

Health and Social Care Committee

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

Tuesday 21 September 2021

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Members present: Jeremy Hunt (Chair); Paul Bristow; Dr James Davies; Taiwo Owatemi; Anum Qaisar-Javed; Dean Russell; Laura Trott.

Questions 66 - 138

Witnesses

I: Helen Lunt Davies, Expert by experience; and Lere Fisher, Expert by experience.

II: Ondine Sherwood, Co-Founder, LongCovidSOS; Dr Adrian James, President, Royal College of Psychiatrists; Professor Martin Marshall, Chair, Royal College of General Practitioners Council; and Dr Melissa Heightman, Clinical Lead, Post-COVID Assessment Service, University College London Hospitals NHS Foundation Trust.

Examination of witnesses

Witnesses: Helen Lunt Davies and Lere Fisher.

Chair: Good morning. Welcome to the second session of the Health and Social Care Select Committee's inquiry into clearing the NHS backlog caused by the Covid-19 pandemic. This is our first evidence session since the House of Commons approved the Government's plans to increase the national insurance amount to create a health and social care levy. In that debate, I was asked whether the Committee would scrutinise how the Government actually use that money to clear the backlog. We will certainly do that, but today we are going to hear some more evidence about the scale of the problem and just how difficult it will be to tackle it.

Later today, we will hear from Ondine Sherwood, the co-founder of LongCovidSOS, to discuss the pressure of the additional needs of long Covid patients on the NHS post pandemic; Dr Adrian James, the president of the Royal College of Psychiatrists; Professor Martin Marshall, the chair of the council of the Royal College of GPs; and Dr Melissa Heightman, the clinical lead for the post-Covid assessment service at University College London Hospitals NHS Foundation Trust. Dr Heightman will give her perspective as a clinician leading a long Covid service.

First, we will hear from two patients who have both suffered from long Covid. We are very grateful to you for joining us. Listening to patients at the start of our sessions keeps us honest. It is a very important context and perspective for all our discussions. A very warm welcome to Helen Lunt Davies and Lere Fisher. Thank you very much for joining us today. Both of you are joining us remotely. My colleague Taiwo Owatemi will start by asking Helen some questions.

Q66 **Taiwo Owatemi:** Helen, thank you so much for joining us today. Can you start by telling us a bit about what it is like living with long Covid?

Helen Lunt Davies: I contracted Covid in the very first wave, in March 2020. My life has completely changed since then. In the last 18 months, my life has been unrecognisable from what it was before. Only in the last three or four months have I started getting anywhere near a normal life again. In the first four to six months, I was pretty much bed-bound. My husband had to do absolutely everything for me, including home-schooling our daughter, while he was doing a full-time job. I used to be really independent. I was very fit. I would walk 5 miles a day with my dog. The last month is the only time in 18 months that I have been able to take my dog out on my own. That is for a very gentle, flat 30-minute walk, whereas before I would be stomping up hills—we live at the top of a hill—for 5 miles. I was fine. I was fit.

Cognitively, I have taken a bit of a bashing. I was very independent. I could jump in a car and drive down the M4 to see my mum and dad at the drop of a hat. They are getting on a bit. Only in the last two months have I done any small, local driving journeys, because I do not trust my



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reflexes. If something jumped out at me, I do not trust that I would be safe enough. I have not yet driven anywhere without my husband in the car either.

I am a jeweller by trade. I have not been able to make anything, because a lot of physical work is involved in making jewellery—sawing, hammering and using fire and blowtorches. I do not trust myself. I do not feel safe enough, or strong enough, to do it yet. Even now, you can probably tell that it is taking quite an effort for my voice to come out.

Q67 Taiwo Owatemi: That must have been quite difficult. What symptoms did you have in the beginning, when you were experiencing Covid? How were you able to go about getting treatment?

Helen Lunt Davies: My very initial symptoms were in mid-March, when I had a very upset stomach, was feverish and had the worst headache of my life. At that point, nobody knew that those were coronavirus symptoms. For the next week or so, I tried to go about my normal business, but I was thinking, “I am really not well.” After about a week, the more classic coronavirus symptoms came in. I felt like an elephant was sitting on my chest and was coughing. Coughing was never the major part of my illness. It has been much more breathing difficulties, chest pain, palpitations and the cognitive stuff.

Q68 Taiwo Owatemi: What was it like going to seek treatment? How did you find that initially?

Helen Lunt Davies: Really difficult. Everything shut down. I understand why. Nobody knew what was happening. Very early on, it was okay getting the doctor’s phone and video calls. This was in the first two or three weeks, probably. Things really went downhill from there because I was not getting better. I don’t think they knew what to do with me because nobody knew or had heard of long Covid. At that point, it was not long; it was still acute.

I found that I had to do absolutely all the chasing and seeking help. In all that time, I had one phone call from a nurse at the doctor’s surgery, even though by May I was phoning them once a week to say, “I’m still not better.” They gave me five courses of antibiotics by the end of May, just in case it was a secondary infection, but to get hold of those, I had to fight to get past the doctor’s receptionist. Every time I phoned up, I spoke to somebody different, and I did not have a voice and I could not breathe. With my doctor’s surgery—I know that all of them are slightly different—I have to phone at 8 o’clock in the morning. Then they decide whether I can have an appointment or whether I am not urgent enough. The longer it went on, the less urgent they felt that it was, so quite often I could not get appointments. I would be crying on the phone to the receptionist, saying, “What’s going on? I’m not getting any better. I’m actually getting worse.”



At that point—I think it was at the beginning of May—I phoned NHS 111 for the first time. He was really lovely and reassuring. He phoned back much more quickly than I thought. They said that there might be a six-hour wait, but they actually phoned me back within half an hour. I was really impressed, and he was lovely. He said, “Some people just aren’t getting better. It’s not just a two-week thing for lots of people.” He recommended that I try to get on to a Covid hub—a hot hub. My GP eventually referred me to that, but it took about another two weeks. Again, she said, “Some people just aren’t getting better after two weeks, but keep with your doctor. Phone them and keep telling them. Phone every week. Try to speak to the same person if you can.”

That is what was so difficult. In every phone call I made, I was talking to somebody different, so I had to explain myself over and over again and I was getting more and more anxious. I was not anxious in a way that was making me ill, but I was anxious because I was having to do all that fighting. If I was not the person that I am, I dread to think what sort of help I would have got, but I was incredibly tenacious and was not going to be forgotten about.

Q69 Taiwo Owatemi: I love your energy to keep fighting for yourself. That is really important. Many patients have found it very hard to access their GP during this time. I think that you have done brilliantly. From your point of view, could you explain what you thought the NHS did very well and what were the areas where you think it could improve?

Helen Lunt Davies: What did they do well? I eventually got through to UCLH, which involved ever such a lot of to-ing and fro-ing from my doctor, with them saying, “No such thing as a post-Covid clinic exists,” and me saying, “I know people who have been referred.” Once I got through to UCLH, which was in mid-August, I felt looked after. It was absolutely fantastic.

I went in and had a four-appointment with them, and they did everything. They were the first people who listened and believed me. The doctors were getting more and more convinced that it was anxiety that was causing my problems. I would say, “I’m not anxious. I’m asleep, and I’m being woken up in the middle of the night from a deep sleep with a heart rate of 130-plus and not able to breathe.” UCLH were fantastic. They referred me on. I am still having ongoing treatment with the neurologists and cardiologists because I sustained some heart damage and have cognitive problems. They have been brilliant. That is what the NHS has done right—UCLH.

Q70 Taiwo Owatemi: That is great. We will be hearing from UCLH later on, so it is great to hear that.

At the beginning of your testimony, you talked about how long-term Covid impacted on your life. Would you mind elaborating on how difficult it was in other areas of your life?



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Helen Lunt Davies: Sorry; I'm going to get a bit upset. My husband has had to do absolutely everything for me. Until Christmas, I could not even cook. I have a daughter. My husband works full time. I could not even concentrate well enough to make a cup of tea and something like beans on toast at the same time. It is absolutely crazy to think about, but I would just forget what I was doing. I would wander out into the garden to look at some flowers or to pick a cucumber, and I would completely forget that anything was on the stove. My husband would smell burning and come downstairs.

