

Health and Social Care Committee

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

Tuesday 7 September 2021

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Members present: Jeremy Hunt (Chair); Paul Bristow; Dr Luke Evans; Taiwo Owatemi; Dean Russell.

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Witnesses

I: Shirley Cochrane, expert by experience; and James Wilkinson, expert by experience.

II: Professor Neil Mortensen, President, Royal College of Surgeons of England; Dr Andrew Goddard, President, Royal College of Physicians; Dr Katherine Henderson, President, Royal College of Emergency Medicine; and Anita Charlesworth, Director of Research and REAL Centre, Health Foundation.



Examination of witnesses

Witnesses: Shirley Cochrane and James Wilkinson.

Chair: Good morning. Welcome to the House of Commons Health and Social Care Committee's first inquiry of the new parliamentary season. The inquiry is a new study that we are doing on how to clear the enormous backlog of operations caused by the pandemic.

I have to put my hands up and say that we did not plan to open this inquiry on the very day the Government are due to make an enormous announcement on the funding for these very plans, but that makes it very timely, because it is important to understand whether the sums of money announced later will be sufficient, and to understand the scale of the problems that we face and the capacity of the NHS to address those problems across elective care, emergency care, general practice, mental health and, indeed, new areas such as long Covid and, presumably, permanent vaccination programmes. We will look at all those issues over the next few sessions. In particular, we will look at how, faced with the enormous pressure of waiting lists, we can ensure that the quality and safety of care do not deteriorate.

Later this morning we will hear from some experts and people from the royal colleges when we speak to Professor Neil Mortensen, the president of the Royal College of Surgeons; Dr Andrew Goddard, the president of the Royal College of Physicians; Dr Katherine Henderson, the president of the Royal College of Emergency Medicine; and Anita Charlesworth, the director of research and the REAL centre at the Health Foundation.

Before we talk to those experts, we are going to try to understand a little more about what this backlog actually means for patients. I would therefore like particularly to welcome a couple of patients who have experienced the issues themselves: Shirley Cochrane, whose cancer treatment was seriously impacted by the pandemic; and James Wilkinson, whose surgery to replace his aortic valve was delayed significantly. A very warm welcome to both of you. Thank you for joining us. First, my colleague Taiwo Owatemi will ask Shirley some questions.

Q1 **Taiwo Owatemi:** Thank you so much, Shirley, for being so brave and taking the time today to share your experiences with us. It will be very valuable. To start with, are you able to tell us about your experience of seeking treatment during the pandemic?

Shirley Cochrane: It is important to start with my diagnosis. I was diagnosed with bilateral breast cancer on 1 November 2016. I had two different types of cancer, one being triple negative. Only 15% of all breast cancers diagnosed are triple negative. It tends to be more aggressive, there is a higher chance of reoccurrence with it, and we have no long-term, targeted therapies.



After my treatment was finished, which took about a year, I was told that I would have six-monthly check-ups with either a breast surgeon or an oncologist for five years and a yearly mammogram. For the other cancer, which was oestrogen positive, I was prescribed Anastrozole, which I was to take for five years. My GP would issue that, provided that I had been in and had my blood pressure and so on checked. They were very strict about that.

At the start of the pandemic, I received a letter informing me that I now had to self-manage. There was no guidance on exactly what self-management meant. The service was advertised as personalised, but the helpline number provided was just a generic number. At that point, I was just left on my own to get on with it.

Q2 Taiwo Owatemi: That must have been a really terrifying experience for you.

Shirley Cochrane: Absolutely. Yes.

Q3 Taiwo Owatemi: Are you able to tell us how your treatment was impacted in the different stages of the lockdown?

Shirley Cochrane: As I said, at the start of the pandemic I got a letter telling me that all my six-monthly checks were cancelled. Throughout that time, I have had no contact at all with the surgeon or the oncologist who provided the treatment. I have had no official discharge. I have had no appointments with my GP, who, as I said previously, was very strict about me having my blood pressure and so on checked. Throughout the pandemic, they have quite happily reissued a prescription for Anastrozole without seeing me.

I had my first face-to-face appointment with the GP two weeks ago to check my blood pressure. We have had 18 months of a pandemic, so I have missed three appointments with the GP. I feel like I have been abandoned by the health service throughout the pandemic—like someone has literally pulled a security blanket away from underneath me.

Q4 Taiwo Owatemi: Gosh. Throughout the whole 18 months of the pandemic, you were unable actually to see your GP or see any healthcare professional to help you with your treatment.

Shirley Cochrane: Absolutely. Yes.

Q5 Taiwo Owatemi: That is heartbreaking. Throughout the past 18 months, was there anything that went really well?

Shirley Cochrane: The short answer to that is no. Nothing went well. Around the time of receiving the letter telling me to self-manage, I had some concerns. I thought that I had found a lump. I could not really get through on the generic number supplied, so I reached out to my local MP, Priti Patel. I said to her, "We are being told that the NHS is open for business, but I can't get an appointment." She managed to secure for me a telephone appointment, which was followed by a mammogram.



Thankfully, that was okay. But had I not had the strength and tenacity to reach out to an MP, I do not know what I would have done. Had there been a problem—had the cancer been back—we could be looking at a whole different story now.

Q6 Taiwo Owatemi: Do you believe that if you had not reached out to your local MP you would not have been able to get that check?

Shirley Cochrane: Yes. Absolutely.

Q7 Taiwo Owatemi: That should never be the case, because some people just would not think about reaching out to their MP. It is very disappointing. Looking back at the whole experience, what would you have improved?

Shirley Cochrane: I needed more communication from the NHS. Maybe a telephone consultation could have been offered, so that if I had any concerns I could have spoken to somebody. I was assigned a breast care nurse when I was diagnosed, and she was fantastic throughout my treatment, but obviously they are under huge amounts of pressure. There are not enough breast care nurses to see to everybody, so at the end of treatment the checks with her finished as well. If I had been able to have a telephone consultation even with the breast care nurse, just to express my concerns, or if there had been any other follow-up from the NHS—anything—and any clarity as to what my future appointments might or might not be, it would have been fantastic.

Q8 Taiwo Owatemi: How clear do you feel now about any future treatments that you may need?

Shirley Cochrane: I have no idea whether I will have any appointments whatsoever with my breast surgeon or my oncologist. I am now back seeing my GP every six months, but I have had no clarity at all from the specialists as to whether I will ever see them again.

Q9 Taiwo Owatemi: That is very shocking. Have you asked your GP to contact them, to provide some clarity on that?

Shirley Cochrane: I haven't. When I actually saw my GP last week, I complained to her about some back pain that I had. She asked, "When are you due to see your oncologist next?" I said, "I'm not." She just said, "I can't refer you for anything. You need to speak to them." She said that she was not able to refer me on.

Q10 Taiwo Owatemi: When you think about your health and other areas of your life, what impact do you think that this experience has had on you in being able to seek treatment during the pandemic?

Shirley Cochrane: Unless you have gone through a cancer diagnosis, I do not think that you really understand the mental impact that that has on you and the fear of it coming back. The six-monthly checks are vital. During the pandemic, I have suffered with extreme anxiety. I have had trouble sleeping. I have been awake in the middle of the night checking



for lumps, convinced that the cancer is back. It has had a huge impact on me mentally.

- Q11 **Taiwo Owatemi:** Given that you had so much anxiety, it would have been very helpful for you to have a nurse there, or somebody who was willing to reassure you that things were going to be okay and to provide you with comfort and help during such a difficult time.

Shirley Cochrane: Absolutely.

Taiwo Owatemi: Thank you so much for taking the time this morning to share your experience and to give us the information that we need for our recommendations. We really appreciate your joining us this morning.

Chair: Thank you for joining us, Shirley. It is a very important perspective. We often hear about the new cancers that were missed—the 330,000 fewer GP referrals during the first year of the pandemic and the 43,000 fewer cancer treatments starting—but you have told us about the equally challenging experience of people who are living with cancer and have had their supervision and support stopped during the pandemic period.

Dean Russell will now ask a few questions of James Wilkinson about his delayed surgery. James, thank you for joining us.

- Q12 **Dean Russell:** Thank you for joining us, Mr Wilkinson. I hope that you don't mind my calling you James during this session. Thank you so much for sharing your story today. First, can you give us an overview of your experience of seeking treatment during the pandemic?

