HOUSE OF COMMONS

Health and Social Care Committee
Science and Technology Committee

Oral evidence: Coronavirus: lessons learnt, HC 877

Tuesday 26 January 2021

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Watch the meeting

Members present:

Health and Social Care Committee: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Laura Trott.

Science and Technology Committee: Greg Clark; Aaron Bell; Dawn Butler; Mark Logan; Graham Stringer; Zarah Sultana.

Questions 866 - 943

Witness

I: Sir Simon Stevens, Chief Executive, NHS England and NHS Improvement.

Examination of witness

Witness: Sir Simon Stevens.

Q866 **Chair:** Welcome to this morning's joint meeting of the Health and Social Care and Science and Technology House of Commons Select Committees. We are looking this morning at lessons to be learnt so far from the coronavirus pandemic. Our special guest this morning is Sir Simon Stevens, chief executive of the NHS.

Sir Simon, let me start by thanking you and, through you, all frontline NHS staff. The whole country is feeling the pressure of lockdown, but most of us are not doing the night shifts and not having to put ourselves in harm's way. The whole of the membership of both Committees would like, through you, to pass on our thanks to frontline health and care staff for their magnificent efforts. On that note, can I ask you for an update on how things are on the frontline at the moment?

Sir Simon Stevens: Thank you very much, Chair, and good morning to everybody.

The position is that we have just under 33,000 Covid-positive in-patients in hospitals across England. We have been at about that number for the last fortnight. As a reminder, that is a very sharp acceleration since Christmas. We had around 18,000 positive coronavirus patients in hospital at Christmas time. Although we are beginning to see new admissions beginning to turn down slightly, the beds occupied, although decreasing slightly in London, are nevertheless being offset by increases in the midlands, for example. Overall, right now, we have plateaued at about 33,000 Covid-positive in-patients. That is an incredibly high number, and very serious. Looking at the critical care position, we have over 4,000 patients in critical care; about three quarters of our critical care patients are there for Covid-related reasons.

Looking back to the summer, at the beginning of July, in August and the first half of September, Covid in-patient numbers were right down. We then began to see an increase going into October. By mid-November, we were at about 15,000 coronavirus in-patients. We hoped that the numbers would then come down as we headed into Christmas. Instead, we saw them stuck at about 15,000 for another month until mid-December, and then we have had this huge acceleration since Christmas, as I say. It is a very serious position, with all kinds of knock-on consequences, not only for patients and families with coronavirus but for other services as well.

Q867 **Chair:** We know that, nationally, the pressure is easing slightly at the moment. As things stand, are you still confident that we will be able to find intensive care beds and ventilators for everyone who needs them?

Sir Simon Stevens: Everybody is getting intensive care and ventilators who clinicians think would benefit, but let's not disguise the fact that this is stretching the system in an extreme way. We have about 3,700 core

critical care beds across the NHS in England. As a result of the work that hospitals did to prepare over summer and autumn, we have surge beds and facilities, of which about 2,170 are occupied by patients who need critical care. Said another way, it is more than 50% of critical care beds on top of the core capacity. That requires a flex in staffing levels, and staff are working under incredible pressure to deliver those services.

Chair: Let us talk about the impact on some of the other services.

Q868 **Paul Bristow:** Sir Simon, what steps are you currently taking to maintain as much cancer treatment as possible?

Sir Simon Stevens: The first thing to say is that during autumn and early winter we saw a very good rebound in the number of urgent cancer referrals coming back into the system. Since March, around 1.3 million patients have been urgently referred for a cancer check, of whom nine out of 10 were seen within a fortnight.

To answer your question directly, the area we are most concerned about is cancer surgery. Chemotherapy and radiotherapy are continuing, for the most part, in an uninterrupted fashion. In cancer surgery, in particular for patients who need an operation within a month—so-called P2 categorised patients—everybody is doing everything possible to create dedicated surgical facilities, surgical hubs in some parts of the country, and to make use of the independent sector hospital capacity that we have contracted, and to make sure that, if an individual hospital needs to ask for support from another hospital, patients get that care elsewhere.

There is huge focus right across the health service on trying to make sure that those services are sustained. Obviously, there is particular pressure on anaesthetists at the moment, many of whom are being diverted to help the critical care surge for coronavirus patients.

Q869 **Paul Bristow:** On the particular point about cancer and elective surgery, I think Professor Neil Mortensen, the president of the Royal College of Surgeons, was quoted as saying that not enough private sector capacity had been secured. Is he right?

Sir Simon Stevens: Not at this point. I don't believe he is, no. We have the ability to make use of whatever independent sector capacity in a particular city or area is deemed necessary by the local services. It is less a question of facilities and more a question of people. As you know, Mr Bristow, and as Professor Mortensen will know, for the most part, the surgeons and the anaesthetists who operate privately are exactly the same surgeons and anaesthetists who would also be providing care in the national health service.

Q870 **Paul Bristow:** That's right. There was a leaked letter I read the other day to the *HSJ* that suggests that non-urgent elective activity in the NHS was continuing in the independent sector. Would that capacity not be better used to deal with some of the urgent cancer surgery?

Sir Simon Stevens: That is exactly what is happening. Hospitals across the country are prioritising those urgent operations through the independent sector. Particularly since Christmas, as there has been the big surge in Covid in-patients, that is the reprioritisation that is happening.

It is worth saying that, although there are pressures right across the health service, we see the differential impact of a high number of coronavirus patients in particular parts of the country. To put that in context, in London and the south-east, and the east of England, at the moment, for every one coronavirus patient we are looking after in hospital, we are looking after two non-coronavirus patients, whereas in the north-east and Yorkshire, and the south-west regions, where coronavirus has been more under control, there is instead a ratio of more like one coronavirus patient to three or four non-coronavirus patients.

The single biggest thing we can do to make sure that the full range of services can continue to be provided is to get the infection rate down, and hence the Covid hospitalisations.

Q871 **Paul Bristow:** You say that is what is happening at the moment. Why do you think that NHS England officials and people felt the need to write that letter? Why do you think it was leaked to the *HSJ*?

Sir Simon Stevens: As I say, I have just described the facts. The facts are that right across the service people are looking at those so-called P2 urgent operations that need to get done, and are moving heaven and earth to get them done. That is the fact of the matter.

Q872 **Laura Trott:** Sir Simon, what is your assessment of the impact on maternity services during the pandemic?

Sir Simon Stevens: The first thing to say is that obviously maternity services, in terms of childbirth services, continue throughout. There have been some freestanding midwifery units alongside birthing units and home birth services that have been disrupted as a consequence. There has been an ongoing debate about visits of partners of women who are pregnant to maternity units during the course of the pandemic.

On the objective data on outcomes, the initial figures from the Office for National Statistics suggest that the quality of care has continued to improve, certainly between January and September, in line with the trends that we have previously seen, which is encouraging if sustained. But there is no part of the health service that has not been affected in some way, and that is certainly true of maternity care.

Q873 **Laura Trott:** Data seems to suggest that the stillbirth rate nearly doubled last year. How would you and your service be looking to address that, making sure that the women, partners and families affected have the correct mental health support afterwards?

Sir Simon Stevens: Perhaps I could take that in two parts. I think the ONS data that we have from January to September suggests that the stillbirth rate has continued to come down. In terms of maternal mental health services, a big part of the investment programme in mental health in the round is upgrading perinatal specialist mental health services. Those have continued to expand during the course of the pandemic.

The area, frankly, where we are seeing real pressure in mental health services is in the increase in urgent referrals for eating disorder services. Although we have had improvements in access to those services over the last several years, they are now really under pressure. We have another £500 million, which the Chancellor made available in the last spending review, to invest for extra mental health needs during the course of next year. Eating disorder services for young people will be towards the front of the queue for that.

Q874 **Dr Davies:** I am interested in the impact of the pandemic on very long waits for procedures. It is fair to say that before the pandemic there were very few instances of patients waiting over a year for treatment in the NHS. A report in the *Health Service Journal* recently suggests that nearly a quarter of a million people are waiting for that length of time.

Could you confirm that that is the case, and give some kind of indication as to the median weight for those waiting over a year, and perhaps the maximum wait?

Sir Simon Stevens: Certainly. There is a mixed picture overall on waiting times for routine care. The biggest impact, as you rightly say, is that the number of people waiting 52 weeks or above has shot up during the pandemic as a result of disruptions to non-urgent care. The figures just reported for November 2020 stood at 192,000. The year before, it was under 2,000. That is very impactful.

There are two other points to put alongside that. The overall size of the waiting list—the number of people on the waiting list—when you account for estimates and missing data, is slightly lower now than it was a year ago. The median wait for a planned test or operation has been falling quite substantially since July. In July, after the effect of the March/April/May bulge in coronavirus was felt, the median wait for planned care was over 19 weeks. That had fallen to around 10 and a half weeks by November. The health service used the summer respite from coronavirus very well to rapidly re-establish diagnostic and planned care to get the average wait down very significantly.

