DEL0096

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All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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First Special Report	Process for independent evaluation of progress on Government commitments	HC 663