James Wilkinson: I was diagnosed before the pandemic happened and told that I needed heart surgery. I had a rare condition called endocarditis, which was an infection of my heart lining that ate away my aortic valve. Before the pandemic hit, we knew that I was going to have to have the operation, which was booked in for May.

A few weeks before the operation, it was cancelled, which I expected. It was cancelled again because of a mix-up with dates, and then three times after that. I was supposed to go in that September. I was checked into hospital on Sunday, for the operation on a Monday. Three times I was told—*[Inaudible]*—the morning of the operation that it was called off again. I was there with my chest shaved and ready to go. As you can imagine, that inspired quite a lot of anxiety.

- Q13 **Dean Russell:** Obviously, that will have been a huge emotional experience for you. How did your family respond to the challenges of that, knowing that you had had all the pressure and stress of going in, getting prepped and then having to come back to them to say, "Actually, it's not happening"?

James Wilkinson: It was quite bad for my wife, because she was dropping me off at the hospital and then having to come back the next day to pick me up. There was a lot of anxiety for her. I had to prepare



my six-year-old daughter before the operation and tell her what was going to happen, without going into too much detail. The next morning, she would come home from school to find me at home and say, "Oh, that was quick, Daddy." Every time, I had to tell her, "I'll be in again." *[Inaudible.]*

Q14 Dean Russell: You mentioned that this happened three times. How was your treatment impacted at each of those stages? Were you given additional support when each cancellation happened, or was it just back to square one, as it were?

James Wilkinson: I went straight back into isolation. They were quite good at getting me booked back in, but knowing that it was going to get cancelled every time. There was nothing in between. The nurses and doctors were all very apologetic and sympathetic. There were difficult days, but there was nothing they could do about it. To be fair, the first time, an actual emergency came in, which took up my ICU bed, but the next two times Covid patients were involved. One was on my ICU ward, which shut the whole ward down on that morning. The last time, there were no nurses available to look after me, because they were all dealing with Covid patients.

Q15 Dean Russell: In terms of the process, was there anything that went well throughout that time, or was it all negative?

James Wilkinson: It was very much the same as for Shirley. Nothing really went well. I was isolating for three months. Every day I sat at home, not hearing or knowing anything. Every day I was feeling worse. Every week my health was getting worse. As Shirley said, the anxiety is terrible.

Q16 Dean Russell: I cannot imagine how awful each of the cancellations must have been, especially by the time you hit the third cancellation. Even with those in place, was there anything else that could have improved the experience? I am thinking about communications and so on. Was there anything that would have made that at least easier to deal with?

James Wilkinson: It is one of those things. It is not something that somebody could have foreseen. I cannot put the blame for it on anybody particularly. Obviously, the first cancellation was the worst. By the third, you are slowly getting used to it. With the first one, I could not speak for emotion. I tried to call my wife to let her know that it had been cancelled, and I couldn't get the words out. You find yourself just sitting there, shaking and thinking, "What happens now? What do I do from here?" As I said, they got me booked back in pretty much straightaway, but then you have to isolate every single time. You have to do Covid tests— *[Inaudible.]*

Q17 Dean Russell: What about the communication that you received in between those times? Was there clear communication around what treatments you needed? Obviously, you were isolating. What would you



have improved during that time?

James Wilkinson: I cannot say that I would have improved much. As I said, I had an operation done very quickly afterwards. Maybe there could have been some reassurance. You know that your operation is very invasive. You are going to have yourself opened up. There is a very small chance of worse happening. Maybe I could have had somebody speaking to me more to reassure me, but there was nobody to talk to.

Q18 **Dean Russell:** Are you clear now on what the next steps for you are? I understand that you ended up going private to have the operation. Are you clear on what the next stages are from an NHS perspective, or are you dealing with that separately now?

James Wilkinson: Going back to the private operation, I was very lucky, as my wife had private healthcare through her work. We wanted that to be a last resort, really. If it wasn't for the private healthcare, we don't know when my operation would have happened. It would have happened by now maybe. It could have been going on for weeks and months still.

As far as any other treatment is concerned, I was lucky to be able to have cath rehab in the private hospital. I believe that the NHS also does that, but it was not doing it during the pandemic. I was able to build up my fitness again through private healthcare. As of now, I have no more treatment to come. I am actually—*[Inaudible]*—complications. With my age and fitness, they did not really know how to deal with me. I have a—*[Inaudible]*—and am a keen runner. I have been told that I have got to keep my heart rate below 121, but generally that is written for people who are overweight or have a general heart condition. I am having to go along with that guidance. I have been trying to contact the cardiologist. I contacted him because my blood pressure was slightly high. He got me on a 24-hour blood pressure monitor several months ago, but I have not heard anything since. I do not know what the outcome was. I have asked to speak to Mr Davis to find out what I can do, but he has not answered.

Q19 **Dean Russell:** Finally, if you don't mind sharing, what impact has this had on your life generally, both your family life and from an emotional perspective? We often think of health as being a very physical thing, but it has a much wider impact on our mental health and on those around us. Would you mind sharing what you would say that experience was for yourself?

James Wilkinson: Again, it is just anxiety, just not knowing. They have assured me that I am not going to have a heart attack, pretty much, but it could cause damage to function—damage to my pump—that could eventually cause a heart attack. Until I get to speak to somebody who really knows what they are talking about, I am in limbo when it comes to knowing what I can and cannot do, so there is anxiety.

As far as my family is concerned, we are just living every day. Personally, I get on with life and am quite positive. You try not to worry about it. I don't know anything for definite, so every time I go out running I watch



my heart rate. I have to stop if it is up to 142, which is not very high at all.

Q20 **Dean Russell:** James, thank you so much for sharing your story. It is really invaluable for the reports that we do in the Committee. I appreciate your opening up to us. Thank you for your time.

James Wilkinson: You're very welcome.

Chair: Let me add my thanks to both James and Shirley. What the media report are numbers of people waiting for operations. What we do not hear about is the distress caused by delays in operations and care, and by failure to communicate. We really appreciate your time this morning. It will frame our discussion about the backlog in a very helpful way.

Examination of witnesses

Witnesses: Professor Mortensen, Dr Goddard, Dr Henderson and Anita Charlesworth.

Q21 **Chair:** On our second panel, we have three royal college presidents and Anita Charlesworth from the Health Foundation. I think I am right in saying that the royal college presidents are all practising or practise part time, so they have had experience themselves during the pandemic of what it has been like dealing with patients.

Perhaps I could start by asking for your reflections on what we have just heard from James and Shirley, and on any other experiences that you have had during the last 18 months. Let me start with Professor Mortensen from the Royal College of Surgeons.

Professor Mortensen: Good morning to everybody on the Committee. James's and Shirley's stories are all too familiar, regrettably. As you rightly point out, the bald figures of record waiting times—5.5 million, with nearly 6,000 waiting nearly two years—do not really reflect people's individual personal experiences. We tend to think of them as numbers—just another case to get done—but they are all very moving personal stories. I thank James and Shirley for setting the scene.

What they describe is the panic and terror that occurred during the first wave of the pandemic. Hospitals and critical care units were completely overwhelmed. Ordinary, everyday activity in hospitals largely stopped—the follow-up of breast cancer, for example. James described the experience of having his surgery cancelled because there was no critical care facility and because of the dangers of having surgery at the time of Covid. We now know that that would have led to four or five times the rate of mortality, compared with non-Covid times. We have learnt a lot about how we need to have a resilient, sustainable health service that can still function at a time of crisis like this.

Q22 **Chair:** Let me ask you one follow-up on that. You are a surgeon, so in a way your responsibility is for the operation, but do you think there is a



broader issue about communication with patients? That may not be your direct responsibility as a surgeon, but when someone comes into hospital after isolating for months, is prepared for the operation, and is suddenly told, “No,” and sent home, do you recognise that picture, where the way these things are communicated to patients and the support given to patients is not as good as it might have been?

Professor Mortensen: I do. It is very difficult, though, isn’t it? Surgeons can control the things within their control. If there is a problem with testing or there are problems contacting the patients to get them in and so on, that is all extremely difficult. I agree completely that a really important part of any surgeon’s function is good communication, but I think in these exceptional times, it all fell apart.

Q23 **Chair:** Let me bring in Dr Goddard from the Royal College of Physicians. What are your reflections on what we heard?