Q875 **Dr Davies:** I understand that. Certainly, many people have been working hard to try to ensure that waiting times are kept at a reasonable length. There is still a cohort of patients waiting over a year, and because of the way the statistics are published it is not entirely clear how long they are waiting. Is it possible that you could write to us with further detail on that?

Sir Simon Stevens: Sure, yes. Of course; absolutely. I think it is possible, by the way, to de-compose those data from those published. I will certainly get that to you.

Dr Davies: Thank you.

Chair: We are now going to move on to the vaccine distribution programme.

Q876 **Greg Clark:** Perhaps, Simon, I could echo Jeremy's thanks to you and all staff right across the NHS and the care system, the vaccine roll-out being a prime example of the extraordinary mobilisation that is achieving such good results.

We heard overnight from the European Union that there are moves afoot to put bureaucratic obstacles in place to the delivery of vaccines manufactured on the continent. Are you worried by that?

Sir Simon Stevens: Were that to happen, of course it would be a worry, but, as I think Government Ministers said on the airwaves this morning, they think that is not something that is likely at the moment. The reality is, as you say, that we are off to a strong start with vaccination. We have a shared interest in every country doing well on vaccination, given that the virus moves across borders with extreme ease. Equally, this country did well to secure our vaccine supply from multiple sources. Our regulator did well to expeditiously, but authoritatively, look at the safety and efficacy data, and I think GPs, hospitals and all of our partners are doing well to get the vaccinations under way quickly.

We do not want any of that progress stymied, while of course not wanting to see slow vaccination anywhere else in the world either. We all benefit from significant vaccination uptake everywhere.

Q877 **Greg Clark:** Would it prevent the attainment of the 15 February target for the most vulnerable groups if such obstacles were put in place?

Sir Simon Stevens: We are on track for 15 February. As I think Nadhim Zahawi said this morning, 15 February remains our line of sight, but clearly we have a combination of sourcing from Oxford-AstraZeneca, principally from this country, and from Pfizer-BioNTech from continental Europe.

One of the things that arises from this—since I know you are thinking more broadly about the lessons of the pandemic—is that, alongside international co-operation, actually having strong UK manufacturing capability, including in life sciences, is an important part of our future resilience. Very extended supply chains do not necessarily serve you well.

Q878 **Greg Clark:** The Oxford vaccine is a great triumph of scientific endeavour and discovery. It has now been administered to over-80s in the UK since 4 January. Three and a half weeks on, are you aware of any hospital admissions of people who have had the AZ vaccine?

Sir Simon Stevens: Of course, there will be hospital admissions for people who have had vaccines, for a whole range of reasons, but the pharmacovigilance process that the MHRA has put in place, with the support of those who are giving the vaccines, is continuing to report. At this stage, there is nothing of concern. MHRA will be publishing its pharmacovigilance data shortly.

Obviously, we took particular care in the first several days after both vaccines were authorised. We began by administering in hospital hubs so that we could be sure, if there were to be any significant allergic reaction, that full support and back-up would be available. On both counts, that has gone very smoothly since then.

Q879 **Greg Clark:** I am thinking in particular of people admitted for Covid. Whether it is the Oxford vaccine or the Pfizer vaccine, are you aware of anyone who has been admitted for Covid reasons since they have had either of these vaccines?

Sir Simon Stevens: I do not have those figures in front of me, Mr Clark. As you well know, there will be people who, within the first fortnight or so of having had their vaccine, will go on to contract a Covid infection, because the immune response particularly kicks in after a 12 to 14-day period. There will be those individuals, and the question is about making sure that the curves diverge, which is what the trial data showed in both cases.

Q880 **Greg Clark:** Indeed. We are in a position, as time goes on, to be able to establish pretty comprehensively how effective those vaccines are, and to quash the suggestion, we hope, that they are not efficacious. That data is very important. Perhaps you might write to our joint Committees with it as soon as possible, because it would be tremendously reassuring.

Sir Simon Stevens: I will certainly ask June Raine to do so, because it is the MHRA that is leading the continuing post-authorisation surveillance.

Q881 **Greg Clark:** You were very clear that the pressure on hospitals continues, although it has stabilised. Would you say something about the age composition of patients, both in intensive care and generally? Are they mostly the very elderly, or is it more evenly distributed?

Sir Simon Stevens: That is an important question that connects to some of the wider policy debates about what the future regime for reducing social transmission looks like. I suspect that might be the question behind the question.

In terms of the figures, as I have previously said, about a quarter of hospital admissions for Covid are for people aged under 55. About half of in-patient bed days for coronavirus patients relate to patients under the age of 65. Clearly, deaths are highly concentrated in the older age groups who are in the first four categories of high priority recommended by the Joint Committee on Vaccination and Immunisation: people aged 70 and above, the clinically extremely vulnerable and the health and social care

staff looking after them. Independently, that has been estimated to account for 88% of the deaths that have occurred so far.

When you look at the use of hospital resources, it is not quite as concentrated at the apex of the pyramid of risk, shall we say.

Q882 **Greg Clark:** If our aim is to reduce the pressure on hospitals, as well, obviously, as reducing deaths, we need to make sure that not just the over-70s are protected but lower age groups as well. That follows, I take it.

Sir Simon Stevens: Yes. Could I clarify the answer I just gave? When I said half of coronavirus-related bed days, that was in critical care for the under-65s. For general hospital beds and acute beds, more like a quarter of bed days are for people aged under 65. In other words, by the time you are vaccinating people aged 65, 70 and 75, you are beginning to make a big impact on hospital bed usage, not just the avoidable deaths.

Q883 **Greg Clark:** When it gets to the point, hopefully soon, when we have vaccinated all the over-70s and the people who are extremely clinically vulnerable, is the logic of reducing pressure on the NHS to vaccinate next those in their 60s and perhaps the over-55s?

Sir Simon Stevens: Yes, that is the logic. I think that is the current proposition. Once we have offered vaccination to everybody aged 70 and above, and to the clinically extremely vulnerable, the next group of people will be those in their 60s and 50s, although there will also be a discussion—legitimate, in my view—that the Joint Committee on Vaccination and Immunisation will have to advise on, as to whether or not there are certain other groups who should also receive priority at that point, such as people with learning disability and autism, certain key public service workers, teachers and the police. They will all have to be factored into that post-15 February prioritisation decision as well.

Q884 **Greg Clark:** As the person running the NHS, and in terms of reducing the pressure on hospitals, would you want to vaccinate people who are being admitted to hospital with Covid in the 60s and 50s age groups rather than—there might be other reasons to vaccinate them, but from the NHS point of view—healthy professionals who are working in other areas?

Sir Simon Stevens: Purely from the point of view of reducing the number of hospital beds occupied by patients with coronavirus, that is right. But that is not the only consideration that policymakers would legitimately want to take into account. That is why, on teachers, the police and other key public service workers, that will be one of the discussions that will need to be had.

To state the obvious, fundamentally the most important thing is just to get the overall infection rate down. This is not principally about pressure on the NHS; it is principally about reducing the avoidable death rate. It is our excess infections that give rise to excess deaths.

Q885 **Greg Clark:** Indeed. It is certainly reducing deaths, but it is also protecting the NHS. It is part of the slogan, part of the phrase. It has been an important imperative, so it is important to know what would help to achieve it.

Sir Simon Stevens: That's right, although on that particular phrase, as some of us have discussed before, seen from the point of view of staff across the health service, it is not so much protecting the NHS but protecting the NHS's ability to look after the full range of patients.

Where coronavirus is out of control, it obviously begins to disrupt other care. As I have written to the Health Committee, that has been the experience in many other European countries over the course of the pandemic. We have seen that in France, Germany, the Netherlands, Switzerland, Belgium and the United States, and in Japan right now. This is an international phenomenon; it is not some distinctive feature of the UK or the NHS that when you have coronavirus out of control it disrupts other care.

Greg Clark: Absolutely. Thank you, Sir Simon.

Q886 **Sarah Owen:** Sir Simon, the success of any vaccine roll-out depends on take-up by the majority of people. Research presented to SAGE found that, worryingly, just 28% of black, Asian and minority ethnic people intended to be vaccinated, compared with 85% of white British people.

Are you aware of such issues? How are you ensuring that take-up is high among people from higher-risk groups? How are you collecting that data? Do you have any information that you can share with us today?

Sir Simon Stevens: Thank you. You raise an incredibly important point, and it is a genuine and deep concern. We are seeing more vaccine hesitancy on the part of some groups in the population. Overall, at this point, I have to say that, given the targeting at the moment on people aged over 80, over 75 and so on, take-up has been fantastic in the round. We are seeing a very strong response. When we originally put forward the vaccination strategy, we hypothesised that the population take-up might be something like 75%. We are at 80% already in the over-80s. Over half of people aged 75 to 79 have now had their first vaccination.

The uptake is going very well, but, as you say, there is a combination of access and systematic efforts to misinform and lie about the vaccination programme, targeted particularly at minority populations. In some cases, there is long-standing mistrust of public services that stands in the way of people coming forward. There is a whole range of things that are being done to try to ensure that that does not stand in the way of equitable uptake of the vaccine.