It was the most simple, basic things. I could not empty the dishwasher. Only since Christmas have I started cooking again. I—you see; this is when my train of thought goes. Before, I was a really competent chef. I could cook and multitask. I could do a million other things. I would always make things up. I wouldn't follow recipes. Now I have to follow recipes. It has to be one step after another. I cannot look ahead at what I might be doing. That is improving. It is getting easier to cook. Now I can empty the dishwasher, but I still cannot put things up on high shelves, because I do not have the strength, and my palpitations start. Sorry. What was the question?

Q71 **Taiwo Owatemi:** You have answered the question. It was about how other areas of your life have changed.

I have one final question. What recommendation would you give this Committee, moving forward, on what we can advise?

Helen Lunt Davies: I don't think that people who are as ill as I was should be left to fight for treatment every step of the way. I dread to think how many people are at home having not been like me and have not been able to access any sort of treatment at all. I am surprised at myself for having had such a backbone while being so ill.

If somebody has been diagnosed with long Covid, they need to have somebody looking after them and helping them to seek treatment and find the information. I found all the information through online websites and a friend who had long Covid. I found everything out and told my GP. They kept denying that these things existed. I would come back to them, saying, "I know they exist. I know people who have been referred." The to-ing and fro-ing between me and my GP was probably one of the hardest things, above being ill. I was ill. That was horrible. Having to fight for treatment was worse, in a way, because it made me feel that they were helpless. They did not know what to do with me. There should be some sort of liaison and support for people with long Covid so that they are not just abandoned. I felt completely abandoned until I got to UCLH.

Q72 **Taiwo Owatemi:** Thank you so much for sharing your experience with us today. You are right. No one should have to fight for their treatment, and no patient should have to feel abandoned. We will take that on board. Thank you so much for joining us this morning. It has been



wonderful speaking to you.

Helen Lunt Davies: Thank you.

Q73 **Chair:** Thank you, Helen. For context, for people who may be following these proceedings from home, 384,000 people are reported to have Covid symptoms a year after getting the disease, according to the ZOE study, so you are speaking for a lot of people in what you have just told us. Thank you for joining us.

We have one more witness with long Covid. My colleague Dean Russell is going to talk to Lere Fisher. Lere, thank you for joining us.

Lere Fisher: Thank you.

Q74 **Dean Russell:** Thank you for joining us, Mr Fisher. I have a few questions, similar to those that were put to the previous witness. Would you mind giving us the context? Could you start by telling a little about what it is like living with long Covid?

Lere Fisher: The first thing is not being believed. We can talk about symptoms and the effect on your health, but it is also about the effect on your mental health. It is not feeling that you are taken seriously.

I will go through a bit of my story. The biggest health challenge when I contracted Covid on 20 March 2020 was that I slept for about 16 hours. I had chronic fatigue and the worst headache ever. I knew that this was not flu. It was something a lot more serious. At the time, with the pandemic, the whole world was in that situation, so I knew that it was Covid. I experienced delirium, chest pains—dull aches in the chest—and brain fog. It is a situation where you cannot plan, not even the next day, sometimes not even the afternoon, and sometimes not even the hours ahead. We could be having a conversation like this and then, within five minutes, I would need to go and lie down and sleep for a few hours.

Quite often, there was a continuation. When I woke up in the morning, I might have four symptoms. I would probably have chest pains and a few other things. By the afternoon that could change. No two days were the same, and probably no two half-days were the same.

Q75 **Dean Russell:** Would you mind talking about the very early stages? What were your initial symptoms? What got you to seek treatment for them?

Lere Fisher: The first was chronic fatigue. That was the big one. I had severe headaches, nausea and stomach cramps. I did not cough once. I did not have a sore throat at all. Those were the first symptoms that I had.

With that, I rested and self-isolated for about 10 days, maybe two weeks. After that period, I went for a walk. It was not a long walk, but by the time I got in I literally felt like I was going to collapse. I had a burning sensation in my chest. I felt I was going to collapse, so I called the



ambulance and they came out. At that point, they diagnosed me as having Covid.

Q76 **Dean Russell:** In terms of seeking treatment, what has it been like so far, both in the early stages and as time has gone on?

Lere Fisher: Absolutely horrendous. It is probably based on the fact that, at the time, tests were only given to frontline workers. We weren't allowed to have any tests at the beginning. Because I was not allowed to have any tests at the beginning, that set a precedent for the help that I got further on. It was as if I was not believed: "Are you telling the truth? You think you have Covid, but I am assured that you don't." When I spoke to my GP, they actually laughed when I said, "These are my symptoms, and this is what I believe that I have." I was told to have paracetamol and to drink a glass of water. I was not offered any form of referral or any other advice, or anything other than that, to be honest.

Q77 **Dean Russell:** From what you have said, it was difficult to access care and you were not particularly supported by the NHS in attempting to get that.

Lere Fisher: Correct.

Q78 **Dean Russell:** I am sorry to hear that. What, if anything, would you say went well throughout that process?

Lere Fisher: The thing that went well was support groups—LongCovidSOS. That was when I realised that there were other people who were feeling the same as I was feeling. At the time, I thought it was just me, because I was part of that first batch. I had to do my own research, only to find that there was a whole community of people experiencing exactly the same as I was experiencing, but not getting the same help that I was getting.

Q79 **Dean Russell:** Is it correct to say that those support groups were outside the NHS?

Lere Fisher: Correct.

Q80 **Dean Russell:** What, if anything, could the NHS have done better to support you? It sounds like access to support groups would be one thing. Are there other things that you would recommend?

Lere Fisher: I always say, "Listen." I am 47 years old. When I am sick, I know that I am sick and can probably explain the sickness that I have. I am not a medical expert of any kind, but I quite often know what I am feeling. If I do not know what I am feeling, that is an opportunity to listen and to go a bit deeper, to find out why I am feeling that way. What are the symptoms that are unusual?

Q81 **Dean Russell:** We heard from the previous witness that not being believed was one of the biggest challenges. From your experience with the NHS in terms of support, did you have the same sense that the



frustration of not being believed or understood was as bad as having long Covid?

Lere Fisher: Yes, it was. There was no face-to-face care. Without face-to-face care, you cannot see me visually, to see how I look. I cannot even say that it was frustration. It was like a fight—a fight to be heard. Trying to get a call back was very difficult. In the end, when I had an antibodies test, which came back negative because it was so far away from when I first contracted Covid, I was referred to a chronic fatigue syndrome clinic. I think there was a lot of gaslighting through that whole period. When I contacted them again to find out what was going on with the clinic, I was told that there was no funding for it and that the only thing they could offer me was counselling.

Q82 Dean Russell: I see. Obviously, it has had a massive impact on your health. Beyond that, what other impact has it had on your life? Please feel free to mention the health impacts, but I am interested to know what this has meant for you as an individual, for your family and friends, and for your career.

Lere Fisher: It has been absolutely major. I am a learning development consultant—a speaker, host and presenter—so I spend a lot of time on my feet speaking, talking and delivering. This made it impossible. I did not have the energy and capability to do that, which affected my income. That meant that I had to move in with my parents. I was not able to drive. I have not driven for the last 18 months. I could not afford so many things. I had to go on to benefits. I was bedridden. It completely affected my whole life and my income, to put it mildly.

Q83 Dean Russell: Thank you for sharing that. I know that it must be difficult. In this inquiry, we are keen to understand what can be improved. Could you give me two or three recommendations we should be looking at and recommending as part of our work?

Lere Fisher: Yes. There are a few things. One is about the pathway. For example, when I could not get through to the GP, they said, “Go online.” Each time I went online, it led me up blind alleys. You are pushing buttons to try to find out which is the best way of getting information, but at the end it says, “Okay, you’re having a heart attack. We need to get an ambulance out for you.” No, I am not having a heart attack, but those are my symptoms. That pathway online definitely did not help.

The pathway of having a conversation with the GP did not help. Also, I should not have to go private just to get help. If you do not have the money to be able to afford to go private, where does that leave you?

The last thing is that I am probably at a stage where I am 85% or 90% back to full health, but I am still living with long Covid. I should not have to be forgotten at this stage. I have had to nurse myself back to health, but what does the future look like? I do not know. I do not know whether I have internal damage. I do not know whether it is going to have any



effect on my life in five or 10 years. Is my body resetting? I do not know. I should not be forgotten.