Dr Goddard: It is very difficult to hear stories like that, isn’t it? It reflects what many people are hearing in their clinics every day at the moment. I was struck particularly by Shirley’s use of the word “abandoned”. I do not think that any doctor working in the NHS, and I feel passionately about the NHS, wants to work in an organisation that leaves people feeling abandoned.

James concreted down some of the specific issues. During Covid, beds were shut because of Covid. They continue to be shut because of the infection prevention and control measures that we need. A lack of nurses means that you cannot keep beds open. It is fine having physical beds, but if you have no staff you cannot run them. The Nightingale hospitals that we saw during the pandemic were fantastic. We managed to get all of that up and running, but there were not enough staff, so we could not use those beds. We have to be very careful moving forward when we think about how to manage the backlog. We must ensure that we do not just create physical space. It is human resource that is most important.

Shirley’s story resonated with me, in particular. I had cancer of the kidney in the same year as Shirley. I am under regular follow-up, too. I have been very lucky in so far as I have had a cancer specialist nurse whom I have been able to contact. While my regular scans are being delayed because there is a massive waiting problem with diagnostic tests—something else we could discuss—I have been able to have a contact point. We know that many cancer specialist nurses and other specialist nurses have had to move to other parts of the hospital in order to support the Covid response. When you have limited human resource, you tend to put it where you need it that day.

In my mind, many of these problems would be resolved with more people. There would be more people to talk to, so that patients could get the reassurance they need. Time and time again when I talk to patients, they say that not knowing and not hearing are the things that cause the problems. It causes a huge amount of mental stress, both for them and,



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as James described, for their families as well. It is difficult not to be moved when you hear stories like that. As Neil said, sadly this is happening day after day.

Q24 **Chair:** Dr Henderson, you are from the Royal College of Emergency Medicine, so you represent all the A&E doctors. What has been the impact on emergency care of all these delays in elective care? What have you noticed?

Dr Henderson: We understand that people want information. When they find it difficult to find information, they go to the place where the lights are on. Almost inevitably, we will have seen patients who have questions that, unfortunately, we cannot answer. Primary care has been seeing that patient group as well. They will have seen people whose questions they will not have been able to answer. We need to make sure that we have the ability to answer those questions in the right place; otherwise, it is a very ineffective system.

Q25 **Chair:** We will ask you some more questions later about the impact on the A&E side of hospitals. Our next session will be on primary care, mental health and the community impact, but this morning we are focusing more on the hospital impact.

I welcome Anita Charlesworth, who has given us a lot of help over the last year or so on our social care thinking. We will see whether that comes to fruition today. We are all keeping our fingers crossed on that one.

Let's look at the backlog, which will also be addressed by the Prime Minister in his announcement today. We have heard some very personal stories. It is important to try to quantify how big the issue is. That is what you do professionally. Could you give us some sense of the scale, the number of people going through the kinds of experiences we heard about from Shirley and James?

Anita Charlesworth: I will speak about those numbers, but the reality is that the scale is so large that all of us will have been affected and will know someone who is affected. Before the pandemic, the waiting list in England was just over 4.4 million people. Before the pandemic, in 2019, waiting times were increasing. The waiting list was growing by about 300,000 patients a year prior to that. We have not met the constitution standard of seeing 92% of people within 18 weeks since 2016.

Over the pandemic, up until June this year, the waiting list has grown by just over a million. We now have around 5.5 million people on the waiting list. That increase in the waiting list is not uniformly distributed. Parts of the country that were most impacted by Covid have seen the waiting list grow most. We have also seen, very worryingly given the concern of this Committee and many others around inequalities, that waiting times have grown most in deprived areas. While this is a nationwide problem, it is not being borne equally by everybody. Five and a half million people is an



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enormous number of people. It means that at the moment, now, around a third of those on the waiting list are waiting more than 18 weeks.

I guess the thing that really makes this such an enormous challenge is that we know it is not the totality of the problem. Through Covid, many fewer people presented or were referred for care. The estimates are that, through the pandemic, anything up to 8 million people we would have expected to come through our system have not come through the system.

One of the key questions is, first, what level of harm has been done as a result of that treatment not occurring? Much of it will be emotional, but we are also seeing a lot of physical harm as well; for example, the number of people getting diabetes treatment is down significantly. Obviously, good management of things like diabetes is really important for the long term. As regards the maintenance of good health outcomes, I do not think we will know for many years quite what the implications for that are.

If around 75% of the people needing treatment that did not appear re-emerged, we potentially face the prospect of needing to treat about 12.5 million people. If only half of those people do not appear, we are looking at around 10.5 million people. Those are enormous numbers in a country of 55 million people. It is why all of us will know somebody who is affected.

Today, we are hoping that there will be an announcement on funding, but with numbers of that size the challenge is enormous. Our estimates are that if you want to get back to the 18-week standard by the end of the financial year 2024-25—broadly speaking, the end of this Parliament—and if 75% of those missing patients reappear, you would have to spend in total around £17 billion. I will say that again: £17 billion. That is just over £4 billion a year.

That is obviously an enormous sum of money. As Dr Goddard said, finding the money is one challenge, but actually the bigger challenge is having the real physical resources to do that. That would equate to needing just over 18,000 more nurses and over 4,000 more consultants to get through that backlog.

Funding is absolutely critical to this—

Q26 **Chair:** Do we actually have those nurses and those consultants? Do 4,000 consultants exist that we could recruit who are not there at the moment?

Anita Charlesworth: Not easily. The likely way that we would have to do it would be to encourage existing staff to work longer hours. Part of our cost estimate is that it is very unlikely that we would be able to do this activity at the normal cost of providing care. It will cost extra because we will also have to use a lot of the independent sector and



develop long-term partnerships with them. We will have to work differently. We will almost certainly need international recruitment. Eventually, we need to pull every lever that is available to us to get anywhere close to that.

Q27 Chair: Can I ask you how realistic that is? Let's say that the Government find the financial resources that are necessary. Given that countries all over the world are facing their own Covid backlogs—the WHO says there is a global shortage of 2 million doctors—and independent sector doctors themselves work in the NHS, is it actually a solvable problem by just looking at workforce capacity, irrespective of funding?

Anita Charlesworth: I think it is incredibly hard to do it over that timeframe. Realistically, it may well take quite a bit longer than four years. One of the other factors will be what happens with Covid. As the testimony showed, and medical colleagues on the panel have emphasised, elective care does not exist in a bubble. What is happening in the wider healthcare system will have profound implications for our ability to meet the backlog.

The other thing to say is that patients waiting is not without impact on the health service as well. People get worse. They need reassurance and follow-up while they are waiting. The sense that we have the luxury of parking people somewhere and saying, "We'll deal with you later," is quite unlikely. The urgent challenge is to think through very carefully how we best recruit and retain as many staff as we possibly can. The workforce report that you did recently on the importance of retention is critical. We have a mountain to climb, but it looks like Everest if we cannot retain staff. All of those issues are absolutely critical.

We need to also think very carefully about how we design the way we deliver care to people on that pathway—there are lots of innovations going on—so that we use every bit of resource that we have optimally to get through as many patients as we possibly can.

Chair: Of course, there is the Anita Charlesworth amendment to the Health and Care Bill, supported by the royal colleges, which would be another thing that helps. I will bring in my colleagues now to talk about some of the things that we might think about doing. Let me start with Dr Luke Evans.

Q28 Dr Evans: Professor, I want to dig down a little bit into the surgeons' aspect. My crude understanding is that surgeons were redeployed and have not been doing as much cutting as they would like to do. They are raring to go, but part of the problem is that the anaesthetists have been moved across to the intensive side to deal with Covid, and then are coming back and are washed out. How much of a characterisation does that fit? Where is the bottleneck from the surgeons' point of view?

Professor Mortensen: I think it is a combination of the two. Clearly, we started from a low base in the sense that in anaesthesia about 10% of all consultant posts are vacant at the moment. Most operations need



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anaesthesia. One of the innovations is trying to see how many surgeries can be done with local anaesthesia and variations on that, but none the less you cannot get round the fact that you need a surgical team. The surgical team will not just be the surgeon; it will be the anaesthetist and the theatre team. All of those have pressures.