The NHS will be fairly offering it to everybody, but we want to make sure that we do not have distortions in uptake. The first thing, of course, is tracking data. Those uptake figures, while protecting people's

confidentiality of course, are being shared at small, area level with local authority directors of public health, so that they can do the great work that they are well known for, engaging with local communities, with faith leaders, community groups and others to encourage uptake.

Secondly, there is targeted action to address misinformation, using communication channels and people who are trusted in different communities. Thirdly, over and above that, it is making sure that the places where vaccinations can be given are sufficiently accessible and diverse so that they do not stand in the way of uptake.

There is a lot of work, both nationally and locally, involving public health directors, local authorities, faith groups, community leaders and the whole of Government.

Q887 **Sarah Owen:** Do you collect data on ethnicity for vaccine take-up? Can you confirm that?

Sir Simon Stevens: Yes.

Q888 **Sarah Owen:** I have another question around vaccine take-up. We have lots of overseas workers in the NHS. We have seen some worrying reports that, unless you have an NHS number, you will not be eligible for a vaccine. That would discount many overseas black, Asian and minority ethnic workers in the NHS.

Sir Simon Stevens: Fortunately, that is not true. It is completely untrue.

Q889 **Sarah Owen:** Thank you for confirming that. How are you planning to reach those with no recourse to public funds for the vaccination programme?

Sir Simon Stevens: We are going to be doing outreach. Are you talking about people without a permanent address, homeless people, Travellers and other groups?

Q890 **Sarah Owen:** And migrants.

Sir Simon Stevens: Yes. That is why we are working with directors of public health. It is not the case that you have to be on the electoral register or anything like that in order to be invited. As we move through each successive cohort, there will come a moment when we say, "If you haven't been contacted, then please come forward yourself." Right now, because we have been asked to move down the risk pyramid, the NHS is asking people to book an appointment. We are saying, "Wait for us to contact you, rather than you phoning your surgery," for example. As we get to the end of each cohort, we will be saying very clearly, "If you fall into this category and you haven't been vaccinated, here's how you can come forward and be vaccinated," alongside the community outreach that I have just described.

Q891 **Rosie Cooper:** Good morning, Simon. Could you explain to people how

they will know when they are getting the second vaccine? I do not just mean by a date. If we are going to meet what I presume is the Prime Minister's target of 14 February, when do those people get their second vaccine?

Sir Simon Stevens: The target is that everybody in the first four categories should have been offered the opportunity to have their first vaccine dose by 15 February. The second doses will follow within 12 weeks of whenever the first dose occurred. What many, if not most, of the vaccination services are now doing, at the point when somebody has their first vaccination, is giving them a little card with a date on it that says, "This is when you will come back for your second vaccine." In the case of people whose appointment had to be rescheduled, they will get a call from whoever gave them their first vaccine.

Q892 **Rosie Cooper:** Most hospitals and doctors surgeries do not know when they are getting their vaccine. They do not know when it is due. The supply seems to be intermittent. How can you be sure that you are going to be able to meet all that?

Sir Simon Stevens: At the moment, we are pretty much using up each week's vaccine as we get it. As we receive it through the safety testing and the batch testing, and distribution to the NHS, it gets sent out across the country. We want to do it in a fair way, so that each part of the country has enough vaccine to be able to offer all of their 70-year olds and above, their high-risk patients and their staff the first vaccine. That is why, for the time being, we are on the so-called push model for fairness.

What we will then do—to your question, Rosie—for the second doses, will be partly moving to a so-called pull model, where the local services will be saying, "I need this many vaccines next week for my second vaccinations," and then the vaccination team will make those vaccines available to them.

Q893 **Rosie Cooper:** I have many constituents, including staff at Southport and Ormskirk Hospital, who caught Covid more than three weeks after their first vaccine. I know that the Government are doing a communications push on that.

Do you think it is misleading for the Prime Minister and Ministers—I have heard it this morning on this Committee—to keep referring to the number of people vaccinated, not the number of people who have received their first vaccination? That is misleading.

Sir Simon Stevens: Not as long as we are all clear what we are talking about. I have tried personally to be quite clear on that point. The good news is that, based on the data that the MHRA, the Joint Committee on Vaccination and Immunisation, the chief medical officers and Jonathan Van-Tam, the deputy chief medical officer, have put before us and published, the protection you get after your first jab appears to be very significant. Clearly, the recommendation, which the NHS will deliver on, is that people get a second booster jab as well.

Q894 **Rosie Cooper:** But not within the stated 21 days. I spoke to Pfizer, and they are clear. They are not happy.

Sir Simon Stevens: That has been a well-discussed topic. Indeed, I think yesterday the chair of the JCVI, the virologists and clinicians who led that recommendation, together with Jonathan Van-Tam over the weekend, explained their reasoning.

In very personal terms, my parents are both in their 80s. I know they won't mind my saying so. If it were my choice—which it was not because it was obviously an expert recommendation to Government—and it was a choice of one of my parents having two jabs or both of them getting their first jab, I would far rather both of them had their first jab. Fortunately, that is what has now happened. There is a good logic to that, but clearly the evidence needs to be kept under continual review.

Q895 **Zarah Sultana:** I want to carry on with the line of argument that Rosie was taking. For the Pfizer vaccine, the studied and approved interval is 21 days between the first and second dose. For the Moderna vaccine, it is 28 days. For the AstraZeneca vaccine, the trial was two doses 28 days apart.

Within the NHS we have seen staff illness rates higher than usual, and confidence in the profession badly affected. What evidence is there to reassure NHS staff that they are adequately protected after a single dose of the vaccine?

Sir Simon Stevens: Perhaps I might quote Professor Anthony Harnden from the Joint Committee of Vaccination and Immunisation, who is well placed to answer that precise question. This is what he said earlier in the week: "We examined the data from the Pfizer study and concluded that there was really no substantial evidence that a second dose gave substantially longer and better protection…Pfizer technology is the same as Moderna"—which, as you know, is the messenger RNA-type vaccine—"and the latter", Moderna, "recently submitted a document that shows 90% efficacy even after two months from just one dose, so we think this is the right public health decision, but it is difficult to communicate."

Q896 **Zarah Sultana:** Thank you for that. Preliminary data from about 200,000 people vaccinated in Israel shows that a single dose of the Pfizer vaccine may provide less protection than originally hoped. Their study shows that the effectiveness of the vaccine after one dose is as low as 33%, rather than the 89% initially suggested.

I and others would argue that the Government's vaccination strategy is clearly rooted in overcoming supply shortages and meeting the target of 15 million by 15 February. Could this be doing more harm than good, based on the data that is coming from Israel?

Sir Simon Stevens: When that point was put to Professor Harnden, he said that "our clear steer is that one dose with a delayed secondary dose is going to save many more lives nationally." I think you will have seen

that the Israeli Ministry of Health has clarified that the figure you refer to is unlikely to be accurate.

These things need to be continually kept under review, but your key point was whether this is being done because of a supply shortage. The answer to that is, of course, yes, there is a supply shortage. If there were unlimited vaccines, you would not see what the European Commission were saying yesterday. You would not see Italy attempting to sue one of the manufacturers. You would not see Germany in uproar, as it is today. Of course there is a supply shortage. We have done very well in this country to get the supply we have available to us. The question is how we use it to best effect.

Q897 **Zarah Sultana:** Thank you. You mentioned having the data constantly reviewed. Are the NHS and the Government committed to independent scientific review of the data?

Sir Simon Stevens: The MHRA is independent of the NHS and of Government. The trial data on which they base their decisions have also been published in peer-reviewed journals.

Q898 **Zarah Sultana:** My final question is on the language around vaccinations. We hear Government Ministers and others referring to people who have only had one dose as "vaccinated". There is a risk that people think they are protected against the virus and will let down their guard. Of course, that affects public health as a whole. Has the risk been considered in terms of the language that is being used?

Sir Simon Stevens: I think it has, and I think you are right to raise the point. Jonathan Van-Tam wrote very clearly on the point in one of the Sunday newspapers, and it was then widely picked up.

There are two issues. The first is that, within 12 or 14 days of having been vaccinated, your immune response, and perhaps your T-cell response, has not kicked in sufficiently, and you are not getting the effect you would expect. The second point is that people will need their second dose in order to get the full benefit.

There is an unknown, which is the extent to which, having been vaccinated, as well as protecting you as an individual, it also reduces your chance of passing the virus to other people—the transmission effect. Obviously, understanding those data will be very important as they become available, not just in this country but internationally.

Zarah Sultana: Thank you.

Q899 **Dr Davies:** Sir Simon, from March, there will be large numbers of individuals coming forward for their second dose of vaccine. Are you expecting that to slow down the roll-out of the first dose to the remaining groups 5 to 9?

Sir Simon Stevens: You are right to make the point. First and foremost, those second doses have to be delivered. We know that 12 weeks on

from when the first doses were delivered has to be the first call on the vaccine available in those weeks. Over and above that, as we get increasing clarity as to what the available supply will be, it will shape the speed at which we can advance to the other groups.