Q84 **Dean Russell:** Absolutely. I can appreciate the uncertainty. Mr Fisher, thank you so much for your openness and for sharing incredibly powerful and important testimony with us today.

Lere Fisher: Thank you.

Chair: Lere and Helen, thank you so much for joining us. It takes a lot of guts to speak publicly about any medical condition. You have really helped us. You are welcome to tune in to the rest of the session. We are going to ask the experts what they make of what you have said. We are really grateful for your time and courage in coming forward this morning. We wish you the very best of luck with your conditions and getting back to normal life.

Examination of witnesses

Witnesses: Ondine Sherwood, Dr James, Professor Marshall and Dr Heightman.

Q85 **Chair:** On our second panel, I welcome Ondine Sherwood, the co-founder of LongCovidSOS; Dr Adrian James, the president of the Royal College of Psychiatrists; Professor Martin Marshall, the chair of the council of the Royal College of GPs; and Dr Melissa Heightman, the clinical lead for the post-Covid assessment service at University College London Hospitals, which we heard about in the earlier session.

We are talking about our inquiry into the post-Covid challenges facing the NHS and the backlog. Part of that is long Covid. I will stay with the long Covid theme to begin with. We will then move on to broader questions. Perhaps I could start with Ondine. You and I have a good friend, Robin Gorna, who is a long Covid patient and campaigner. We heard two very powerful testimonies from Lere and Helen. What is your reaction to what you have heard? How typical are those stories?

Ondine Sherwood: The aspect of not being believed is highly typical, certainly in the early days. Despite the fact that we knew from the first SARS epidemic that there were many people who did not recover in months or years, the whole system seemed to be completely unprepared for that possibility. Therefore, when people were not getting better, there was absolutely nothing. There were no resources for them. There was no information. I think that each individual felt alone. Certainly, that was my experience. I did not realise that there were other people in the same situation. I thought, "There's something wrong with me. I can't shake this off." Everybody was unprepared. When they tried to speak to medical professionals, the medical professionals knew nothing. A lot of people said that they would go to A&E and be met with shrugs, because people did not know what to do for them.

Q86 **Chair:** With a new virus, there will be lots of things that we do not know, but we now know about long Covid. How much has it changed on the



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ground? If someone had long Covid symptoms now and went to their GP, would they still experience the same things Lere and Helen talked about?

Ondine Sherwood: I would have thought not, but unfortunately we still hear about people really struggling to get referred. Some doctors still do not seem to be fully informed about the condition. There is an issue with communication between medical professionals. I know that the medical royal colleges are doing their best to run webinars and provide information leaflets and so on to try to make sure that everybody understands what this disease is about, but from what I can gather there are a lot of people who are still having trouble getting care.

Unfortunately, a huge number of people who were ill in March 2020, in the first wave, have still not been able to be properly assessed. We heard from Helen that she was diagnosed with heart problems. Very luckily for her, she had those diagnostics, has been given some treatment to help her and is slowly getting better, but we still speak to people who have not had those tests. Some of them have been told to try online self-help and are not able to get into the clinics. They have symptoms that sound to me like they need investigating, but they are not considered eligible for the clinics.

Q87 Chair: For the people who get care, we now have the NHS long Covid clinics. Helen said that she got great treatment at UCLH. Overall, across the whole NHS, those clinics are supposed to provide integrated, multidisciplinary assessment services. In your judgment, do they do that?

Ondine Sherwood: There are a few centres of excellence that are doing a pretty good job, but no, it is very variable. Some of the assessment centres barely do that; they do not even assess, let alone offer any treatment. I know a lot of people who have been very frustrated because it is a matter of a virtual consultation and then a discharge before they even get to be seen in person. There is huge variability, and it needs to be addressed.

Q88 Chair: Professor Marshall, you heard Helen's comments earlier about the difficulty of getting understood by GPs. Ondine has said she thinks things are probably better now than they were with respect to understanding long Covid. What is your view, or the college's view, about the challenge of long Covid?

Professor Marshall: Good morning, everybody, and thanks for inviting me to give evidence to the Committee.

Listening to Helen and to Lere's testimony is distressing. It is distressing to anybody. I cannot imagine there is a GP in the country who would listen to those stories and not feel that it is a real shame that it happened in that way. I do not think there is any doubt that we all have a lot to learn from this process.

Helen's story in particular highlighted two issues to me that I think are relevant. The first, as you have mentioned, is that long Covid is a new



condition. The second is the pressure that general practice is under at the moment.

In terms of it being a new condition, I have been a GP for over 30 years, and I am not sure I can remember very many new conditions that have come along in that time. We always have to update and there are developments in every condition, but to have a completely new condition is a real rarity, so it is not surprising that, as clinicians, we did not know very much about it. The evidence developed at not a particularly fast pace, but it developed and we as a college work very closely with NICE in England and with SIGN in Scotland to develop guidance. It took quite a long period of time to do so, but we have done that and I hope that we have made a significant contribution.

Because it is a new condition, it is one of those slightly strange conditions where it is not uncommon for patients to know more than their GP does about it. For common conditions we know a lot about everything, but when you only have one condition and you are following the research and all the discussions and you are on the online groups that Lere talked about, you learn a lot. It is always an interesting challenge for a GP, where your job is to bring your body of knowledge, when maybe your patient knows more than you. That is an interesting challenge.

I am sure we will come back to the pressures on general practice in a few seconds. It has been very difficult for general practice to deliver the quality of care that we want to deliver, and it is becoming increasingly difficult. I am sure we will come back to that. There is an element in which the care that patients are experiencing for long Covid is a reflection of that pressure.

As you said, 1.1 million people have symptoms at four weeks; 830,000 have symptoms at 12 weeks; and 380,000 have symptoms at a year. That is an awful lot of people. If you were to average that out, about 60 or 70 patients per practice have long Covid. That is a massive challenge when the resources to help us deal with it are very thin on the ground.

Q89 Chair: A couple of specific things came up there. One is more generalised, but I think I should ask you anyway. Helen made the point that she was never able to speak to the same GP, or that she found it very hard. She was always speaking to someone different. As we get capacity back into general practice, do we need to move back to a system where people have their own GP who knows them and their family's history?

The other point that is obviously in the press a lot at the moment is the difficulty of getting face-to-face appointments. Again, that is something people feel is a barrier to access. What are your views on both those issues?

Professor Marshall: As far as the first is concerned, I think the essence of general practice is the long-term relationships that patients and their



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GPs are able to develop, and that give you an understanding of people's health beliefs. It allows you to make diagnoses more effectively and allows you to treat problems more effectively.

The concept of continuity of care has long been something that has been an important part of general practice. Not all patients need continuity all the time. Some appointments in general practice are quite transactional and quite quick and easy to develop, but continuity is really important. There is no doubt at all—we have good evidence—that the extent to which continuity is a key part of general practice has dropped as a consequence of a range of things, of which workload is one. There are other factors as well. Patients are less likely to stay in one place for a long period of time. GPs are more likely to work part time and are more likely to be geographically mobile as well. There are a lot of societal factors as well as health service factors that have contributed.

You said that it was as we build the general practice workforce. I think you are right. If we build the general practice workforce, we have to get back to general practice being able to deliver more personal care, and GPs and patients getting to know each other more effectively. We are a long way from that at the moment.

Q90 **Chair:** And the face-to-face issue?

Professor Marshall: It is a massive issue. How long have I got?

Q91 **Chair:** Briefly now. As you know, the basic charge is that people say, "I want to see my GP face to face and I'm not allowed to."

Professor Marshall: We know the figures. About 80% of general practice was conducted face to face prior to the pandemic. At the height of the first wave that was down to 10%. Now around 56% of consultations are face to face. What we have learnt from the pandemic is that we can do more in general practice remotely than we thought we could. That is a positive bit of learning. There is a lot of stuff that can be done without having to examine someone or be in the same room.