Coming back to the surgeons, the retention issue is really important. As Anita has brilliantly pointed out, surgeons do not grow on trees. We cannot buy them very easily off the street. They take a long time to make. We have to work really hard to try to keep the ones that are there. As you know, there are lots and lots of pressures, around pension contributions, the lifetime allowance and all that kind of stuff.

If you are going to say to a relatively senior surgeon, "We'd like you to do weekends and nights," and they say, "Fine," even if Anita persuades the authorities to pay them a bit more, they will say, "Actually, in certain circumstances it's not worth my carrying on doing this."

Q29 **Dr Evans:** Is the pension issue resolved?

Professor Mortensen: No.

Q30 **Dr Evans:** It is still ongoing.

Professor Mortensen: It is still a matter—

Q31 **Dr Evans:** It seems to have gone very quiet. There was a temporary measure put in place to cover it off, but given the fact that most NHS surgeons are also in the independent sector as well—so, if you are looking at the independent sector, you need to cross over—we want to incentivise people to come back, and it seems that the pensions one is a sensible investment to solve to be able to get to this problem. I think you can sell that to the public and say, "This is the reason we are incentivising people. They are not going to do it off their own bat. They have had a hard pandemic." How close to getting resolved is it, from your aspect? Where is the sticking point now?

Professor Mortensen: From what I have heard in the meetings I have attended, there are still major roadblocks in the way. You talked about surgeons particularly, but I think this applies to all medics. We have mentioned the independent sector. The independent sector relies on nursing staff very often from the local NHS hospital doing shifts and so on. There is a finite resource, and you cannot just shift it to the independent sector, although during the pandemic, and now subsequently, the independent sector has provided a safe haven to a degree. There have been safe sites on which surgery can be carried out, includes James's, as he pointed out.

Q32 **Dr Evans:** You said surgeons do not grow on trees. Can you talk about the impact it has had on the training for surgeons? Surgeons need operating time and are managed on the number of cases they do, the hours they do and the number of procedures. Clearly, Covid will have



impacted on that because we have had 18 months of losing SHOs and registrars—cutting time, effectively. How has the college managed that, and what can be done to help it?

Professor Mortensen: We are just about to see the figures on where our surgical trainees are on their numbers to allow them to become credible surgeons. Around 50% of surgeons in their last two years of training do not meet the requirement on numbers and experience to graduate from the training programme. We have this new pipeline of new surgeons about to come along, but they are greatly under pressure because they have not had enough experience.

What is being done about it? We are measuring it. We are trying to assess the scale of the problem. We are looking at issues like AI, simulation training and so on. Those are all pretty good early in your surgical career. Later in your surgical career, there are all the subtleties of the individuality of a case and its complexity, which need to be appreciated in real time in a real patient, obviously helped by an experienced consultant surgeon. You are absolutely right; it has had a massive effect on trainees.

One of the things we are also concerned about is retention of trainees. Some trainees have become deeply disillusioned. That is another tribe we need to work really hard to retain.

Q33 **Dr Evans:** Thank you very much. Dr Goddard, perhaps I could come to you. From my experience in hospital, all roads led to the radiology department, and testing is really important. You will know this from physicians asking for CT scans and MRI scans. Do you perceive that as a bottleneck going forward?

Dr Goddard: Getting the scans is a bottleneck. We have lots of people, particularly in out-patients, who are waiting longer times to get diagnostic tests. Getting them reported is a bit of a bottleneck, although reporting—because images can be sent around the world—can be done and then you can have reports done in the middle of the night UK time when it is daytime in Australia, for example.

I think pathology is probably under bigger stress, certainly from the point of view of histopathology—looking at query cancer specimens that are taken. That is much more of a pressure and a worry. Clearly, at the moment getting blood tests is a real problem.

Within the waiting times we are talking about, specifically the 18-week times, about two thirds of people are under the 18 weeks. They are still on the waiting list, but they may be waiting for tests. We do 1.7 million blood tests a week in the NHS. That number has been significantly curtailed because of the blood bottle shortage. It seems likely that, because of Covid and all the issues with the supply chain, there are going to be added complications that will lead to further delays in diagnosis. You cannot start a treatment and therefore get off the waiting list until



you have a diagnosis. The surgical aspects are really important. Trauma and orthopaedics is the biggest group waiting for a treatment, but if you go down, about half the number waiting for hips and knees are also waiting for heart interventions, which might not be done by surgeons but are done in cardiological departments and gastroenterology departments—my own speciality. We have to think about the diagnostic processes, as you have alluded to.

Q34 Dr Evans: You have both highlighted it perfectly, which is what I was hoping you would do. Do you think the NHS has a joined-up plan? I always think that Sky Cycling was infamous for taking percentages across weight and aerodynamics. Suddenly, if we make the percentage better on the bottles and in operating theatre efficiency, we can hit the 120% efficiency that is being asked of hospitals at the moment.

Do you think the NHS has a plan to be able to do that or is putting it together? Is it coming through to you in your positions at the coalface? That is really important for us to be able to say, "Look, are we seeing this joined up?" You have given a list already off the top of your head. I am sure that list will be tenfold. That is really important because, until someone is pulling that together to knock them all out, it becomes very hard to deal with and break down the scale that we are looking at.

Dr Goddard: It does not feel like there is a coherent plan. The challenge, therefore, is that we are all interconnected. We know that winter is coming. Clearly, winter has been here already. I was on duty a couple of weekends ago, and because of Covid sickness and staff absences there were no trainees on my ward. Normally, I would go round with a trainee or an advanced clinical practitioner. Both were off sick, so I did the ward round on my own. These are things that are impacting on a daily basis.

During winter, we would normally see the medical wards get full; we spill over, and what becomes the winter ward is normally an orthopaedic ward. Immediately, Neil and his colleagues cannot operate on people who are on the waiting list. I do not see that being any easier this winter. If anything, I think it is going to be much worse this winter because of Covid infection and prevention, as I talked about before, but also because we are expecting a bad flu season this year; people have not been exposed to flu over the past year so it is likely to be much worse.

The news about the £5.4 billion funding is fantastic, but let's be under no illusions: this winter is going to be remarkably hard. It is going to impact waiting lists probably more than anywhere else.

Q35 Dr Evans: That leads me to my final questions, which are for Dr Henderson—the perfect place because A&E is always the brunt and the traffic light for the health service. We are hearing GPs next week, but can you talk about the experience of what you think the primary care and A&E relationship is at the moment? There is talk in the newspapers that GPs are not opening and it is putting pressure on A&E. They would push back and say, no, it is because there are significant pressures and people



are changing their behaviours. Does the college have a position on that?

Dr Henderson: We are back at pre-pandemic levels of attendance in emergency departments. July's numbers were the second highest ever, and our A&E performance is at our lowest ever, at about 68% for type 1 performance. We are not surprised by this. There is no reason why patients would not be coming back, but there are a number of reasons why we seem to be seeing them coming back very fast.

We are seeing patients, yes, who say they cannot get face-to-face appointments with primary care. We are also seeing primary care patients who cannot get their surgical treatment, their out-patient treatment or diagnostic treatment. It is not about one side of the service versus the other side of the service. I think the media have been incredibly polarised and very unfortunate and unhelpful. If we are trying to do a joined-up plan, we actually need to work out where the right place for the patient is, and not get into that.

We know that NHS 111 has seen an increasing number of phone calls, particularly during the day. While the conversion rate is not necessarily translating to more going to A&E, the sheer numbers—because it is a very high-volume service—mean that more come to A&E. The admission numbers are going down, which means that there are more low acuity patients coming in through that route.

There is clearly a churn of patients in the system who are not receiving the care that they feel they need to get. Where you get that is by having the whole system joined up and talking to each other, with ready access and good communication, using technology to get the advice that they need. I cannot help a patient about a very specialist drug therapy that they are getting from some oncologist in my unit. I do not have the knowledge to deal with that. They should not need to come near the emergency department to get that advice.

Q36 **Dr Evans:** Whose job is it to signpost that?

Dr Henderson: The team that originally was involved with that patient's care should make it possible for patients to get the advice that they need, or for their GP to be able to access the advice they need. We have done joint statements with the GPs and with the physicians to say that patients should never need to attend a hospital unless it is adding value to their care. They should certainly never need to be admitted to hospital unless it is adding value to their care.