My expectation is that we will do two things simultaneously as we move to working-age adults more broadly. The first is that, when we have a lot more supply, we will be able to make vaccine available in many different outlets. Lots of high street pharmacists will be able to offer vaccine because there will not be such an issue about having inventory held rather than injected. At the same time, the larger vaccination centres that we have established will be going all guns blazing for increasing numbers of people. Right now, supply is constrained, and we have over 1,000 GP-led primary care networks doing vaccinations. We have over 250 hospital sites that are doing vaccinations. We have pharmacy services coming online, and we have 49 larger vaccination centres. We want to give people choice and combine accessibility with scale as supply increases.

Q900 **Dr Davies:** On supply, there have of course been bonus doses that have been obtained from vials. In the case of Pfizer, there have been six doses from a 1.8 ml vial. In the case of the AstraZeneca Oxford vaccine, I think there have been 11 and nine doses from vials otherwise designed to contain 10 and eight. Do you have any data on the extent of success from obtaining the extra doses?

Sir Simon Stevens: The first thing to say is that we were the first people to spot the fact that that was possible, given that we were the first country to be using Pfizer in that way. Generally, in most batches, vaccinators have been able to get six doses rather than five. It is not in every batch, I might add. It is partly the prescience of our supply team in ordering the right kind of needle. It has a special little rubber stopper that means that all the vaccine goes out of the end of the needle rather than any being left in each administration unit. That has clearly helped. The same is true with AstraZeneca. I think Pfizer either have changed or will change the formal authorisation to identify six doses as the expected yield for each vial.

Q901 **Dr Davies:** What is your working assumption as to the return of the NHS to normal operation, bearing in mind that vaccines are being deployed but there is the risk of waning immunity and new strains? How do you see the coming year or so?

Sir Simon Stevens: Obviously, there is a big cone of uncertainty. The first half of the year is probably mainly going to be a story of vaccine roll-out. The promising feature of the new vaccine technologies that are being deployed—in particular, the messenger RNA—is that BioNTech and others have said that it is relatively quick to repurpose if a further booster is required for a different strain. I think the head of BioNTech was talking about a six-week turnaround, and then he obviously has to do the

authorisation, look at the data and so forth. Nevertheless, that is a huge turnaround.

Until the Covid vaccines, one of the fastest developments of human vaccines was mumps in the 1960s, which took four years. We are in a completely different place thanks to brilliant science here. In the first half of the year, vaccination will be crucial.

A lot of us in the health service are increasingly hopeful that in the second half of the year and beyond we will see more therapeutics. We will see more treatments for coronavirus. The ones that have already surfaced are well known—the corticosteroids, dexamethasone and the repurposed arthritis drugs. There are a number of others in the pipeline. It is possible that, over the course of the next six to 18 months, coronavirus becomes a much more treatable disease, with antivirals and other therapies, which, alongside the vaccination programme, hold out the hope of a return to a much more normal future.

Q902 **Chair:** For the final part of this morning's questions we want to focus on some longer-term reforms that may be sensible, given the experience that we have had through the pandemic. I want to start, if I may, Sir Simon, with the question of workforce. There has been so much discussion throughout the pandemic of the pressures on the NHS and social care workforce.

The 10-year plan was published three years ago, but the Treasury still won't allow the NHS to publish its own projections of the numbers of doctors and nurses you think you will need over that 10-year period. We have no idea whether we are training enough. Obviously, a lot of extra people have been brought in during the pandemic, but would a long-term solution to the perennial question of whether we are training enough doctors, nurses, endoscopists, oncologists and so on be for an independent body like the ONS to work with NHS England, and every year publish the long-term workforce requirements of the NHS so that we can make sure that we are training enough people?

Sir Simon Stevens: There is great merit in what you suggest, Chair. The paradox is that, fortunately, the health service has a medium-term outlook for its revenue funding—its day-to-day funding—but sometimes the outlook for workforce training, and indeed for capital investment in infrastructure, has tended to be more short term. Of course, those are the things where the planning horizon is much longer. Anything that can bring predictability to those decisions—both investing in people and in infrastructure—would be strongly welcomed.

As it happens, I think there are some very positive signs on the workforce front, particularly for nursing. We have seen strong growth in the number of young people inspired to enter undergraduate nursing. We saw significant reductions in nurse vacancies over the course of the last year. We are up 13,000 whole-time equivalent nurses as well. I think we are on track for the goal of 50,000 more nurses net, which is one of the

Government's manifesto commitments, as it happens. My view looking out over the decade is that, whereas over the last five years we have seen an increase in nursing of about 25,000 whole-time equivalents—we are looking at 50,000, by comparison, over the next equivalent period—we are going to need significantly in excess of 100,000 more nurses over the course of the next 10 years. Keeping that focus, and matching it with the actions that are needed, makes a lot of sense.

Q903 **Laura Trott:** Sir Simon, to deal with the pandemic, you have had to redeploy a huge number of staff from their jobs elsewhere in the NHS. Have you encountered any barriers in trying to do that?

Sir Simon Stevens: Generally, no, in that people, under the most difficult circumstances, have all pitched in with incredible esprit de corps while recognising, frankly, that people across the health service are tired, stressed and frustrated. I am speaking very frankly.

This coming Sunday, it is a year since the first group of people were repatriated to this country, if you remember, from Wuhan to the Arrowe Park hospital nursing accommodation. This has been an incredibly intense and difficult year for most staff across the health service and, indeed, for families and the country as a whole. Have people chipped in? Have people responded incredibly flexibly? Yes, they have. We have medical students helping out. We have nursing students helping out. We have consultants from other disciplines helping out on the acute medicine ward. We have therapists and nurses flexibly supporting their colleagues in critical care.

The silver lining, if one can even allow oneself that phrase, is that it has shown that under these circumstances health service staff will always go the extra mile, but that is not a sustainable basis on which to think either about the future of the pandemic or indeed the future of the health service.

Q904 **Laura Trott:** Absolutely right. When we are thinking about making recommendations as a Committee for how we can change things in the future to help prepare ourselves better for future pandemics, the exam question is: do we want to make any changes in contracts in terms of specificity and emergency for staff? Is there anything in and around that area that you think we should be looking at or recommending?

Sir Simon Stevens: There are two or three things that get to your question, Laura. One is that often in healthcare people make a career choice about which specialty or discipline they are going to enter, and they might make that choice in their 20s. Then, in effect, they spend their 30s, 40s, 50s and 60s—the next 30 or 35 years—working in that area.

What this force majeure has brought about is a lot of people adding something else to their clinical practice and experience. That is not to say that it should be a permanent part of people's future careers, but I have

talked to a number of staff who feel that it has been a professionally important thing to have an adjunct discipline. There is a sort of reservist idea, not of people outside the workforce, but a reservist supporting critical care even though their fundamental professional endeavours are in a different area.

There is also a question about people wanting to change disciplines mid-career. It is quite hard to do that. You sometimes find people moving out of hospital medicine and into general practice, less so vice versa. Finding ways for people mid-career to switch specialties or sub-specialties is quite important for personal development and for the flexibility of the health service.

Q905 **Chair:** Sir Simon, when you arrived as chief executive you persuaded me of the need for a five-year plan. Then, in spring 2018, we both fought very hard to secure a 10-year plan for the NHS, which I think has been an important way of allowing long-term planning.

In the pandemic, there has been a lot of discussion about the lack of resilience in the social care system. Do you think the social care system too needs a 10-year plan?

Sir Simon Stevens: I definitely do. In fact, I think both the Committee and you, Chair, have made that point. I said the same last July when it was the 72nd anniversary of the national health service. I said that, given all the pressures and the tragedy we have seen in the social care sector through the pandemic, one fitting legacy of that would actually be once and for all to resolve the question about fair funding and reform of adult social care.

It is easy to say that. The question then is, what are some of the judgments and trade-offs that are needed in order to make it a reality? The Health Committee published a report on 22 October that identified a requirement for additional funding by 2023-24. In some senses, that is a significant sum, but relative to some of the emergency expenditure that has occurred during the course of the pandemic, it looks incredibly modest.

What you were proposing as a requirement for adult social care in 2023-24 is less than a third of what it is budgeted to spend on the test and trace programme this year, for example. Where there is a will, there is a way, but there are a number of interesting and important trade-offs that have to be thought about.

First, for any extra public funding going to social care, what proportion of it should be used to make the current financial burdens fairer—in other words, to make things that people currently pay for free—versus what proportion of that extra public funding should go to meet unmet need and buy more social care? Obviously, buying more social care is a crucial part of having dignified support in old age.

There is a set of judgments to be made around not just supporting care homes, but giving people wider, more flexible options, including housing with support, so that as people's needs change they do not necessarily have to move from where they are living. Adult directors of social care rightly remind us that support for older people is perhaps only half of the budget for adult social care they are responsible for. People with learning disabilities, autism, mental health and physical disabilities are also a big part of social care, and they need proper attention too.