Having said that, face-to-face contact is a really important part of dealing with, particularly, more complex problems. There are three categories of patients. There are people who like and get real benefit from remote care. There are patients who absolutely need face-to-face contact in order to get high-quality care to pick up the right diagnosis, not just examining but picking up soft signs. Then there is a large group of people in the middle who would like to have face-to-face care, but general practice currently does not have the capacity to deliver it. That is the bit that is the real problem for patients and for general practice.

Q92 **Chair:** So that people understand, do you have a right as an NHS patient to say, "I want to sit in front of my GP"?

Professor Marshall: People are saying that patients should have a right, but there is no point in having a right if it is undeliverable. It is



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essentially undeliverable at the moment because of the workload pressures. You can try to meet the preferences of patients, and ideally what you want is shared decision making between a GP and a patient to decide at triage whether face to face is necessary or not.

Q93 Chair: We understand that general practice is under a lot of pressure, but it was under pressure two years ago, before the pandemic, and people could actually get in front of their GP when they wanted to, usually relatively quickly. What has changed now that means that the profession cannot offer that service to some people who want it?

Professor Marshall: Two things have changed. First of all, the workload has gone up increasingly in that period of time, and indeed over the last decade. The second thing, really importantly, is that the pandemic is not over. We would like to think it is, but it is not. It might be over for pubs and nightclubs. It is not over for health services. It is really important that if you run a health service, whether it be in general practice or in hospitals, you protect vulnerable patients. The prevalence is still that about one in 70 or one in 80 patients in this country has Covid. The idea of having somebody who is fit and healthy but shedding the virus sitting next to someone who is vulnerable in a waiting room is not something that is acceptable.

Q94 Chair: I am going to bring in my colleagues, but I would like a quick comment from Dr Heightman and Dr James first. Dr Heightman, what do we now know about the best way to treat long Covid? We have heard that your service is one of the best in the country, so it would be very interesting to know what you have learnt as to the best way of doing it.

Is the funding sufficient to roll that out? Thirdly, is there a particular occupational risk to healthcare workers? Does the NHS need to take special measures to look after NHS staff, given the disproportionate numbers of NHS staff who have long Covid?

Dr Heightman: In terms of what we now know about long Covid, I think it is fair to say that we had to develop some degree of expertise at pace last May. We were working from a truck at the back of our hospital so that we could see patients face to face. This is a condition that you cannot understand if you cannot see patients in person and get the diagnostic tests that you need.

We have benefited from input from a large number of specialists in the hospital that we were able to access because we were in a hospital setting, to help us understand this confusing condition. What is difficult about long Covid is that it is very much a multi-system disease. It is not like anything that I have managed before in my experience as a respiratory physician. It is also something that is quite difficult to predict in an individual. Some of the effects of Covid are correlated with the severity of their initial illness and others are not correlated at all. That was a particular surprise to us as doctors. It obviously meant that we had a huge number of patients who became unwell at the same time in the



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pandemic, which caused problems for primary care and services such as ours.

As to how we manage long Covid now, our role as an assessment service is, No. 1, to affirm that it is the right diagnosis. The symptoms could be explained by other conditions that would need different treatment. That is the first thing. We then define how long Covid is affecting that individual and develop a personalised treatment and recovery plan based on their symptoms.

The most important part of treatment is, first of all, giving really good quality self-management advice, from what we have learnt over the last year, about how to manage these really difficult symptoms. This is something that a patient is dealing with every day. The next component can be supported therapy. The most difficult symptoms are usually fatigue and breathlessness. We are finding approaches to manage fatigue better for patients, which is about finding the right balance of activity and rest for them to support their recovery. There is also a big improvement seen with respiratory physiotherapy to help patients with what is called a disordered breathing pattern. That is an unusual aspect of long Covid that we still do not really understand, but patients get better with treatment for that.

There is a small role for pharmacotherapy in treating certain symptoms such as the tachycardias that Helen mentioned, and for managing pain effectively. Really important is giving psychological support because their psychological wellbeing is really important for effective recovery. That is something that ideally needs to be integrated with the physical healthcare offer.

Q95 Chair: I am going to ask Dr James about that in a minute. Can I ask you about the funding point and the occupational hazard point?

Dr Heightman: It was a big relief for us last October to start to get funding as a service. Up until that point, we were running at cost to our organisation. We continue to be funded now up until next March. At the moment, our funding is adequate to deliver our service to a certain level of capacity, but our waiting times are too long. They have crept up to four months, which is not a good time period for somebody who is unwell—somebody like Helen.

The real challenge for us is not knowing about funding for next year. We are trying to stabilise services and recruit into vacancies. We have a serious shortage of therapists in the system, which has always been a problem for the NHS. I think we have made a really good starting point with the funding, but we definitely need more. Primary care needs more support.

Q96 Chair: And the occupational point?

Dr Heightman: The occupational point is really important to us; 10% of our patients are our NHS staff. Many of our colleagues come to us for



help. We have had to open up a compassionate pathway for them to access us because occupational health departments have struggled to be ready for this need in their staff. Going forward, I think it is a really important thing for all NHS organisations to have good processes to identify their staff in need and the right pathways for them to access help.

Q97 Chair: Thank you. Dr James, tell me the extent to which we are integrating psychological and physical support for people with long Covid, in your judgment.

Dr James: Hello, and good morning. We have heard from witnesses already, particularly Lere, about the mental health impact of long Covid. It is very important that mental health sits alongside the multidisciplinary team in terms of assessment and treatment. We know that some of the symptoms of long Covid are symptoms of mental illness. Long Covid, by definition, is a long-term condition. People who have two or more long-term conditions are much more likely to develop a mental illness alongside those conditions.

It is also important, whether you call it long Covid or not, that, as a recent study in *The Lancet* showed, as a result of the pandemic you would expect about a third of people who have had Covid-19 to have an additional mental health or neurological condition; a third of people after six months will have a mental health condition. About 10% of those who have had Covid will have a mental illness or a neurological condition that they would not otherwise have had. They might not have long Covid, but from a patient's point of view they are part of that bigger picture. It is very important that the mental health impact of Covid is recognised, not only in relation to so-called long Covid but also for people who will have a mental illness they would not otherwise have had.

Q98 Chair: Are you noticing any overlaps with other conditions with chronic fatigue like ME, Lyme disease and so on?

Dr James: It is a controversial area. Undoubtedly, Covid is a virus. We know that there are post-virus syndromes that include fatigue. That is very well recognised. We know that after you have had a virus, your chances of getting a mental illness, anxiety and depression, are much higher.

It partly depends on your experience of having had the virus. If you have been on an intensive care unit or ventilated, you have a much higher risk of things like post-traumatic stress disorder and are more likely to have depression. Of course, there is the impact on those around you; 135,000 people have died as a result of the pandemic in the UK. That is a lot of people around people who have experienced huge grief reactions. A lot of them have been very complex because of the restrictions of the lockdown. We have a lot of complex grief reactions as well.

Chair: Thank you. Before we move on to the broader aspects of coping



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with the backlog, do any of my colleagues have questions on the long Covid side of things?

Q99 **Dean Russell:** Dr James, I am interested more in the mental health side of things, especially as you have mentioned mental illness. Do we have a sense of the statistics yet as to how many people who have long Covid are showing similar issues around mental health, mental wellbeing and mental illness?

Dr James: The research is very early. It is a new condition. We need to ensure that there is adequate research. We know that people who have a chronic physical health problem are much more likely to develop a mental illness. We know from those who are working in long Covid clinics where they see mental illness a lot that people value the role of, for example, liaison psychiatrists in assessing people for depression, anxiety and post-traumatic stress disorder. It is front and central to much of what is happening in terms of long Covid.

From a patient's point of view, if you have a mental illness that you would not otherwise have had without Covid, that is the most important thing. It might not be part of the 12 symptoms that the ONS quotes for long Covid, but you have a mental illness you would not otherwise have had. We know that Covid attacks the nervous system. We know that there are new cases of dementia, psychosis and depression directly as a result. There are also the broader, social issues that have arisen. People have been isolated. We know that that can have a negative impact on your wellbeing. People have not had contact with other people. There is a lot of uncertainty around jobs and housing. People are in financial difficulties. People have had to live in conditions that are not conducive to good mental health, so a whole range of issues arise.