We need everybody to take responsibility for their patients, to make sure that they are getting the advice that they need and that they do not go, as I said before, to where the lights are on. That stops us doing our job. I am really quite good at managing the undifferentiated, seriously ill and seriously injured patient. I am not that good on the chronic disease management side of things.

Q37 **Chair:** I have a quick follow-up on that, Dr Henderson. Last year, you



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were very passionate in telling the Committee—it was very helpful for our previous inquiry—that the model we use in A&Es needed to change to, essentially, a call before you walk triaging system where people contacted 111 first before they went to an A&E, to make sure that that was the right place for them to go, or find out whether they needed to go to a GP or pharmacy instead.

There are obviously very important infection prevention and control reasons why you thought it would be wrong to have crowded A&E waiting rooms. As we move beyond the pandemic, do you still believe that we need to move towards a triaging system before people just turn up at A&Es?

Dr Henderson: We need to move to a system that has the right people giving advice. The problem with the NHS 111 first system is that it does not work unless there is adequate clinical validation. If there is not adequate clinical validation, unsurprisingly a call handler will default to the least risky option. It is entirely understandable that people would do that. We have had a pilot of—

Q38 **Chair:** To be clear, you do not think there is enough clinical validation of what the call handlers are saying.

Dr Henderson: We know there is not enough clinical validation. The only pilot that we have any data on is Portsmouth; part of the problem is that we are not seeing data and we need to see some data. They could do a 50% change of destination if they got a call-back within 30 minutes. If you just had the 111 algorithm, that drops to 20%. There is a massive difference if you have clinical validation.

The same has been shown in the only other pilot that we have data on, which is around paediatric care. An experienced paediatrician as part of the triage system can give advice and prevent attendance, but 50% of my members would say that they have seen an increase in the workload because of 111 rather than the opposite. You cannot set up a system that does not—

Q39 **Chair:** So that I understand your position, you are not saying it is the wrong solution to have a “call before you walk” triaging process, but it has to be properly clinically staffed, so that it is a doctor or a clinician who is making a judgment rather than a call handler. Is that your position?

Dr Henderson: There are two aspects. One is that there needs to be appropriate clinical validation from somebody who is able to give that level of advice. There also needs to be a range of possibilities. If the call handler does not have anything to say other than, “Get an ambulance to A&E,” or, “Try to get a GP appointment,” it is not going to work. There has to be a range of options; this thing called the directory of service has to exist in a proper fashion that has options.



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Whether it is an urgent treatment centre, a GP appointment, self-care advice or whatever it is, there needs to be an option that is not just, at the end of the day, the least risky thing, which is to go to A&E. I completely understand that. I completely understand it from a patient's point of view, but we are in a real pinch point at the moment. We are equally fearful of winter. We have been seeing levels of crowding in our departments over the summer that are worse than people have ever seen. It was not as though 2019 was exactly a glorious year for emergency medicine. We were really struggling back then. We are really struggling again now.

Our problem, however, is not the 111-type patients—the low-acuity patients. The reason emergency departments are crowded is largely because of what happens to the patients who need admission. Although a lot of attention gets paid to the demand aspect of this, what we actually need is flow through the department, and patients moving from the emergency department to a ward. We have lost beds in the pandemic. We started from a low-bed base. We then ended up with patients waiting in corridors. We know that long waits in emergency departments cause longer lengths of stay. They increase adverse events. They increase mortality. It is an inefficient way of running a system if we cannot get patients through. We need to sweat the resources as much as we possibly can. The last bad flu winter resulted in pretty well all elective surgery being cancelled in January 2018.

Chair: I remember it very well.

Dr Henderson: I am sure you do. How are we going to get through this winter, when we really do not want to cancel elective surgery, unless we can sweat every bit of the assets, making sure that every bit is working as effectively as it possibly can and we do not do anything to patients that wastes clinical time or wastes their time?

Chair: Thank you.

Q40 **Taiwo Owatemi:** Thank you, all the members of the panel. Anita, you spoke earlier about how Covid has obviously exacerbated the health and equality that exists in the country. How long is the waiting list in deprived areas currently?

Anita Charlesworth: I will give you an example. Covid-19 obviously had a bigger impact in certain parts of the country, particularly in more deprived communities. The north-west and the midlands were highly impacted by Covid. Their waiting lists have grown the most, and that has been concentrated among more deprived groups, partly of course because ill health is concentrated among deprived groups as well.

As we have begun to recover, part of the recovery has obviously been about NHS services getting back up and running, but part of the recovery has been the NHS paying for care in the independent sector. Sixty per cent. of independent sector capacity is in London and the south-east, so the ability for us to mobilise extra care and take patients off the waiting



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list is not necessarily distributed based on where need is greatest. Even within London, we see that care has recovered most for the least deprived. Those are people who can travel and things like that.

After the funding, we are going to need an elective care recovery programme, clearly, that will cover multiple years. Within that, there will need to be an awful lot of focus on, if you like, operational efficiency. There will need to be a focus on prioritisation and management because people are going to be waiting for a considerable amount of time and for many years. We must make sure that issues of inequality and an understanding of that is at the heart of the way we manage that waiting list. That seems to me to be incredibly important.

One of the things the NHS has to decide, therefore, is to what extent that is done. Is it hospital by hospital or do the new integrated care systems that are being created have a responsibility for looking system-wide? That is not just for the equity point. If we are to manage the system efficiently, we need really good pre-operative management, and that requires many people to be involved. Things like social care will be very important. We are going to need to discharge quickly and effectively as well. The need for the partnership between the NHS and the social care system that enabled us, just about, to get through Covid does not go away from now onwards. It is just as critical.

If you think back to the 2000s, it took us six years, with a really tight programme, to manage the waiting list to get down to 18 weeks. I defer to colleagues; winter will be incredibly important. If this is managed as a repeat series of crises, we will not do well. We need a longer-term plan that thinks system-wide from a patient point of view in all parts of the country. It probably needs to be quite tightly tailored, given the very different dynamics in different parts of the country.

Q41 Taiwo Owatemi: Given the fact that, as you said, private hospitals are predominantly in London and in the south, that the areas most affected are in the north-west and the midlands, and that earlier you spoke about how things such as AI and technology can play a significant role, what percentage would that help in addressing the current waiting list?

Anita Charlesworth: The issue we have is that typically one in five people on the waiting list needs an admission, but among long waits it moves to two in five. Our backlog is greatest among people who need admission. Many of those people are more likely to be from deprived communities, where travel, social support and things like that are more of an issue. Often, the waiting list condition is part of an overall picture of people's ill health and needs to be managed holistically.

The idea that we are going to ship people around the country really easily to deal with this, and just deal with the hip in a disconnected way, is unrealistic, which is why we have to think about capacity. We have had long debates for many years about whether or not we need what are called, in the jargon, cold sites. Do we need to build some extra capacity?



There are plans in place, which Sir Mike Richards has developed, to create diagnostic hubs. You need to look in the plan at a whole range of measures that enable us to have more resilience across the country, tailored to the needs of different parts of the country. I do not think there is going to be a national one size fits all. What the national system needs to do is focus on its part, the enablers, which is a lot of the workforce, funding, et cetera, but then ensure that there are local plans that are really well thought out that look system-wide.

Q42 Taiwo Owatemi: To all members of the panel, what factors do you think we need to take into account when we are trying to quantify the backlog caused by the pandemic, in the short, medium and long term?

Chair: Can I ask for fairly brief answers from everyone, just because we want to move on?

Professor Mortensen: Following on the health and equality issue, obviously a patient goes on a waiting list, but they are not static; it is not just that they have been put on for that and then we can wait as long as we like and suddenly do it. During that time they may develop other health issues. More importantly, their primary condition will deteriorate. For example, you might lose your job because you are not mobile any more. That will obviously have an economic impact on an already deprived area. I think it is important to see individual patients on waiting lists in a dynamic rather than a static situation.

Coming back to the overall effects on waiting lists, if, for example, you have an undiagnosed cancer and you go in as an emergency—say it is bowel cancer, my area—you are more likely to have a more advanced bowel cancer. That is going to take longer to operate on. It is going to be longer to manage through the whole of its path through the hospital. It might need chemotherapy and all the other things. You have the added effect of the delay in diagnosis and management.

There are obviously short-term effects. We need to do the emergency patients. There are the medium-term effects, but the longer-term effects are much more difficult to quantify.