On provider resilience, part of the Committee's recommendations were around increasing support to shore up the structure of current provision. We have a very plural set of providers in social care. We have to be quite thoughtful about the needs of a small, socially driven care home versus one of the larger private equity-backed chains out of the Cayman Islands.

In other words, it is not a question of there being a pre-baked recipe. On the other hand, the shape of what a sensible outcome would look like has been well debated down the decades. I think it is possible to get there.

Q906 **Barbara Keeley:** I put forward my admiration for the work done by the NHS staff and the extent to which, as you said, Sir Simon, they have gone the extra mile. My questions are set in that context, but there are some issues, particularly around how the NHS, social care and carers work.

The first is about hospital discharge guidance. The discharge to assess model makes no mention at all of family carers. There is no mention of carers' assessments, which is a right. There is no discussion of a person's willingness or ability to care. That is a major omission in the policy, and it causes deep concern. Can you comment on that, and whether the guidance should be reissued inserting that missing detail?

Sir Simon Stevens: I am certainly happy, Barbara, to raise that with the team. I know that they have been working closely with Age UK and a number of other groups on it. Those all sound very sensible points and very fair.

Q907 **Barbara Keeley:** I am going back to questions about vaccines, but this time they are about prioritisation. Despite the JCVI identifying unpaid carers as a priority for vaccines in group 6, the vaccines delivery plan does not mention carers at all in priority 6, and carers are concerned about it. Can you comment? Should the vaccine delivery plan now be updated?

The other key issue is how those carers will be identified, as their NHS records may not reflect their caring role. There is some good practice among GPs sometimes to identify carers, but it is certainly not across the board. How will that aspect of carers getting their vaccines work?

Sir Simon Stevens: As you say, JCVI referenced the important role of carers. Once we have got to mid-February, and hopefully the first four groups have had their offer of first vaccination, there will be a need to

take stock of what the next phase of the vaccine programme looks like. You are quite right to raise the important role and the needs of carers. I will make sure that that is taken into account by the JCVI when they put forward their next set of recommendations. I obviously cannot speak for what they will say, but I will make sure that they hear the point.

Q908 **Barbara Keeley:** This is part of the difficulty. In the end, if carers are not mentioned in guidance or vaccine priorities, they just feel that they are beavering away providing care, which we all rely on in the same way as we rely on your NHS staff, but that nobody cares about it.

I have a final point about vaccines. There is real concern about whether home-care staff are being vaccinated. Hospital vaccination hubs are meant to work with local authorities to identify those care staff, but I am hearing that communication with care providers is patchy or even absent. I understand that it is difficult; you have talked about the plurality of the type of providers out there, but if care staff are not being reached, it is an issue. What could be done to ensure that communication improves from hospital hubs so that they can identify care workers out in the community and invite them for vaccination?

Sir Simon Stevens: The Department of Health and Social Care is writing to care providers to clarify exactly the points you raise. Principally, the responsibility for identifying those care providers rests with local authorities, working with care providers in their local area. Employers make available staff to be vaccinated in the hospital hubs, vaccination centres or wherever it may be.

The reality is that the hospital hub or the vaccination centre will not know who all those people are. The people who do will be the care providers and the local authorities. Local authorities have been assigned that role by the Department of Health to mobilise—

Q909 **Barbara Keeley:** I understand that. I said that in the preamble. The point is that we are hearing that, to some extent, it is not working. Communication from the hospital hubs to the care staff is not working. It is patchy in some places, and in some places it is absent. There is a serious thing there about care staff not being vaccinated.

Sir Simon Stevens: To be clear, the hospital hubs are not in a position to directly communicate to a care assistant. They would not know who they are.

Barbara Keeley: I understand that.

Sir Simon Stevens: It is the agency or the local authority who is responsible. They generate the names and book them into appointment slots. Then the NHS does the actual vaccinating.

Q910 **Barbara Keeley:** If we can feed into the process that in some places it is not working all that well, and perhaps improve the communication, I think that is the key thing.

Sir Simon Stevens: Sure.

Barbara Keeley: Thank you.

Q911 **Chair:** I want to talk about another aspect of the pandemic, which is the very unequal impact on different groups within the population. Should the levelling-up agenda be expanded to cover health inequalities so that disadvantaged groups, people from minority ethnic backgrounds, people from deprived communities, the clinically obese and so on are less exposed and less at risk in a future pandemic?

Sir Simon Stevens: Yes.

Chair: That is very clear; thank you. Let me bring in Sarah Owen on that point.

Q912 **Sarah Owen:** I want to dig a little bit deeper into that. The mortality rate from the virus in deprived areas, compared with more well-off areas, is double. As well as having the levelling-up agenda extended to health, is there one other thing that could be done to mitigate the huge health inequality that we are seeing, particularly as the financial impact of Covid will be felt for the coming years?

Sir Simon Stevens: You are right in what you say. There is a nexus of social explanation that explains why there is that higher mortality rate. Generally speaking, it is not because of differences in treatment but because of differences in the infection rate, and the prior circumstances that mean some people are more likely to die as a consequence. For example, if you have diabetes—both type 1 and type 2—you are at a much elevated risk of dying if you contract Covid.

It is a combination of occupational exposures, crowded housing, prior health risk, including obesity, as the Chair said, and broader inequality. That has all compounded to create the differential that you describe. Race and ethnicity is an independent explanation over and above those other variables as well. Not just as part of the response to Covid but as a catalysing need for change, it is a very powerful reminder that levelling up in the way that the Chair described, and that you describe Sarah, needs to take place.

Q913 **Chair:** On long-term lessons, what has the pandemic taught us about the right balance in doing things locally and doing things centrally? For example, with test and trace, there has been much criticism of a top-down approach, but on vaccines we seem to have a command and control system that has worked pretty well. What have you learnt in the pandemic about how to get that balance right?

Sir Simon Stevens: I would not characterise the vaccine programme quite like that, Chair. It is still a work in progress; we are still in the early stages of the vaccination programme, so it is too early to draw definitive conclusions. We have thought very carefully about the things that need to be done nationally and the things that need to be done on a highly localised and distributed basis.

Clearly, procuring vaccine and vaccine supply is not something you distribute. Indeed, that has been done on a UK-wide basis. On the other hand, rather than creating a national, vertical, stand-alone vaccination programme, the judgment I took was that we have groups of GPs, pharmacists and others who have a fantastic track record on vaccination, and indeed on vaccinating the right people at the right time.

Because of the particular handling properties of the Pfizer-BioNTech vaccine, we could not have just distributed it to all 7,000 GP practices or 9,000 pharmacies in England and said, "Off you go." We had created primary care networks as part of the long-term plan. There were about 1,200 or 1,300 of them, which is exactly the right population level to organise a locally sensitive vaccination campaign. We have supplies nationally; fair distribution across the country; local mobilisation, including of volunteers, such as the St John's Ambulance; and the use of premises that lots of organisations, including local authorities, have put in, but with our primary care network as the building block. Three quarters of vaccinations so far have been delivered through local vaccination services led by primary care. That has, so far, proven to be the right combination. It is not either a central or a local; it is figuring out which things need to be done nationally and which things need to be done regionally or locally.

Q914 **Dr Evans:** Sir Simon, I am interested in the red tape and bureaucracy culture coming down from the top. Time is short, so could you answer this question? In your previous jobs you have seen a lot of different systems. On a scale of nought to 10, when you came into the NHS—10 being the most efficient with no red tape and zero being all red tape—what was your assessment at that time? Just a number.

Sir Simon Stevens: There are various ways of answering that question. One is to ask a nurse on a ward or a junior doctor, "How much of your time is spent patient facing and caring?" What those staff, of course, say is that actually a proportion of their working week is spent on data entry, medical records and all the rest of it, so there is some of that. By the way, it turns out to be an international phenomenon; it is not an NHS-specific phenomenon.

The overarching red tape, or our administrative costs, are very low. We spend about two pence in the pound on administration in this country compared to five pence and six pence in France and Germany, and way more than that across the Atlantic. Our on-costs are very low.

Q915 **Dr Evans:** The vaccinator is a good example. On the frontline, when the vaccination programme was brought in, there were 14 different pieces of information that someone needed in order to sign up, including manual handling and spotting potential terrorist threats. The NHS acted very quickly and scrapped all that to make it more streamlined. That was due to the necessity of the pandemic.

Thinking to the future, what do you try to do as the leader of the NHS to

install that kind of rapid response for when we are, effectively, in peacetime? Clearly, the NHS can change. What are you doing to give it the chance to change?

Sir Simon Stevens: I agree with the point you have just made, Luke. Those requirements were streamlined very quickly. The Department of Health had a very productive conversation with the Home Office and said that maybe the prevent terrorism requirements did not need to apply in this situation. We had very good dialogue very quickly with the Care Quality Commission around some of the requirements that they would normally have, and with the medical royal colleges and so on and so forth.

That has been the experience, and it has been pretty well recorded across the health service. When people focus on the goal, everything else is just a means to the end. If it is not contributing, you get rid of it. That is absolutely the essence that we want to continue with.