Q100 **Dean Russell:** Obviously there has quite rightly been a lot of talk about putting more investment into social care, and the NHS of course. Where do you think the balance lies, moving forward, for helping people with long Covid? Is it an NHS issue, a social care issue or a bit of both? Where do you see investment being needed specifically around the mental health side of things around long Covid in the coming years?

Dr James: Long Covid is an illness. It requires a health response. That has to be the focus of the investment and the service we provide. It has to be in primary care. It has to be in liaison psychiatry services. It has to be in long Covid clinics. Of course, alongside those things, as we have heard from our witnesses, there are social consequences.

We heard from Lere about the impact on his life and the things he could do that he cannot do. We need to look at benefits as well. We need to look at the social care response. I think you have to go side by side with both of them.

Dean Russell: Thank you.

Q101 **Paul Bristow:** Dr Heightman, do you think there is anywhere else in the



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world that you would look to, for their assessment and the way they are dealing with long Covid, that you think we can learn lessons from?

Dr Heightman: I wish there was. I think England, at least through the NHSE work, has been a bit of a frontrunner. I have joined WHO working groups and we seemed to be ahead of the game in defining pathways, operational standards, clinical standards and treatment approaches. Hopefully, other countries will start making progress that we can learn from.

Q102 **Paul Bristow:** That is quite encouraging to hear. What more can we do in order to make the UK, if you like, an exemplar for its assessment and treatment of long Covid?

Dr Heightman: A good long Covid pathway provides us with quite an exciting opportunity. Because it is a new scenario, we have tried to work as an ICS in my area, so that we are really working across organisational boundaries. Getting the pathway right happens from the positive test, so that patients are getting the right advice then and you have the right assessment happening in primary care. We support GPs to do that with a standardised process. You are giving self-management advice, and then you get access to assessment and therapy. It is just a way of working across organisational boundaries to achieve integrated care. I think that is something that we are striving to do in other long-term conditions. This is like a blank canvas; we could try to do it better than we have done before.

I think the role of the assessment clinic is about trying to achieve quality assurance of that pathway and making sure that patients have access to specialist support when needed, but we must not create an ivory tower. It is about bringing specialists out to patients so that they can be looked after close to their homes.

Q103 **Chair:** Professor Marshall wants to come in on that point.

Professor Marshall: I agree entirely with that. From a GP perspective, we need to do things to be able to manage long Covid more effectively. One of them is better access to diagnostics in the community, recognising in particular that only a small proportion of the 1.1 million people with long Covid will get to a UCLH-type model, or indeed probably need a UCLH-type model. We need better access to diagnostics in the community. We certainly need better access to community rehab services. It is that treatment option that is deficient and is another reason, perhaps, why GPs say, "Look, I'm really sorry but there's nothing I can do about this because we don't have access to the services that you need."

Q104 **Paul Bristow:** Ondine, do you feel that your organisation is being involved in this work? How do you feel patients are feeding into this type of work?

Ondine Sherwood: Sorry. Could you say that again, please?



Q105 **Paul Bristow:** If we are trying to create a model and looking for the UK to be an exemplar, and we are ahead of the game when it comes to the treatment, management and identification of long Covid, what sort of role do you feel your organisation should have in that?

Ondine Sherwood: As an organisation, we have been working with NHS England for about the past year to help inform their decision making and to try to guide them to provide the right sort of services. We have been asking for multidisciplinary clinics from the word go.

Personally, I am a patient and public voice partner in NHS England. Certainly, patients need to be involved all the way through. In fact, what I would like to see is more patients' involvement in the individual clinics. It is all very well patients talking to NHS England, but NHS England only has a certain amount of control as to what is happening in the clinics. At the moment, we do not really know exactly what is going on in the clinics and which clinics are actually fulfilling the role they are supposed to do. There are plenty of patients who would be delighted to help guide the services in their local trust, in order to make sure that they are providing the right services.

In terms of provision, having seen the data from NHS England, about 5,000 patients were seen in July. In a year that would only be 60,000 of the 600,000 that the ONS has identified as having their lives impacted by long Covid. In fact, nearly 200,000 have had their lives impacted a lot. They are not going to get seen at this rate. Although not every long Covid patient needs to be seen in an assessment centre, I think it is certainly a lot more than are getting seen now. A lot of people are waiting for way too long, as Melissa pointed out.

Q106 **Chair:** Thank you. I am going to move from long Covid to more general questions about the scale of the backlog. Perhaps I could start with you, Dr James, to talk about the mental health backlog and, in particular, the question of the mental health investment standard that was raised by some mental health organisations following the announcement of the health and care levy last week. Talk to us, if you would, about what your members are saying about the scale of the backlog in mental health.

Dr James: It is important to say that we started from a relatively low base. Nobody says that mental health has had the investment that it has needed year on year. The most staggering statistic is that the adult mental health survey shows that only one in three people who could benefit from evidence-based treatments actually gets those treatments. The base is relatively low, but we have benefited from increased investment over the last few years. It is really important to say that where there has been investment we have made a real difference.

There used to be a myth that you could pile money into mental health services, and you would not see any difference as a result. We have shown that we have had huge numbers of people being seen in much better quality services—for example, in perinatal services. Liaison mental



health services have grown hugely, and there has been investment in children. One of the most important areas has been the investment in schools, which, for those who have had mental health support in schools, has been transformative.

We found, at the beginning of the pandemic, that the numbers of people presenting dropped fairly briefly, and then we had historically high levels of presentation. The issue for mental health services is not how we can get the services going again; it is how we cope with the increased demand. We know that anxiety levels have gone up. Depression has gone up. We have already mentioned the extra mental illness as a result of the pandemic. Levels of contact with mental health services have been at historically high levels. Referrals to child and adolescent services, particularly eating disorder services, are sometimes two or three times the level of referral to those services.

Q107 Chair: That is very interesting, and worrying, but could you help us quantify it? We understand the concept of a backlog—in other words, people who were not able to access mental health care during lockdown and so on. There is obviously going to be a catching-up process. What about the additional pressure of people who have had additional mental health problems caused by the pandemic? You said that only one in three people was getting the mental health care they need, according to that survey, before the pandemic. Can you tell us what the figure is now?

Dr James: At the moment, we estimate that about 1.5 million people are waiting for mental health treatments. Obviously, for those people it is absolutely devastating for their lives, for their families, for their work and for their contribution to society. That is what we estimate. Going forward, the Centre for Mental Health has done a study showing that it is estimated that probably, over the next three to five years, we will have about 10 million more people presenting with mental illness. About 8.5 million of them will be adults and 1.5 million will be children.

Q108 Chair: And the mental health investment standard?

Dr James: The mental health investment standard has been a very powerful tool to drive investment in mental health services. As you know, it says that the investment in mental health services should be significantly above the overall investment in any part of the health services at CCG level. It should be above the level of general growth.

Q109 Chair: The growth in mental health should be above the growth in the NHS—

Dr James: And for child and adolescent services it should be even more than that. That has been very powerful. It is all part of the parity of esteem agenda. There are a number of things I want to say about that. Of the £5.4 billion that was announced, we do not know how much of it will go towards mental health. We absolutely need that to be clarified. If the mental health investment standard applies to that money, and there is, as we know, a huge backlog and a huge amount of unmet need in



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relation to mental illness, we estimate it should be about £1 billion. That meets what we believe is the cost of the extra people who will be presenting with mental illness year on year, which is £1 billion extra every year over the next three to five years.

Q110 **Chair:** Do we have the capacity in the system? Do we have the psychiatrists, the mental health nurses and the therapists who are able to treat those extra people?

Dr James: It has been a real struggle. There was a report from Health Education England called “Stepping forward”, which estimated the number of extra mental health staff needed to meet the commitments in the long-term plan that goes on until 2023-24. For example, for consultant psychiatrists we are about 470 consultants down on the number that we would expect at this time. It is a real challenge.

In spite of the numbers not being where they should be, we have managed to see an historically high number of patients who have had contact with mental health services. Mental health services have really put their heart and soul into trying to meet the need, but it has not been possible to meet that need. That is why we need more investment in staff. It is why we need a more independent look at staffing and how it matches the need in the health service. It is why we need an investment in our medical schools. The Royal College of Psychiatrists has argued that we need to double the number of places in medical school. In the comprehensive spending review, which is coming up, we have had an extra 120 places for training in psychiatry. That is core level psychiatry—the first rung of training. We managed to fill those 120 extra places, so we have 100% recruitment into psychiatry at core level. Historically, that has not been possible.