Q43 Chair: Brief answers on that from Dr Goddard and Dr Henderson.

Dr Goddard: I think we need to know where we are aiming. If you go back to 2009, when the waiting lists were at their lowest, there were still 2 million people waiting for treatment on waiting lists. Is that the target we are aiming for, or are we aiming for the trajectory that we were on and there has been a steady increase? It has doubled over the past decade. Understanding where you want to be with your backlog is really critical to deciding what resource you need to get to that point.

Q44 Chair: Thank you. Dr Henderson?

Dr Henderson: I am obviously not involved in the backlog specifically. It is about what we are trying to get. We are trying to get a health service



that is delivering the health needs of the population. The most deprived 10% use emergency services twice as much as the least deprived 10%. We have a health system that is already doing things differently because of deprivation. Actually, it is not about the health service. It is much more about what we are trying to do as a society for the health of our population.

Q45 **Chair:** Thank you. Anita, finally?

Anita Charlesworth: We need money; we need people; and we need really well thought-through plans.

Chair: Thank you. It reminds me of what someone once said people want from a Secretary of State: they want money and silence. Let me bring in my colleague, Paul Bristow.

Q46 **Paul Bristow:** Anita, your point at the end about money, people and a plan is basically what I want to talk about. I have been involved in health politics for 20 years. Every time there is a review and every time there is some sort of crisis or analysis of the situation, it is always money, people and a plan. Seventeen billion is an enormous amount of money. It just seems to me that we need to think a little bit about how we do things differently. You talked about that in terms of innovation. There are new pathways and new models of care. How do we capture those things? How do we identify the things that really work? Productivity and innovation has to go hand in hand with any more money, or we will keep repeating the same mistakes and we will be in the same situation. There will never be enough money; let's put it like that.

Anita Charlesworth: No. It is innovation, but effective implementation of the innovations that work, scaled. If everyone is innovating, it is great in one sense, but that does not do it. You then have to have a pipeline for the innovations that work. You have evaluated, so you know what works, and then you implement that consistently and effectively, tailored to local contexts. That becomes really important now, not just for the money but because we are so tight on the physical capacity of both people and premises. We cannot afford pathways that are not optimal through this time. It is "cannot afford" in the sense that it will waste resources, but there is also a moral imperative. If we are not treating the number of people that we could be treating if we optimised, people are waiting longer and they are, as Professor Mortensen said, deteriorating and having other things going on for them, and their lives are being impacted.

In this sense, the efficiency argument and the human imperative are the same. The big challenge is to innovate and then to adopt, change and optimise. What you need are the people who are involved in the care having the time and the headspace, and the emotional space at the moment, to take a step back and then come together to look at what needs to be done, try things, learn and then share that with colleagues.



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Those colleagues can adapt them. That all requires time, support and skills.

One of the challenges that we have, when everyone is running so fast to stand still at the moment, is that you know there might be a better way to do things that is probably part of the answer, but you need to create some time out of an impossible job at the moment to do it. One of the things that is really important in local leadership is how we try to protect some time, hard though that is, in the short term for people to try different ways of doing things so that we can get out of a vicious circle and closer to a virtuous circle.

Those local plans need really strong local leadership and dedicated resource. They need everybody to agree that that is the endeavour we are going on. We need to have a five-year timeframe. We have to try some new things. We have to come together. There are lots of collaboratives—we co-run one called Q—which share what is going on with people. The royal colleges have a really critical role to play in that. All of that work will need to happen.

Nevertheless, if you have potentially a waiting list backlog of 12.5 million, you need to be more efficient about how you do that. It is really important, so that your trajectory is better. The reality is that there is no way round treating 12.5 million people costing an enormous amount of money. That is a societal choice. How short do we want the waiting list?

Q47 Paul Bristow: I do not disagree with anything you have said, especially about the headspace. I have been in situations where I have seen accelerated access reviews. I have seen all sorts of plans to spread innovation, best practice and new models of care in the NHS. They don't work. There are cultural issues within our NHS that prohibit the adoption of innovation, new pathways and new ways of doing things. There is a "not invented here" syndrome: "Well, that might have worked over in that part of the country, but it couldn't work here because we've got this situation."

How do we overcome that? Is there a role for the centre to almost impose different ways of doing things on different areas? Locally, it works on occasion, and it is normally best if it comes from a bottom-up situation. There are so many examples where this has not been adopted, even though the new ways of doing things are proven time and time again.

Anita Charlesworth: There is a challenge of spread, and spread is a skill.

Q48 Chair: I am sorry to interrupt. We have the Chancellor answering questions at 11.30 and it is quite an important day to ask the Chancellor questions, so we are going to try to finish at 11.15. Could I ask everyone to be fairly brief in their questions and answers? That would be great.



Anita Charlesworth: The challenge of spread is really important. It needs local ownership alongside resources facilitated nationally in order to do that. There are lots of examples of innovation in cancer, for example, where good evidence of what works made a difference, but training, support, networks and all of the things that give people the confidence to do things differently work as well. It is a blend of the two that really needs to be there. Spread is a specific thing. Innovation does not naturally lead to improvement. It needs spread and adaptation.

Q49 **Paul Bristow:** I have two more quick questions. The new health Bill that is being proposed has proposals about how we might change the way tariff works. I think tariff is going to have a huge impact on how we deal with the elective backlog. I wonder whether you might want to comment on that.

Professor Neil Mortensen, you talked about how disillusioned trainees are and about how senior surgeons may say—I am not saying it is their natural instinct—that working nights and weekends is not worth their time because of certain issues. How would you resolve that? This is a national effort as big as Covid, if not more so, to deal with the elective backlog. We need everyone pulling in the same direction and going the extra mile to resolve the issues.

Anita Charlesworth: I have just written a piece on the form of tariff. I agree with you, and I will send that in. In essence, I am arguing for a three-part tariff: a fixed payment to providers, plus an activity component to incentivise care, and a quality component. There is broadly quite a lot of agreement across the NHS that that is the right sort of way to go. There is a long way to go to get there, and probably quite a lot of money has moved around the country, not in optimal ways, for getting out of that. That kind of system will be quite important. You are absolutely right; it is a really important issue. I will send something in.

Professor Mortensen: It goes with the previous question, too: exemplars and champions. For example, in our document “New Deal for Surgery” at the end of May, we asked to promote the notion of a surgical hub. They come in different shapes and sizes, and you obviously have to properly fund them and provide the staff to make them work. We have two very good examples in the London area in Croydon University Hospital and Redbridge University Hospital, where surgical staff have taken the initiative and created a hospital within a hospital. It has been ring-fenced and has allowed surgical activity to carry on safely without the intervention of the virus and problems related to the virus. Both those institutions have managed to get to 120% of pre-pandemic activity.

What is the effect on the staff? The effect on the staff is electrifying. There is a sense of teamwork and achievement. There is a sense of getting things done. If you provided those as examples and champions for the rest of the country, a surgical hub of some kind in every integrated care system would be a way of generating a sense of innovation and purpose.



Paul Bristow: The first new initiative that can be rolled out across the country and replicated everywhere else. I hope so.

Chair: I want to bring in my colleague, Dean Russell, but I think Luke has a quick question.

Q50 **Dr Evans:** It is really quick, and you have slightly hinted at it. Where is the hope coming out of this? We have delved into how difficult it is going to be. You guys are leading at the forefront of your respective professions and colleges. How do you see this panning out?

Dr Goddard: Don't waste a good crisis. Every time a major challenge comes to the NHS, we innovate. You can see the transformation in out-patient management, certainly for medicine. We produced a report in 2018 talking about how we would like to see 30% of out-patient appointments being done virtually. People laughed at me openly about that and said, "This is impossible; you can't do it." Along comes the pandemic and we are now at a higher level than that. Talking to patients, many want to be seen face to face, but many are completely happy to be seen virtually because it saves them two bus journeys, long waits and trying to find a car park. Most people who come to my out-patient clinic face to face are so stressed from trying to find somewhere to park that it is a challenge.

There are lots of opportunities to transform. As a rule, doctors love new treatments. If you give Neil a new toy or a new robot for him to operate with, he will get really excited. It is the same with physicians. We want to innovate. We want to improve practice, but there is the IT. If I lose my job, it is most likely because I am going to throw my computer out of the window, given the amount of time that doctors, nurses and other healthcare professionals waste waiting for IT to work, or for systems to talk to each other so that I know what is happening in my ED. Primary care and secondary care can easily communicate. That is where innovation really needs to happen. An effective IT system throughout the NHS and social care would work wonders.