Q916 **Dr Evans:** How are you going to keep that spirit up?

Sir Simon Stevens: I think that has turned out to be the fuel in the tank driving clinical change in all kinds of ways across the health service. People can see it is working and they want to sustain it. When it comes to setting up home-based services, and monitoring with pulse oximetry and oxygen, clinicians who have seen that have had the ability to get on, innovate and then spread it across the service. When it comes to establishing new clinics for long Covid, where we have more than 60 opening, that began with clinicians in places like Leicester, Newcastle and University College hospitals identifying a problem and doing something about it. We then got NICE in to say, "All right, what does this need to look like in a more standardised fashion?" That is the change model, and I think we want more of it.

Q917 **Dr Evans:** I am really keen to hear that. You, as the leader of the NHS at the moment, are going to come into contact with almost the entire population of the UK for 15 minutes when they come in and have their jab. What plans are in place to get opportunistic public health interventions into those big centres, like stopping smoking and obesity, because this is the one time that you may be able to contact people the NHS has never, ever been able to have contact with?

Sir Simon Stevens: That is a great point. To clarify, the 15-minute wait is particularly for the Pfizer-BioNTech vaccine rather than for the Oxford-AstraZeneca vaccine. That is an interesting observation. I will put it to my colleagues and see what they come up with. If you have ideas in the meantime, please say.

GPs locally, exactly in the spirit of this conversation, are themselves already taking this opportunity. Down the line, I hope that it is not only the opportunistic contact you describe; it would be great if the Covid vaccine and the flu vaccine end up being combined in a single vaccine.

We might see that, if not for this winter, for future winters. There are a lot of opportunities.

Q918 **Dr Evans:** It is in the spirit of thinking what we can do better in the future. I do not expect you to give answers to us on this, but maybe you could give a commitment to the Committee that you would be happy to submit a plan to us about how you are thinking about the big picture for the future and the best ideas that we can take forward. That would be very welcome.

Sir Simon Stevens: Sure. If, in the meantime, you or the Committee have particular ideas on that as well, I would love to hear them. Definitely.

Q919 **Neale Hanvey:** Sir Simon, I want first to go back to cancer therapy and ask about the cancer recovery plan. It was released on 14 December, but the work on it would have been done at a time when we did not expect the situation to escalate in the way that it has since it was published. You mentioned earlier that it was really over the Christmas break that we realised that things were beginning to get challenging.

Given that there is quite a short timescale for the cancer plan, and it was worked up when we did not expect things to be as challenging as they are, is there a fundamental need to revisit it and consider the recovery of cancer treatment in the long term?

Sir Simon Stevens: I don't think so, no, inasmuch as the various themes and actions that were set out in the plan are the right actions. As you say, though, we are in much more challenging circumstances relative to coronavirus than were envisaged when it was written. Are the things in that cancer recovery plan the right things to do as soon as we are able, to the maximum extent? I think they are. As you know, we develop them with our partners in the cancer charities: Cancer Research UK, Macmillan and a number of others. We are listening very hard to what they tell us makes sense.

If it is of any solace, I can say that urgent referrals appear to have been holding up. Obviously, one of the big concerns in the first wave was that the number of people coming forward fell. That was why we have been repeatedly asking people to help us help you by coming forward to have a lump checked out if they are concerned or if they have chest pain from a heart problem. In the week ending 3 January, two-week urgent referrals were above the volumes we had at this time last year. The most recent treatment data I have suggests that we are at around the same level as we were in the prior year. You are right to raise it. We need to keep it very tightly under review.

Q920 **Neale Hanvey:** That is reassuring. I guess the key question is the short-termism of a March date. Without any critical element to this statement, there is no way that the backlog in cancer treatment is going to be fixed by March. We need a much longer-term look at how that is going to be recovered. Organisations like Macmillan and others have already

identified that there is a shortage, as it currently stands, in the cancer workforce. It is important to emphasise that.

I want to move on to test and trace, and the third component of that, which is isolate. At the moment, as I understand it, £45 billion has been allocated to that endeavour. A large component of that is for lateral flow tests. Even the Government's own evidence from the Liverpool data shows that there is somewhere around a coin-flip of reliability on the in-field testing rather than the controlled environment of a lab. Given that the whole point of it is to understand community transmission, but we know that less than a third of people who should be isolating are doing so, and that will have a consequence on community transmission, do you feel that there could be other, more helpful ways to utilise that significant amount of money?

Sir Simon Stevens: I cannot comment specifically on test and trace because, as you know, that is run by the Department of Health and Social Care rather than by the NHS or NHS England per se. What I would say is that lateral flow testing as a way of helping keep NHS staff safe has been an important development and, once Test and Trace was able to make sufficient lateral flow tests available to us, we made them available to our frontline staff. With sequential testing, twice a week in the case of NHS staff, that provides improved sensitivity and specificity that deals with some of the concerns that were raised in a one-off community screening methodology.

To state the obvious, for test, trace and isolate to succeed it has to overcome at least two obstacles in any country. First of all, the third bit is crucial. People actually have to isolate. The other point is that, given the high proportion of infections that are asymptomatic, you cannot just rely on the front end being filled by symptomatic presentations of people wanting to get tested. You have to deal with those two things. You have to deal with the asymptomatic element and the isolate element. That is true in any country.

Neale Hanvey: I have used up my time. Thank you very much, Sir Simon.

Q921 **Taiwo Owatemi:** My questions will be around core non-coronavirus essential services. In the first lockdown, we saw a decrease in the number of patients presenting to A&E with heart attacks. It was the same for the number of patients being admitted to hospital wards. What is being done to ensure that heart services are given the level of priority needed during this wave of the pandemic and beyond?

Sir Simon Stevens: You are quite right about that. Even during April the health service, unusually, began directly communicating and advertising for people to please come forward for emergency care, and we have carried on doing that as part of the Help Us, Help You campaign.

As I think I may have mentioned earlier, this has been a problem in a lot of countries. In France, we saw reductions in out-of-hospital cardiac

arrest patients presenting. The same was true in Germany, Italy and so forth. We have been doing our level best to make sure that people get the message that, if you are experiencing these symptoms, please dial 999 or come to hospital to be looked after.

Q922 **Taiwo Owatemi:** That is really important because many patients are still cautious as to whether or not they are able to go to the NHS for those kinds of healthcare conditions.

I want to move on to elective surgery. In August 2019, there were about 660,000 patients waiting more than 18 weeks for an elective procedure. That number tripled in August 2020. What is the current estimate of patients waiting for elective surgery, and what is being done to reduce the number of patients waiting?

Sir Simon Stevens: The knock-on consequence of having a third of our hospital beds full of severely ill coronavirus patients who need looking after is that, obviously, hospitals have been able to do much less routine, non-urgent operating. The key to getting back on track is going to be, first and foremost, getting coronavirus occupancy coming down.

Secondly, it will be continuing with partnerships where that is needed, as it will be, with other providers. Thirdly, we have to look at the new model of diagnostic care. We have an opportunity, following a report by Sir Mike Richards, which I commissioned, to change the way people get their tests done right at the start of their elective care pathway—their scans or lab tests. We are investing specifically in stand-alone diagnostic centres over the course of the next 12 months so that you do not always have to be routed through your GP to a hospital to get the tests. You can get started on your elective care pathway. A very high proportion of people who are in the overall waiting period are actually waiting for their diagnostics.

Q923 **Taiwo Owatemi:** As I understand it, the Government have allocated £1 billion support for the NHS in managing the elective backlog. Do you believe that will be sufficient?

Sir Simon Stevens: At this point, we do not know what the total shape of the backlog will look like because we are still knee deep in the current wave—more than knee deep, actually. That is a judgment we will have to make in the spring or summer. It will require not just money. Obviously, we have constraint in terms of the number of surgeons and anaesthetists, as I discussed. Everybody can see that that is crucially important, but there are some other unmet needs that we have to take seriously as well. I have mentioned mental health and the exacerbation that we will have seen in mental health needs. I have mentioned long Covid and some of the other conditions that a proportion of patients are continuing to experience many weeks after their initial coronavirus infection. The shape of need in the health service will have changed as a result of the pandemic.

Q924 **Taiwo Owatemi:** Thank you. Lastly, I want to ask about the dentistry industry. The British Dental Association has criticised the new unit of

dental activity target, which requires practices to achieve 45% of their pre-pandemic activities. From your data, how many dental practices are currently able to meet the UDA requirement and how realistic is the requirement? What support is being given to allow them to reach it?

Sir Simon Stevens: That is only a target for the last three months of the year. For the bulk of the financial year, practices have had the vast majority of their income protected. In the round, the Government have provided dentists with significant financial support, as well as PPE, testing and so forth.

There is a difficult balance to be struck. We obviously have the urgent dental centres still going. There is a backlog of routine dental care that patients desperately need. There are constraints on what dentists can do, given the aerosol-generating procedures and the time gap between patients. That was the judgment that the Department of Health came to for the last quarter of this year. Obviously, it will have to be kept under review going into the new financial year as well.