As a profession, we have worked hard to make sure that we can fill those places. We need to make sure, in the comprehensive spending review, that we have that cohort who run through their training, but that it is year on year, so that we get another 120 this year and more the following year. It is that year-on-year growth. We do not want to be in the situation we are in at the moment, where there has been a real shock to the system because of Covid-19, which we know has an effect on mental illness, and we are not able to respond in a way that the public deserve.

Q111 **Chair:** Thank you. Let me ask a similar question of Professor Marshall. First of all, what is the scale of the backlog and the catch-up facing general practice? What needs to happen to the workforce to give you the capacity necessary to address it?

Professor Marshall: There are two elements to the backlog in general practice. There is the responsibility of general practices, if you like, for the hospital backlog—for the 5.4 million, maybe growing to 13 million or 14 million. Who knows what will happen there? That is about general practice making most of the referrals to those services. General practice



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is looking after the patients who are on the waiting lists, which I think is really important because they have needs, and the responsibility for those needs being met is largely in general practice.

The other issue, as you say, although it is rather hidden and does not have the same political profile as the backlog in the hospital sector, is that there is a backlog in general practice. There is a lot of unmet need. We know that the number of consultations has gone up dramatically over the last decade. Depending on which dataset you look at, somewhere between 5% and 10% more patients are being seen now than were being seen in an equivalent period pre-pandemic. In addition, we are seeing many more complex problems in consultations. The average consultation is 9.8 minutes and the average number of problems dealt with in it is now nearly three. Three minutes per complex problem that we are dealing with in general practice is very difficult to deliver.

On top of that there are extra things that general practice is contributing to. There is the immunisation programme, of course—the Covid and flu immunisation programme. There are other things that general practice can do that maybe we could not do five or 10 years ago. The need and the demand is going up; the supply is not. It has been recognised for some years that we need more GPs. In 2019, there was a commitment to 6,000 more GPs by 2024. If you look at the data now and look at whole-time equivalents, we actually have 2.5% fewer GPs now than we had in 2019 and 4.5% fewer than we had in 2015. The number of whole-time equivalent GPs is going down.

The reason for that is not so much recruitment, because we are managing to get more training places, which is great. Our training places, as with psychiatry, are full. That is great. The main problem is that the plug is out of the bath; more people are leaving the service, either by working part time or by retiring early. That is a consequence of the fact that general practice is a highly pressurised job and it is impacting on clinicians' mental health. We have a big problem with GPs, and we also have a significant problem with the non-doctor workforce, which is very important in general practice, and the numbers of that.

Q112 **Chair:** It is going to be a challenge to get there, but do you actually accept the 6,000 figure? Do you think that if you got the 6,000 by 2024 that would broadly get you where you need to be in meeting the demands you face?

Professor Marshall: I think it would make a very significant contribution; 6,000 is still the figure that as a college we are lobbying for, plus 26,000 other health professionals working in the primary care team.

Q113 **Chair:** Your request as royal colleges that there should be a body that independently projects workforce needs is one that we have echoed in multiple Select Committee reports, so we are at one on that. The Treasury objection to it is that, effectively, by doing that, you are giving the NHS a blank cheque because, if you allow an independent body to



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decide how many doctors and nurses you train, they could require huge numbers to be trained, which, in the end, the state would have to fund. What would your response be to that Treasury objection? Obviously, we all have to have some responsibility for taxpayers. I am interested in your view on that. Let me take Dr James first.

Dr James: Health is the No. 1 spending priority for the general public. I think any Government would have to recognise that. Within health spending, the No. 1 priority at the moment is mental health. I think that deserves a pretty robust response.

What has been happening until now is that the link between the service that is required, and which the Government say they are going to provide, and the workforce that is necessary has not been very explicit. If that had worked, we would not be calling for this. I think you have to link those things up.

Ultimately, if an independent body makes a recommendation, it would still be up to the Government to decide. In pay, we have a similar system. I think it is a response to what the public want, and that is what Government should be doing.

Q114 **Chair:** Thank you. Professor Marshall?

Professor Marshall: I agree entirely with Adrian. It seems to me a strange position for the Government to say, "We are not sure we want to invest in a larger workforce and therefore we don't want to know the scale of the problem." We have to know the scale of the problem because very clearly it is impacting on patient experience, on clinician mental health, and on the recruitment and retention of clinicians—and indeed on the sustainability of the NHS. We have to know the answer to the problem, and the answer is an independent group. The absence of workforce planning in the NHS has been a dreadful problem for the NHS since its inception, and it is getting worse.

Chair: Thank you.

Q115 **Laura Trott:** Professor Marshall, the Royal College of Emergency Medicine has said that GPs delivering phone-first services has significantly increased demand for emergency medicine. Do you accept that?

Professor Marshall: Surprisingly, perhaps, there is not very much evidence to prove that. We know that emergency departments are under enormous pressure. If you look at the most recent statistics, that pressure is not the consequence of a larger number of patients being seen. It is the pressure of the dynamics in the emergency department, such as social distancing and the inability to get patients out of emergency departments into the hospital sector.

There isn't a dramatic increase in the number of patients who are being seen. Having said that, although the data does not support it, I think it is probably reasonable to suggest that, when general practice is under



pressure and patients feel perhaps that they cannot get access to their GP, maybe they will go to the emergency department because, as Dr Henderson said, the lights are on. It is a place you can go to. To me, that is a consequence of the whole system being under pressure and there being pressure points in general practice, as Dr Henderson described very well. In particular, and it is my responsibility if you like, when general practice is under pressure, the rest of the NHS feels it.

Q116 Laura Trott: I understand the point about general practice being under pressure. I want to drill down into the point about face to face versus phone, and whether that is making a difference. The survey data from the Royal College of Emergency Medicine says that phone-first services had increased, or significantly increased, demand in their emergency department, and 50.7% of members agreed with that. There is clearly a view in the College of Emergency Medicine that this is having an impact, specifically the phone services.

Professor Marshall: Yes, but I don't think that is supported by the data. That is my response to that. I think it is probably fair to say that at the height of the crisis, when general practice was being told to go remote and to ensure that we had good infection control, it was quite likely that more patients who needed an examination were being sent elsewhere. That is possible. It is less of an issue now.

Q117 Laura Trott: You are arguing that because the number of appointments that GPs are having is increasing, and because the demand on emergency services is broadly stable, there is no impact from phone services driving appointments to emergency services. Do I understand you correctly?

Professor Marshall: I think the answer is that we are not sure. I do not think there is good evidence to suggest that there is an impact. Although we know that the number of face-to-face consultations has dropped, most GPs, when face-to-face consultation is required, will make the decision to see somebody face to face. That is certainly what I do. I suspect that most GPs do that if they possibly can in order to avoid an unnecessary referral, either self-referral or clinician referral.

Q118 Laura Trott: You made the point earlier about many GP services feeling that they could not sustain face-to-face appointments for everyone who wanted them because of the pressure on GPs. Many patients feel that a phone appointment is not a substitute for a face-to-face appointment. Do you accept that that is the case?

Professor Marshall: Yes, I do, absolutely. I think it is very important. I talk to colleagues, perhaps in more progressive practices, who started using remote methods of consulting way before the pandemic, maybe five years ago. Almost invariably, they say that, despite being progressive practices and well organised, it took two or three years for their staff and their patients to get used to behaving in a more remote way.



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General practice across the board introduced remote working in two or three weeks in March last year. It is hardly surprising that it is taking time for both clinicians and patients to get used to it. I suspect that patients will get used to it. I do not think we are going to go back to 80% of consultations in general practice being face to face.

Q119 **Laura Trott:** Do you think it should be patient-led in terms of what they prefer, whether it is a phone or in-person appointment?

Professor Marshall: I think it should be both. It has to be a shared decision between a clinician and a patient. Frequently, we still have pretty much 100% triage in my practice in east London. Quite frequently, I have conversations with a patient on the telephone about the pros and cons of face to face. They are usually very reasonable consultations, and usually the patient will be happy with whatever they end up with, whether it be face to face or remote. I think it should be a shared decision.