Dr Evans: Between me and Dean, our hobby-horse in the House is to raise that. Given a pay rise or improved computers, I know what NHS staff would take because it makes a difference.

Chair: Thank you.

Q51 **Dean Russell:** Thank you, all our panellists for today. I would like to go into the technology piece in a moment. I should say that I am the chair of the all-party parliamentary group on digital health, so I would like to ask you some questions on that.

First of all, I would like to delve into a point that was raised earlier about GPs, although I appreciate this is none of your remit. Dr Henderson, one of the things I am hearing is that GP surgeries are still not all opening up, on the whole. My concern slightly is that there are patients who perhaps do not want to do virtual meetings with their doctor, and are perhaps being lost in the system. Perhaps they do not have the technology or



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perhaps do not feel comfortable having a telephone consultation.

Do you have any thoughts on whether GP surgeries not opening is pushing people to go to A&E first to get some help with their health issues, or are they just being missed out, which will make an even bigger backlog in the next few years?

Dr Henderson: I do not know about them being missed out entirely because I would not see those patients and know. Yes, we know that some patients are coming to us because they want a face to face. We know that some patients are coming because they have been asked to come to be seen. We are also very aware that there are patients going to primary care who should not need to go to primary care, because of secondary care problems.

I am very keen to accept that at the moment patients are looking for care and that we need to make it available to them. It is not the patients' fault if they are finding it difficult. Primary care is not a single entity. It is hugely variable, just as it is hugely variable due to deprivation. The number of GPs in the most deprived areas is much lower, which is one of the reasons why more of that patient group will go to their local emergency department.

The emergency department is the place that has the lights on. We are aware of that. We can absolutely understand why patients are doing that, but it is a problem of a system in crisis and not because one group of doctors is doing something differently from another.

Q52 **Dean Russell:** I have worked in different guises with the NHS; not in the NHS but with the NHS in healthcare and social care over many years. It often feels that it is a very siloed system. A patient might go with a problem about their knees to one expert, but will speak to someone very different about physiotherapy or mental health that is caused by that. How do we join up those dots? I think the pandemic has highlighted those silos more than ever. Are there any thoughts on what we need to do to improve that, moving forward?

Dr Henderson: Absolutely. That is why we produced a joint document with the GPs, the Society for Acute Medicine and the Royal College of Physicians, saying that we need to make sure that the patient journey is optimised for the patient. We are talking about emergency care, coming into emergency departments, but there is a lot of urgent care. Urgent care patients can go through other routes if the routes of communication are there for them to use, or their primary care physician has them available to use. I am aware that patients will come to an emergency department, sent by their GP who has been trying to get through to somebody to get some advice. They are on an old-fashioned phone and bleep system and it drives them completely nuts, so they give up and say to the patient, "Just go up there."

That is fine, but it may take an awful lot of time. It is not the best use of my time to be on the phone trying to hunt down the right person. There



is technology that should help us with this. We should maximise it. I cannot necessarily see GP records beyond my own patch. If I could see GP records, I might be able to find the right person. The technology side of knowing who I am trying to contact would be incredibly helpful, particularly if you are a tertiary referral hospital where patients are driving from Kent to get advice about an oncology problem. I have never met them before in the hospital, yet they view us as their local hospital, which is entirely understandable, but it is not the right place for them to be. We have to try to make those pathways better.

Q53 **Dean Russell:** Thank you. If I may, I would like to talk a little bit about technology. I am not sure whether I should come to you first, Dr Goddard, given that you mentioned it earlier. How do you see IT moving forward? One of the things I am very aware of is that many years ago there was a big push for a big IT project, and it went terribly wrong and cost an awful lot of money. For me, it always feels like whenever you talk about IT in healthcare there is an almost phobic reaction from people about spending more on it.

Do you think there is a need now to say that, whatever funding goes in—we obviously have to pay for people, salaries, new hospitals and so on—we need to invest in technology? Is there an appetite for that?

Dr Goddard: Yes, and it is not just capital investment. It is revenue investment. It is something that has to be invested in repeatedly. You do not buy a new bunch of kit and say, “Well, that’s the job done.” It is not. To me, interoperability is the key. Clearly, user acceptability is the other key. Having lots of stand-alone systems that do not talk to each other is the bane of my life, having to have four different programmes open in out-patients, some of which crash. As Dr Henderson pointed out, I cannot access information that would be in the patient’s best interests. Coming up with ways in which we can get it interoperable, fast and easily usable would be lovely.

Q54 **Dean Russell:** Thank you. I agree wholeheartedly. There is an element as well, though, of the patient experience, with the number of people who have Fitbits, Apple watches or whatever monitoring their hearts. There are all the technologies that people are using. Have there been discussions, from your perspective, of how the NHS and social care can engage with that sort of data? It feels to me like that sector—the Apples of this world—is going way far ahead in technology. There is almost a healthcare consumerism now for being able to do that, but it is not necessarily tracking back to the surgeons, GPs or physicians.

Dr Goddard: There are huge opportunities when it comes to patient-reported outcome measures, if you like, using new technologies. For certain diseases, like one of my areas of specialty interest, inflammatory bowel disease, it has worked very well. Mental health is a great example of a set of conditions that lend themselves well to app management.



The challenge with apps—I declare an interest because I chair the MHRA group on AI software and apps—is that there are 370,000 medical apps out there. How you regulate those to make sure that you maintain patient safety and patients are not given false advice becomes very difficult. We are at the forefront of a brave new world. I have no doubt that in 20 years' time how patients use IT to interact with health services will be very different from today. We need to embrace that, but it comes back to strategies. We need to know what we are aiming to do and how that is going to work for the entire NHS.

Q55 **Dean Russell:** You made a really important point about regulation. Do you think there should be a regulatory body around healthcare devices in the consumer space?

Dr Goddard: There is. We, in the MHRA, look after that. It is a question of how people define their software as a medical device. The MHRA are working on guidance to that effect. The Bills that are coming through will allow us to talk about medical device regulation in a much more suitable way. Software has fitted outside medical device regulation for too long, and given that most new devices have software associated with them, it needs to change.

Q56 **Dean Russell:** I have just been writing an article on the risks of AI not taking into account diversity from disabilities. I did a lot of work 20 years ago on online accessibility, and saw the impact of the worldwide web alienating a whole swathe of people, especially those with visual impairments, from being able to use the web. Now, on devices you can change the size of screens, read stuff out, and all the rest. Do you think that is being taken into account now, especially when talking about artificial intelligence?

Dr Goddard: It is, but the people who have digital access challenges tend to be the most deprived. They tend, as you say, to have long-term conditions. We need to work extra hard on making sure that those groups get fair access, otherwise the new technology will widen the health inequalities that we have already talked about.

Q57 **Dean Russell:** Anita, we have talked about money, people and plans. One of the things I have seen as a brilliant innovation in my own local hospital, Watford General, is the use of virtual wards. Covid has pushed that very quickly. There is some brilliant work on monitoring people at home and so on.

Are we looking at things wrongly now, in the sense that we are looking ahead to how we build more hospitals? I am all for that; it is fantastic and I am very supportive of it, but should we also be looking at how we increase the role of virtual wards and that sort of support for patients?

Anita Charlesworth: Yes. It is really important that we think about how these different things connect. It is interoperability in a much wider sense than just one bit of tech talking to another bit of tech. It is the extent to which the technology can enable people in different parts of the pathway



to work together effectively as a team to manage the patient, so that the time in hospital is minimised and used optimally for the patient. That is really important. That is what we need to think about, which is why it is really important that all of the work on technology is not done “over there”. It has to be part of, and integrated within, service design and workforce planning.

All parts of the team have to be able to use the IT. One thing we have not talked about today is the ambulance service and paramedics. We have skilled up paramedics and the ambulance service enormously, and in some parts of the country they have tech that enables them to refer to a much wider range of staff and use them. There are other areas where they are still hugely hidebound because it is not connected.