Q925 **Zarah Sultana:** My question is about the impact on mental health. We know that for the foreseeable future we will have huge mental health implications for the population. This will particularly affect young people. What steps will the NHS take to meet the expected increase in demand for mental health services post pandemic?

Sir Simon Stevens: You are right. There are maybe three things to mention. The first is that we already were in the middle of quite a significant expansion of mental health services, tied to the NHS long-term plan. That has meant that for every year since 2015-16 investment in mental health has gone up faster than growth in the overall NHS budget, which is the first time in NHS history that has happened. It is independently audited. That has been helping to address some of the long-standing service deficits in mental health care.

We need to carry on with the priorities that were identified there. They range from early intervention for people with psychosis through to talking therapies, perinatal care, and better mental health support in A&E departments, so-called liaison psychiatry for crisis care and so forth. That is the first thing.

The second thing is that we have to take a very hard look at the exacerbated mental health needs that have arisen through the pandemic. Some of them might be enduring and some of them might be somewhat one-off. The proportion of people who report being depressed, for example, increased this summer compared to last summer. It is not completely clear to the epidemiologists whether that will still be the case next summer and the summer after.

Fortunately, the predictions that some had that the pandemic might lead to an increase in deaths by suicide seem not to be happening in most countries, including this one, but, as I said earlier, in other areas, such as

young people's mental health services and eating disorders, urgent referrals are going up very sharply. The second thing we need to do, over and above what we were going to be doing anyway, is to make sure we have taken account of those new needs.

The third thing we need to do is to underpin all of that with expansion of the mental health workforce. That goes back to the Chair's question right at the start, in that, if we do not have the therapists, the mental health nurses or the psychiatrists, all of the rest will be for the birds.

Q926 **Zarah Sultana:** Thank you. In England in particular, the Centre for Mental Health has predicted that 10 million people—almost a fifth of the population—will need mental health support, with 1.5 million of those expected to be children and young people under the age of 18. What are your thoughts about the suggestion that there should be a counsellor in every school in the country to provide mental health support for young people?

Sir Simon Stevens: As you probably know, at the moment between a fifth and a quarter of schools are working with their local NHS mental health services to beef up young people's mental health support in school settings to see whether doing that not only provides better support for young people but also reduces the number of specialist referrals to children and adolescent mental health teams. The hypothesis is that, if you can go upstream and get support there, it will have downstream benefit. That is still being worked through.

I think there is a very strong desire in mental health to make sure that any form of extra support has a strong evidence base and is shown to have an impact on diagnosable mental health conditions. It is making sure that there is fidelity to evidence-based models, rather than just doing things that might seem like they are going to be good but may not actually have much impact. It is very important to get that right as well.

Q927 **Zarah Sultana:** My final question is about the support being given to NHS staff who are currently going through immense pressure, stress and trauma in many cases. What provisions are there for staff to get mental health support?

Sir Simon Stevens: I think my colleague Prerana Issar, the NHS chief people officer, has written to the Health and Social Care Committee and laid out a range of the supports that are available. We have put in place specialist mental health support for NHS staff, as well as other ways of getting psychological support, such as helplines and local services. I think this is something that will be with us for quite some time to come, frankly. It is an area we are all very worried about.

Zarah Sultana: Thank you.

Q928 **Rosie Cooper:** Simon, how do you think community staff in the NHS are coping? We all understand how difficult it is bringing lots of staff into hospitals and leaving the community undermanned. I had a case where a

man did not get a call back from community services. His family ended up calling 999. He ended up in hospital. He was palliative and could have been cared for at home, but he died in hospital. How do you think this pandemic is opening up the structural problems that the NHS has in the community?

Sir Simon Stevens: That is such a broad set of concerns and considerations. It is hard to give a glib response to that. On community nursing and support for the clinically extremely vulnerable, including people on the shielded persons list, community health services have had to mobilise very significantly, not only the first time around but with the reintroduction of shielding recently.

Fortunately, not just friends and neighbours but volunteers, and the role of local authorities through the LRFs, have played a big part in helping people at home. Community nursing, together with local pharmacists, has obviously had a big extension in the role it has had to play in the light of that. That is before all the other needs, which continue unabated and, in some cases, have increased.

The concern again, as we look at conditions such as long Covid, is that there will be an increasing number of people who need that ongoing type of support, not from hospital clinics per se but from community health services. My colleague Matthew Winn, who leads our community health programme, is working very closely with community health providers on exactly that.

Q929 **Rosie Cooper:** It was a difficult question, and I appreciate how wide it was. Given that in the first wave of the pandemic you paused reforming the NHS and we are now in wave three, which is substantially worse, much worse, than wave one, I am getting an increasing mailbag from people who say they have not had enough time to respond to the various consultations, simply because of the pandemic and the effect it has had on them. They believe that there is an attempt to quietly implement structural change on the NHS and a battered workforce while the pandemic is No. 1 in everyone's mind. How would you address that and reassure them?

Sir Simon Stevens: I am not sure I think that is right at all, to tell the truth. What the pandemic has shown is the vital importance of different parts of the health service working together well, whether that is community nursing working with hospital teams, GPs working with each other and with pharmacists, or indeed the partnerships we have with local authorities and the third sector. The idea of joining up services around the needs of individuals and communities—integrated care, if you want—is at the heart of what the changes to the health service are all about.

The pandemic has not only underlined why that is so important, for the reasons Luke Evans was talking about earlier; it has given lots of people permission to get on with doing it. The reality is that this starts and ends

with patients and with communities. All of the rest of it, in terms of governance and law, is just a means to that end. Ultimately, it will be you, as Parliament, who create the legislative space for people to do brilliant things across the health and care systems.

Q930 **Rosie Cooper:** So you would assure people out there that the changes are absolutely about getting a better integrated health service—

Sir Simon Stevens: Yes, and doing a few other things. As we talked about in the predecessor Committee—you were on the Health Committee at the time, Rosie, but not everybody else would have been—we have thoroughly been through the proposals with the predecessor Committee that we, the NHS, hoped that Parliament would consider. We would like to see a change to the competitive tendering requirements on the NHS, the so-called section 75 of the 2012 Act. We would like all that scrapped so that we can actually get on and join up services. It takes quite a leap of logic to suggest that the very thing that some of those folks have been campaigning for, for so long, represents a move towards the destination that they fear so much.

Rosie Cooper: You will appreciate that MPs' mailbags are full from people who distrust that, and the fact that it is happening right now. I appreciate the integration. We have seen some fantastic things in my constituency and in Liverpool about organisations working together, but I think more needs to be done to reassure those who fear that there is an undercurrent, especially with all the private contracts not being as open and transparent, as may have been the case over various PPE and all that kind of stuff. There is an element of distrust out there, and we are in a serious situation, so your repeated reassurance is what is needed.

Q931 **Graham Stringer:** Sir Simon, you have shown today that you are a clear and precise communicator. Do you think that you have spent enough time in front of television cameras and microphones explaining what is going on, particularly as there are so many myths about what is happening, and about the virus itself?

Sir Simon Stevens: Thank you for that question with a slight sting in the tail, Graham.

First and foremost, I and everybody else in the health service are knuckled down getting on with the job, which is trying to ensure that the health service does as good a job as we possibly can for people with coronavirus and all the other needs that we are here to provide for, as well as now going on to vaccination. There have been lots of people who have been willing to take to TV, the media and all the rest of it. We have a day job to do.

However, I am in no way reluctant to get up and say something when people need to hear it straight. I will do that. I did it last Sunday on "Andrew Marr". I have done it a number of times before parliamentary Committees. Indeed, I have done it at No. 10 press conferences. For most of us in the health service, our key responsibility is getting on with

trying to provide top-quality patient care as best as we are able, as against some of those other responsibilities. I am always happy to take guidance.

Q932 **Graham Stringer:** It was a compliment. I think that, because you are so good at it, you should do more. There are so many myths out there, with people going into hospitals saying that people are not really poorly with this virus.

In terms of the communications strategy, I have found it difficult to get information both about people with Covid and about other impacts of the epidemic on the rest of the health service from local trusts, because, they tell me, they have to go through a very tight central PR control. Is that the case, and if so, why? It is slowing down very useful communication from people at a local level.

Sir Simon Stevens: The TV news over the last two or three weeks has been dominated by news crews that have been in hospitals right across the country. I do not think anybody can suggest that there is not complete openness and transparency about what is happening inside our hospitals and critical care units around the country.

It is certainly the case that, when we are in one of these national emergency incidents, they try regionally to co-ordinate the information to make sure that it is accurate; otherwise what sometimes happens is that you get somebody popping up with something that then causes all sorts of concern but is untrue. A case in point was one of the early questions I got today in this session, which was: "Is it the case that if you are a member of staff, and you don't have an NHS number, you can't be vaccinated?" That was somebody popping up and saying something. Untrue. It ran as a story online. It got a whole load of pile-on people being very rightly concerned about it.