The reality at the moment, as I described earlier, is that there are some patients who absolutely need face to face, and some patients who absolutely love remote consulting. In between is the group where patients express a strong preference, but the system does not have the capacity to meet that preference. That is the problem area.

Q120 **Laura Trott:** In terms of the drivers of why the system does not have the capacity to deliver, you have been very clear in your submission about the need for more GPs. You also mentioned the fact that more GPs are working part time. Has the royal college made any efforts to increase the number of hours that those GPs are working? Obviously, it is cheaper for the state for GPs to work longer hours than to train entirely new GPs.

Professor Marshall: I think we probably need to be clear what we mean by part time. The average working day is somewhere between 11 and 12 hours. Three days a week is pretty much full time. I think we need to be careful about that. GPs are working under intense pressure.

I do not think it would be our job as a professional body to force people into working more sessions, when they do not feel safe working those extra sessions. That is the position we are in at the moment. The pressure that general practice is under not only impacts on our ability to provide personalised care, which is what we want to do as GPs, but it is increasingly impacting on our ability to be able to provide safe care. If I were to force one of my colleagues, in whatever way I could, which I have no levers to do, to work four days a week, and as a consequence they started making diagnostic errors or prescribing errors, that would be no good for anybody.

I think we have to accept, first of all, that while general practice is under enormous pressure there are very few people who feel that they are able to work full time. Secondly, we have to accept the reality that the younger generation of clinicians of all sorts want career portfolios. They



want mixed careers. They do not want to work full time. The model of a full-time GP is probably something we will not see again.

Q121 **Laura Trott:** You accept that that is much more expensive for the state.

Professor Marshall: Yes, it is. The state, I think, needs to understand that and reflect that reality.

Q122 **Laura Trott:** In your submission, you talked about reducing the workforce burden for GPs in administrative and other tasks. Are there any specifics that you would like to highlight to the Committee that need to be addressed?

Professor Marshall: Yes. There are a number. We know from workforce analyses that GPs spend around about 60% of their time in face-to-face contact with patients and about 40% of their time carrying out administrative responsibilities, some of which are absolutely necessary—making a referral is an important administrative thing—but some are not.

The things that I think need to be explored or understood and possibly pushed back on are, first, contractual obligations. There are a lot of QOF-related and payment-related contractual obligations in England that do not exist in Scotland. There is no evidence that care in Scotland is any different from what is happening in England. There is a lot of bureaucracy in ticking the boxes and satisfying those contractual obligations. There is something about QOF that I think is important.

There are a lot of medical forms, particularly wellness certificates and fitness certificates for work, that could be done by other health professionals. They do not have to be done by doctors. I think the expansion of non-doctor prescribing could be helpful as well. There is a big regulatory burden in general practice in particular. The CQC model for regulating health services is, essentially, a model that was designed for large organisations with an infrastructure—hospitals—but it is pretty much being applied to general practice, and it is disproportionate. Our view is that regulation is important. Regulation plays a role at the bottom end of the performance spectrum, but it is disproportionate for the vast majority of practices. Reducing regulation would be very helpful as well.

Laura Trott: Thank you, Professor Marshall.

Q123 **Paul Bristow:** Professor Marshall, I noted some of the statistics you quoted earlier, that 80% of appointments were face to face prior to the pandemic and now it is around 50%. What do you think is an acceptable ratio between face-to-face and phone appointments?

Professor Marshall: Unfortunately, I do not think there is such a thing. I think it will be different in different practices and in different parts of the country. As a GP working in an inner-city area in east London, I look after mostly a very young population. They are socially and economically deprived but very tech-enabled. I suspect that in our practice we will always have a higher proportion of remote consultations than in a



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practice serving an older population in a rural area, for example. If you were to push me, I would say that we are probably round about where we should be. A reduction in face to face from 80% to 56% on average across the country is probably about right.

Q124 Paul Bristow: It is accepted that as a result of the 10% face to face, when they were really limiting face-to-face GP appointments, there were a number of missed cancer diagnoses and diagnosis of other long-term conditions. Would you accept that that is happening now as a result of the 50:50 ratio?

Professor Marshall: I think it is happening less, but there is still a risk of it. The challenge for us as clinicians working with our patients is to be able to make the right decisions about when a face-to-face appointment is necessary and when it is not. When you need to examine somebody or do a blood test, it is obvious that you need face-to-face appointments.

The greater challenge is in the softer reasons for face-to-face consultations. When I see a patient in my room who I do not need to examine but I can see, for example, that they are anxious or I can smell alcohol on their breath, or they are dishevelled and they are usually well-kempt, those are all soft signs that help me to be a better clinician and to make a better diagnosis and give better treatment. Face-to-face appointments are important when they are needed. My point is that they are not needed for everybody.

Q125 Paul Bristow: I would accept that. I think the point you made about serving a younger population is well made. I would include myself in that. I do not necessarily need to go to see a GP in a face-to-face appointment. What concerns me is that the triage system is used inappropriately and that people who need face-to-face appointments are not getting them. Would you accept that the triage system is working, or would you say it is not working and we are still missing cancers and other conditions?

Professor Marshall: I don't think we can pretend it is working. It is a new system that has been introduced at pace in a very difficult time for the NHS, and we are all learning how to use it effectively. Our obligation as professionals is to learn and to improve the system as we are going along, and that is precisely what is happening. We are getting better at making those decisions.

Q126 Paul Bristow: I noted a couple of things that you said. You said that we have one in 75 people with Covid, and it is unacceptable to have those people in a waiting room. I completely agree with that. Obviously, it is totally wrong that anyone who has Covid symptoms or a positive Covid test should be anywhere near a hospital waiting room. Would you suggest that trying to reduce infection in hospitals and trying to control Covid is still a factor in limiting face-to-face appointments?

Professor Marshall: Yes, it is, and it should be. Indeed, that is in line with NHS England guidance. We need to maintain good infection control, irrespective of the level of immunisation, which has been a tremendous



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thing for the NHS. Yes, I still think we need to ensure that infection control is good.

Q127 **Paul Bristow:** I want to make this absolutely clear. Would you say that there are people who typically should be seeing a GP face to face but who are now not seeing a GP face to face because of Covid precautions and infection control?

Professor Marshall: No, I would not say that. If somebody needs to be seen face to face, I will ask them to come in and see me, and I will put on my full PPE in order to ensure that infection control is as good as it can be. That should not be the case.

Q128 **Paul Bristow:** I have one last question, which is a little less taxing perhaps. It is about what you said about non-GP prescribing. I cannot quite understand why that is not much more widely spread across the system. I do not understand why nurse-led prescribing, which we have had for a significant period of time, is not more widespread than it is. Why do you think that is?

Professor Marshall: Good question. I am not sure I know the answer. I guess clinicians tend, by nature, to be a little bit risk-averse. There is something about the training that a doctor has. I was trained for 10 years before I was allowed to be an independent practitioner. That gives me a broad understanding of the risks as well as the benefits of prescribing. There is probably something about that. Having said that, in our teams now we have a lot of very experienced pharmacists who are very knowledgeable about prescribing. I think that shift is being made.

Q129 **Paul Bristow:** What can we do about that? You said that you are reluctant, or that it was not your place, to ask GPs to work longer hours, but if they are doing things they do not need to do, how can we resolve that problem?

Professor Marshall: Sorry, I missed the last bit.

Q130 **Paul Bristow:** You said earlier that you did not feel it was the place of the Royal College of GPs to ask your colleagues to work longer hours. If GPs are doing things they do not need to do, such as prescribing, that can be done by other professionals, what do we need to do to make that happen?

Professor Marshall: A lot of it requires legislation. There are issues about who has the right to prescribe. Probably some work needs to be done there; otherwise, there is a significant continuing professional development need, both for clinicians and doctors to let go of prescribing, in some cases, and other clinicians to pick it up.

Paul Bristow: We need action there.

Q131 **Dean Russell:** I have a few questions. The first is around the role of pharmacies and community pharmacies. Over the past year and a half they have very much been a port of call for a lot of patients, to go in and



speak to somebody. I was interested in your view on whether there is an opportunity to look at the role of pharmacists, moving forward, to support some of the challenges that GPs are having with regard to their time and the pressures on them.