Q58 **Dean Russell:** I wholeheartedly agree. I visited a pharmacist recently. They are saying that some of their systems do not connect with what GPs are doing and what other parts of the healthcare service do. Especially during the pandemic, pharmacists in particular were very much on the frontline. They were probably the one place where people could just walk in and get a one-on-one consultation. Have you heard of any movement in the NHS and social care on focusing on the technology side of things? Are there any commissions or programmes under way looking at how to join up the dots, technology-wise?

Dr Goddard: The structures that have come out of NHSX are the way that will be viewed. We, as colleges, and people like the Health Foundation need to look at those plans to be able to say, “Do they apply to the real world?”

Q59 **Dean Russell:** Is that conversation happening?

Dr Goddard: Yes, the conversation is happening.

Q60 **Dean Russell:** In terms of timelines—I will be brief because of the time—I often think, as you said earlier, 20 years ahead. I will come to you on this, Professor. Twenty years ahead, no doubt people will have very different experiences from healthcare. The patient experience will be very different, primarily because of technology.

Surgery is surgery. I suppose there are robots and so on that can be used for things, but do you think the right investment and innovation is happening now to enable that to happen, or is it the case that it is going to be on a very siloed basis, and some hospitals will do it and others will not? Where do you see us heading in the next 10 or 20 years?

Professor Mortensen: I think there is a danger in always seeing technology as a solution across the piece. It is iterative. You see little steps which, together, make the big changes. Obviously, in surgery the huge change is around robotics and around the use of artificial intelligence, assisted surgical decision making and all those kinds of things. They will happen, but there is still a person, a patient. There is still a vulnerable human being who needs to be interacted with, and that



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can only be person by person. I do not think we can see technology as a final answer. I think it is part of the answer, personally.

Q61 **Dean Russell:** Thank you very much. Finally, we have a new chief executive of the NHS. What is the one thing you would tell them, if they were here, about what should be happening because of the situation with backlogs and so on?

Professor Mortensen: I would say that we need good statistics in the public space. We need honest numbers of exactly who is on the waiting list, with a breakdown of who they are. We need honest numbers around the workforce, and we need honest numbers around cancellations and, if you like, hiccups in the surgical pathway. That is what I would ask for.

Q62 **Dean Russell:** May I ask all the panel?

Chair: Yes, just brief answers.

Anita Charlesworth: I will do what I always do and paraphrase Bill Clinton: "It's the workforce, stupid." In the end, it will be our ability to recruit and retain, and then deploy really effectively, that is the make or break for the NHS over the next few years. It always has been, but never more so than now.

Dr Henderson: I would say it is giving the workforce a sense of vision of what we are trying to aim for, rather than feeling like we are having sticking-plaster solutions to things all the time. Where are we aiming and how do we get the workforce excited about that?

Dr Goddard: As was mentioned earlier, we need a coherent plan where all the parts of the system are seen to be working together to solve the problems. But it comes back to the workforce. The thing that worries me and frightens me the most at the moment is that 27% of consultant physicians say that they are going to retire in the next three years. We have workforce problems now, but they are going to get worse.

Dean Russell: Thank you.

Q63 **Chair:** We are going to wrap up soon, but I have a final point that I want to ask all of you, if I may. Dr Goddard said never waste a good crisis. The last time the NHS had huge waiting lists and a big national programme to reduce them was in the early 2000s. A lot of money was put into it and there was a lot of success in bringing down those waiting times, but we also had the unintended consequence of a targets culture, Mid Staffs and a whole series of quality and safety scandals.

How do we learn the lessons of history to make sure that we do not, when we have the same imperative this time to bring down waiting times, lose the focus on safety and quality that frontline clinicians are so passionate about? Let me start with the surgeon on that one because surgeons always want to talk about safety. How do we make sure that we do not unlearn that very painful decade when we are really focusing on safety and quality?



Professor Mortensen: It is all about balance. It is the balance between getting the targets, getting the numbers, getting the activity and getting the throughput and capacity, and balancing that with the necessary welfare of the staff and the space for training. I am really worried that we will have a huge pressure on getting the numbers—the volumes—done. Maybe that will have an effect on safety. I hope not because, as you say, surgeons are passionate about safety. I am also worried about staff morale and the space for safe and efficient surgical training.

Dr Goddard: I think it is the challenges and standards that are set to organisations. Anita raised the point about the tariff and including a quality payment in tariffs. That is really critical; most of those were driven because the money coming into trusts was based on activity. People had to make the maths all add up, so they focused on that rather than on the people, both the patients that we were looking after and the staff.

It does, sadly, come back to staff. If you look at all the really challenged trusts that people here have heard about over the years, there was a huge lack of staff. They were relying on large numbers of locum and bank staff. It is very hard to run a high-quality service when you have rapid turnover, and everybody is stretched very thinly. We must not forget that it comes down to how people feel in the NHS. That is a human reaction to the humans around them. If you have more staff, I think you will find it easier, but you have to get trust boards to focus on patient quality of care, rather than just the financial bottom line.

Q64 **Chair:** Anita, you talked about the fascinating idea of having a quality element to the tariff. You also talked earlier about how difficult it is to recruit 4,000 consultants quickly and 18,000 nurses. Is there a safe rate at which you expand the capacity of the NHS? More broadly, how would you make sure that we do not make the same mistakes again in terms of safety and quality?

Anita Charlesworth: What is really important this time is to create space for place-based leadership. Rather than having a target-driven approach, there needs to be a very clear articulation nationally of what we are trying to achieve. Dealing with the backlog is part of that, because it is really important, but it locates it within a wider set of objectives. It is not one thing at all costs. That is the problem with the NHS. It would be so much easier if it was one thing.

We need to allow local leaders to act, with proper support and skills, and to work out in their area how to make that happen safely and at the appropriate pace. There just is not one answer across the country. Part of what we have done too often is treat the NHS and the people of this country as if they are all uniform. They are not. Context will be so very different. What to prioritise will need to be very different.

The other thing we need to do is move away from what I call rear-view mirror measurement that says, "Oh dear, look, we wanted to do that and



we missed it," and you know after the effect. Then it is just a blame game as to whose fault it was that we missed that and services were not safe. We need to move to a front-view mirror where we understand much more what things we need to be tracking now, because in two or three years' time they are the things that will mean we can actually deliver what we are trying to do. If we track that, it gives us time to do something about it. We would be having a different conversation between political leaders and people in the NHS, and between leaders in organisations and their staff. It is about what we do about it and not whose fault it was that we missed whatever goal we were trying to achieve.

Q65 Chair: Thank you. Dr Henderson, some of the stories from Mid Staffs were in the elderly care wards, but there were also some terrible ones from the A&E department there. How do we learn the lessons of history when it comes to emergency care?

Dr Henderson: We seem to have been fairly firmly not learning them as we have gone forward. We have not made the four-hour target since 2015. That target was transformational for the amount of time that patients spent in departments. It meant that we did not have patients waiting hours and hours. Since 2015, that has lost its bite and its ability to drive change.

We have got to a situation where, because there are so many pressures in the system, people have tried to make what they could of the target to prevent them from getting into trouble from the centre. That has meant there have been perverse activities going on. We have ended up with a situation where we have huge numbers of patients waiting over 12 hours in emergency departments when we know that that is bad for them, but because the target has been much less aggressive against that, it has been allowed to happen.

The conversation about having proper statistics that are transparent and that people understand, and honourable conversations about what we do with those numbers and what they mean for patient care, is the way we need to go forward. What we must not do is set numerical targets that somebody's job at CEO level hangs on or does not, and they end up doing the wrong thing. We do not want to spend our time saying, "What will the person who is worried about their career do to make it look as though this target is all right?"

At the moment, we have patients waiting hours and hours for a bed. We cannot be transparent about it. We are beginning to move towards that, but if we cannot talk about the reality, and if we are not prepared to say what is actually going on, it makes it very difficult to stay safe. It is not good for staff. They find it deeply depressing if their reality is not reflected in the numbers that come out. Honesty with the public, honesty with our staff and not putting in anything that makes perverse incentives more attractive is a good thing.



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Chair: Thank you. Watch out for perverse incentives is a short summary of that. This has been a very thoughtful and helpful opening session for our inquiry. We really appreciate that.

Dr Goddard, Professor Mortensen, Anita Charlesworth and Dr Henderson, thank you very much indeed. Best of luck to the three presidents with your frontline work as well. Thank you all very much indeed.