We want to try to be as accurate and consistent in our communications as we can, while also being transparent, so that everybody can see what is going on inside the health service. That is the balance we are constantly trying to get right.

Q933 **Graham Stringer:** Would you accept that you may have got the balance wrong? I know the information is in their interests, but it goes to the centre and it gets stopped. For instance, I have tried to get both the local and total costs, and the number of patients who have been treated in Nightingale units. I have found that impossible to get, both for the GMEX centre in Manchester and nationally. Are those figures available? I don't expect you to have them off the top of your head, but can you send them to me?

Sir Simon Stevens: Yes. They are available; in fact, I am pretty sure that they were in an answer to a parliamentary question within the last week or two. I take your point, Graham, but equally I would say that we publish more data in real time about our health service than any other health service in the world and any other public service in this country.

Q934 **Graham Stringer:** I have a very similar final question. Earlier, in answer to a question from Sarah, you said that information on the number of people from different ethnic groups who had been vaccinated was kept. My local public health teams have told me that they have found that local personal information impossible to get. Where would I find that information? Has there been a parliamentary question on it? Is it on your website?

Sir Simon Stevens: The first thing to say is that directors of public health—I think I am right in saying this—are getting the upload of their own data twice a week. I think they get it late on a Friday afternoon and on a Tuesday. That is now broken down not only to borough and district level but to what is called the median super-output area level, which I think is an average population of 7,200. It is very localised, but done in such a way as to protect the identifiability of individuals within that small area. Those data are continually being refreshed with more fields overlaid on them. So they have access to those data.

Graham Stringer: Thank you.

Chair: Finally, to wrap up, Greg Clark.

Q935 **Greg Clark:** Chris Whitty and Sir Patrick Vallance, in evidence to our Committee, have said that we should look at excess deaths as the most relevant measure of the impact of Covid on mortality. Do you share that view, Sir Simon?

Sir Simon Stevens: I defer to Chris and Patrick on the science on that. I think the reason they originally said that was because of the potential for different diagnostic coding practices between countries. I think that was the underlying reason for their suggestion.

Q936 **Greg Clark:** It was to capture the fact that part of the impact of Covid is on people with other conditions, undiagnosed perhaps because they do not come forward for testing, and the pressures, which we completely understand, on the NHS on treatment. The overall impact is beyond people who specifically have died of Covid. I think that is the thought behind it.

Sir Simon Stevens: Yes.

Q937 **Greg Clark:** Given that, and given that we want to minimise the impact on deaths, the JCVI has adopted a rigorous logic about prioritisation, which we talked about earlier, looking very clearly at those at most risk of death and making sure that they are vaccinated first. Is there a case for saying, and have you done this, which NHS services should be prioritised for being cancelled or postponed first, so that there is a rigorous basis for the decisions?

Sir Simon Stevens: Our starting point was that for the NHS long-term plan, yes, we did that; we looked at the biggest causes of early death and disability across the population—so-called disability adjusted life years. That led us to say, "Here are some of the things where we think in

this country we continue to do better and that is where we should be putting particular effort." That obviously related—

Q938 **Greg Clark:** During the pandemic? When it comes to pressure on hospitals, should there be an order, just as the JCVI has done for vaccines, to say, "These are the services that we temporarily close first or restrict, and these are the ones that we keep at all costs"? Is there a consistent set of advice that you have promulgated?

Sir Simon Stevens: For the most acute end of the spectrum we are obviously aiming to provide care for everyone who would benefit from it, and I think we are doing that. We have expanded our surge capacity in order to be able to do that. In addition, clinical urgency has been the way in which decisions have been made about what order people should be treated in—the discussion we were having about some conditions that were waiting longer versus others that were being treated more quickly.

When we get through the current wave in the pandemic, we will need to take stock and say, as we look again at the shape of health need, "Has anything fundamentally changed about the way in which we thought about that through the long-term plan?" I am not actually convinced that it will have done, seen over the medium term. Cardiovascular disease, cancer, musculoskeletal conditions and poor mental health are the big killers and disablers and will continue to be so even when the particular infectious disease threat has, hopefully, retreated.

It will be more a question of ensuring that, over the next month, three months or six months, patients are looked after according to their clinical need and urgency. Looked at over, say, five years, I do not think it will fundamentally change the shape of what we need to get done in the health service.

Q939 **Greg Clark:** I was thinking more of how, during the pandemic, hospitals across the country make these decisions, and whether they could benefit from collective advice based on knowledge of what is going to save most lives.

Sir Simon Stevens: As I say, the approach is the relative ranking of clinical priorities, P1 through P5, which has been developed with the medical profession, including the medical royal colleges.

Q940 **Greg Clark:** Finally, as you know, we are taking evidence in order to look back and to learn some of the lessons that can be applied over the years ahead. One theme that has emerged from some of our witnesses is how the armed forces can make a useful contribution in emergencies of this sort. We saw that with the standing up of the Nightingale hospitals, with mass testing and to a certain extent in the vaccination programme. Do you see a role for the armed forces on a standing basis in future national emergencies?

Sir Simon Stevens: Yes. They have played a fantastic role alongside our NHS staff. We already have a deep relationship with the armed forces,

inasmuch as a number of our full-time NHS clinicians serve as reservists in the armed forces, and a number of armed forces medics practise clinically in the NHS. That is a synergistic relationship that we have built on.

Over and above that, we have selectively been able to benefit from some of the logistics expertise of the armed forces. In the round, we have about 1.5 million staff working in the health service. At the moment, we have about 1,800 people from the armed forces working alongside them. They are making a great difference in every capacity in which they support us.

Q941 **Greg Clark:** Should that be part of the plan in the future? From day one, should the Army have a certain role in responding to a national medical emergency?

Sir Simon Stevens: To some extent, that has been the plan. Obviously, it depends on the other calls on the armed forces at any point in time. I would defer to the Ministry of Defence and the armed forces on that one.

Greg Clark: Thank you very much. Thanks for your time with us this morning, and—

Sir Simon Stevens: Greg, maybe the question behind the question is, should we try to build more resilience into public services rather than running everything to the optimum just-in-time efficiency? I think that is one of the big lessons from the pandemic. We talked a bit about it earlier in respect of extended supply chains versus domestic manufacturing capacity, but that is just one instance of the broader point, which is that resilience requires buffer, and buffer can look wasteful until the moment when it is not.

Q942 **Greg Clark:** That is a very important theme of our inquiry, on which we are hoping to make some recommendations. Another one in the same spirit is whether the right response in an emergency is, perhaps, less a ramping-up, as the expression has been—gradually increasing over time—and more, if you can manage it, an explosive response where you do things everywhere, such as we are doing with the vaccination programme.

If you have that model, the armed forces might be one way in which you can move in emergencies from a gradual, incremental ramping-up to something that has immediate impact simultaneously across the country. We had a session on pandemic preparedness, and there was a very strong theme that the armed forces were very good at that and should be built in as a matter of design.

Sir Simon Stevens: I see that absolutely. All I would add is that, from the point of view of hospitals, it feels like they have had an explosive repurposing of capacity since Christmas day, quite frankly. A lot of that was built on the work that was done over the summer and the autumn, both on extra staffing and physical infrastructure, as well as on the

partnerships we developed with others to tackle the backlog, and new treatments and so forth. Hospitals, and indeed GPs, have moved incredibly fast to repurpose the way in which they interact with patients. This is not me saying it; it has been well commented on by lots of other people looking in on the service. In that sense, the NHS has rightly confounded those who expected it to move at a slightly more sedate pace. It has moved incredibly fast.

Greg Clark: Indeed. Without anticipating the conclusions in our report, I think that is one of the striking features. Where we have succeeded in this pandemic, it has been through that very rapid response, not least by your colleagues in the NHS. That is another reason why we are very grateful to you.

Q943 **Chair:** Thank you, Sir Simon. You have been very generous with your time. I have a final question.

In 1948, when the NHS was set up, it was a pretty traumatic time for the country. We were bankrupt; it was just after the second world war. We do not want to overdo the comparisons with now, but we have had a very traumatic time in this pandemic. It has been the most traumatic time since the founding of the NHS.

If we are going to turn this into another 1948 moment, where we show real imagination in making long-term reforms to the health and social care system, what will be at the top of your list for the things that you would really like to change going forward?

Sir Simon Stevens: I think you touched on it at the beginning, Chair. It is seeing health and social care as two sides of the same coin, and hence having a multi-year outlook for social care. More broadly, there is a series of economic pressures across the country. Let's start seeing the health service as part of the economic engine of opportunity and not just as something that gets spent on when you are deciding what your public expenditure priorities look like.

We are an anchor institution in most communities in which we operate. We are a source of fantastic, high-skill job opportunity. We stimulate and sit alongside a life sciences industry that is going to be a huge part of what the 21st century needs to be. We should view the NHS not only, hopefully, as a highly responsive and high-quality health service, but as part of the economic dynamism that this country needs.

Chair: Sir Simon, thank you very much indeed for your time this morning. The best of luck going forward to you and your team in the NHS. We are very grateful to you for spending time with us this morning.