Professor Marshall: Yes, there is, without doubt. A lot of practices work very closely with their local pharmacies. Of course, we have two models of pharmacies now. We have local community pharmacies as well as our in-practice pharmacies, but I think you are talking about the community pharmacies.

Dean Russell: Yes.

Professor Marshall: A lot of community pharmacies serve a really important role, particularly in the management of self-limiting conditions, which is a significant proportion of what we see in general practice. In many ways, that is one of the advantages of the triage system. We can speak to somebody who perhaps has earache, a chesty cough or a sore throat and say, "Actually, I don't think you need to be seen by a doctor now. Why don't you go to your pharmacist and get some symptomatic advice?" A growing number of pharmacists are providing a really superb service.

There is a mechanism by which pharmacies are paid for that process. My understanding is that uptake of it has not been great so far, but it is something that we work on very closely with the Royal Pharmaceutical Society. We run webinars with them and we have a roundtable coming up very soon to talk through how we can expand that.

Q132 **Dean Russell:** Would you say that there is an opportunity for the Government to look at that in the round as well, as we move forward, to promote more pharmacist involvement with regard to tackling the backlog?

Professor Marshall: Yes, I think there is without doubt. The challenge in many ways is about the public and supporting the public to understand what services are available and how to access them. Pharmacies, of course, have to be open and they have to be able to provide the service. If the public were supported and informed to make decisions about when they need professionalised help and when they do not need professionalised help, that process would be extremely helpful. There is a fair amount of what we see in general practice that could be managed by self-care rather than by professional care.

Q133 **Dean Russell:** Do you think there should be better ways of doing pathways? I think it was mentioned in the earlier session about pathways for long Covid. Just generally, it is about the starting point for patients and the route that they go through navigating the NHS and social care to get the support they need, and to improve the efficiency of the system for outcomes for them and for the system.



Professor Marshall: I agree entirely. In many ways, pathway redesign is the core of health reform. We spend so much of our time talking about new structures, new governance arrangements and new funding, but the reality of an integrated experience for patients is the care pathway. There are some great examples around the country. In my area, in east London, there are some great examples around renal failure in particular, where the renal physicians, the GPs and groups of patients have got together, redesigned pathways and produced a seamless service. It has massively reduced the number of referrals to the hospital sector as a consequence. That is the kind of work that needs to happen across the country. I hope it will be part of the ICS reforms.

Q134 **Dean Russell:** I want to ask about digital innovation. With regard to learning, we have telemedicine and virtual consultations. When I think about virtual consultations, I think about people using iPads rather than phone calls to have a virtual face-to-face session with their GP.

At the start of the pandemic, I remember hearing statistics that many GP surgeries were starting to buy or use iPads to have those consultations. Has there been much uptake in virtual face to face, or is it primarily phone call or face to face from your experience?

Professor Marshall: Not as much uptake as you would have thought or expected, as you say, at the start of the pandemic. It is ironic that the technological advances are based on technology that is 150 years old. The proportion of consultations that are carried out by video is very small.

I think that is largely because of lack of investment in the technology and in the training to allow us to do video consultations well. At the moment, the technology that is available is very clunky. When you have three problems in a 9.8 minute consultation, spending two minutes trying to make the technology work is not time well spent. That is probably one of the reasons why both clinicians and patients have reverted to the telephone. The potential is enormous for investment in the technology, not just for consulting but for interacting with specialist services and for remote monitoring.

Q135 **Dean Russell:** Would you say, from the innovation and technology side of things, that as we look forward that should be one of the priorities for the investment that is coming through around the levy that is being put into place, and the funding from that? The reason why I ask is that it feels to me that whenever I have volunteered at my local hospital, or when I speak to GPs, one of the big issues constantly is paperwork and duplication of effort, especially on paperwork. Do you think it would be helpful to say that we need to earmark a set of money to look specifically at technology, digital innovation and innovation in broad terms?

Professor Marshall: Absolutely. It is essential. Although general practice has a reputation for being probably the most computer literate part of the NHS, we still have a very long way to go. Is it my No. 1



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priority? No. Workforce is my No. 1 priority. Investment in technology is my second.

Q136 **Dean Russell:** Aren't they connected, though? If the workforce are freed up from having to spend hours filing papers, that frees them to do the job they are trying to do.

Professor Marshall: Yes.

Dean Russell: Thank you.

Q137 **Chair:** I have a final question for both of our royal college presidents, if I may, before we wrap up this morning. We have had a very productive and informative session, so thank you to all our panellists.

I want to ask you, Professor Marshall, about the cancer inquiry that we are running at the moment. We have had evidence from people previously about the challenge that we are going to face if we are to raise the number of people we diagnose early from around 55% to 75%, which is the NHS long-term plan aim.

Professor Mike Richards, who was Tony Blair's cancer tsar, quite surprisingly said he thought we need to look at the way general practice functions to work out how we get more cancer diagnoses early. How open would the college be, for example, to moving to a system—just talking about cancer—that they have in France, where people have direct access to specialists and cancer diagnostic tests without having to go through their GP as a gatekeeper?

Professor Marshall: You had an interesting hearing last week. I know that my colleague, Richard Roope, gave evidence to your cancer inquiry. It is a difficult area. There is no doubt at all that we are getting to a place where our threshold for thinking about cancer and referring for cancer is dropping. When I started as a general practitioner, in many ways we saw part of our job as keeping patients out of specialist services. Many of the patients that we see could have cancer, but most of them do not. We were trained to pick up the red flags and the important symptoms and refer those on, but not refer everybody who has cancer because the NHS would collapse if that was what we did.

In many ways, that is still the mindset of many clinicians. Do we have to shift that mindset to a point where our threshold for referral is lower? I think, yes, we do. Do we have to have better access to early investigations, particularly in the community? Yes, I think we do. I am fully in favour of the community diagnostic hubs. I think that is the right thing to do.

Should everybody who potentially has symptoms of cancer be able to refer themselves for a scan or to an oncology team? I think the NHS would collapse overnight if that were allowed. Our ability as primary care clinicians to filter and make judgments is an important part of sustainability. It is why we still have pretty good outcomes in the NHS for a very low spend in comparison with other countries.



Q138 Chair: I have a final question for Dr James. I want to go back to the mental health investment standard. We do not yet know whether the Government are going to say that the mental health investment standard applies to the additional £8 billion a year that will be going to the NHS in the next three years as a result of the new health and care levy. Were the Government to say that, on this occasion, the mental health investment standard does not apply because of the special circumstances of a pandemic, what would your view and the college's view be with respect to commitment to the principle of parity of esteem?

Dr James: I think it would be absolutely devastating, primarily for patients because they will not get the treatment that they need. There are millions of people who will be affected by Covid-19. Millions of people have not had the treatment that they need. We are beginning to make a bit of headway with the mental health investment standard, and with the extra £2.3 billion that is going into mental health services up to 2023-24. We need to make sure that is preserved. We need to make sure that an extra billion goes in year on year to meet the extra demand. We absolutely need to make sure that the mental health investment standard is maintained and that it is written into everything that makes the NHS run. If not, I think patients will be disappointed, the public will be disappointed, and the profession will be demoralised.

There are a couple of other things that I would like to say. We really need to invest in our staff and in our training. In the training context in the health service, trainees, particularly in medicine, are treating patients from day one, so they are part of meeting all the extra demand in relation to Covid.

You mentioned cancer a second ago. Some of the advances for cancer have been because of the extra research that has gone into cancer. We are also calling for an extra amount of money to do mental health research. It is a staggering statistic that, for every patient who has cancer, you have £228 invested in research; for every patient who has a mental illness, it is £9. If you speak to people in the cancer world, they say that research drove the improvements. As part of parity of esteem, we need that investment in mental health research. We are calling for an extra £120 million for mental health research.

Chair: Thank you. It has been a very good session. We really appreciate all of your time, Ondine Sherwood, Dr James, Professor Marshall and Dr Heightman, as well as our star patient witnesses, Lere and Helen, who have stuck with us right the way through the session. Thank you very much for joining us. That concludes this morning's session.