HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Delivering Core NHS and Care Services during the Pandemic and Beyond, HC 320

Friday 1 May 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Amy Callaghan; Rosie Cooper; Dr James Davies; Dr Luke Evans; James Murray; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 1 - 70

Witnesses

I: Gill Walton, Chief Executive, Royal College of Midwives; Professor Martin Marshall, Chair of Council, Royal College of General Practitioners; Claire Murdoch CBE, National Mental Health Director, NHS England; and Dame Cally Palmer, National Cancer Director, NHS England.

Examination of witnesses

Witnesses: Gill Walton, Professor Marshall, Claire Murdoch and Dame Cally Palmer.

Q1 **Chair:** Welcome to this virtual session of the Health and Social Care Select Committee. My name is Jeremy Hunt. I am the Chair of the Committee. We have had a lot of focus on people with coronavirus and how that is affecting the NHS. This morning we are going to have a different focus, which is people with other illnesses or conditions and how their treatment has been affected by the coronavirus epidemic.

We are going to do particular deep dives into maternity services, cancer services, and mental health and GP services, and we have a superb panel of experts to give us advice in those areas. I would like to give them a very warm welcome.

On the cancer side, we have NHS England's national cancer director, Dame Cally Palmer. We have NHS England's national mental health director, Claire Murdoch CBE. On the general practice side, we have the chair of the council of the Royal College of GPs, Dr Martin Marshall. We also have the chief executive of the Royal College of Midwives, Gill Walton. You are all most welcome. Thank you very much for coming.

The first thing the Committee and all MPs would like to do is, through you, to thank the people in your teams, the people who work for you and the people who work with you for the incredible superhuman efforts you have been making to keep the show on the road despite this terrible pandemic. Please pass on our gratitude for the incredible work you are doing.

We are going to start with maternity services. I am going to direct these questions first to Gill Walton and then bring in Dr Marshall, because obviously GPs can be a first point of contact for pregnant women. Gill Walton, I would like to start with the question of maternity safety, because one of the most important elements of maternity safety is to identify higher-risk pregnancies early, so that interventions can be made to prevent stillbirth, complications or even the death of a baby.

The president of the Royal College of Obstetricians and Gynaecologists, Eddie Morris, who is in some ways your counterpart, said to me yesterday that he is worried that some higher-risk pregnancies may be missed because of fewer face-to-face appointments and some missed scans. He thinks we could see an increase in stillbirths and neonatal deaths. Do you share that concern and, if so, what do you think needs doing?

Gill Walton: I do share that concern. Some of it is related to the fear of the pregnant population about presenting to maternity services during the pandemic. That fear prevents them sometimes from just picking up the phone to call their midwife to say that they may be concerned about not feeling well, or that they have reduced foetal movements. Maternity services have tried their very best to keep providing as much of a normal

service as possible, albeit by video and telephone, but also maintaining face-to-face contact. It is important to get the message out that maternity services are still there, still open and that women should come forward and have their normal appointments, so that we can keep them and their babies as well as possible.

Q2 **Chair:** Does the system follow up appointments that are missed, or any scans that are missed? Are we good at getting back to people we would have hoped to see but have not seen?

Gill Walton: I have heard from our members that in fact that has been enhanced. One of the positives from the pandemic is the use of technology; there has been more virtual contact and follow-up with women through midwives and maternity services than before. That is important, and we need to keep stepping it up. While some face-to-face contacts have been reduced, virtual contact and telephone contact have been increased. That is a good thing and something to hold on to for the future.

Q3 **Chair:** We have also heard that, when it comes to Covid, there appears to be a disproportionate impact on people from BAME backgrounds. Are you worried that there could be a disproportionate impact on BAME pregnant women?

Gill Walton: We are worried about that for both women and staff, so it is both those things. It is important that women from BAME backgrounds are treated as more vulnerable than the general population, and our midwives are aware of that. Because we are a trade union as well, we are also concerned about our BAME staff, and making sure that they are seen as a slightly more vulnerable group and have local risk assessments and protection.

Q4 **Chair:** The final question from me has a certain personal element, because I was Health Secretary when we set up the Halve It campaign to halve the number of maternal deaths, neonatal deaths, neonatal injuries and stillbirths by 2025. Do you think we are still on track to deliver that, or do you have some concerns that this could blow that target off track?

Gill Walton: We do not know yet because we are collecting data at the moment; you probably know that UKOSS is collecting data on women who have Covid and the outcomes for them and their babies. We will be getting some reports from that. We have to look at it very carefully. Safety for women and babies is the priority. During the pandemic, that has been the priority, and the decision-making around how maternity services are provided has had safety right at the top of the agenda. The Royal College of Midwives has supported those changes in order to keep women safe. We will be looking very carefully at the data; and re-stepping maternity services up to what they were before, and better, is absolutely everybody's aim. I am hearing that strongly from our members.

Chair: Thank you very much indeed.

Q5 **Laura Trott:** I echo the Chair's comments, Gill, to all your members, and thank them for what they are doing at an incredibly difficult time.

I have a couple of questions about staffing and the availability of pain relief on the wards. Your sister organisation, which the Chair referred to, the Royal College of Obstetricians and Gynaecologists, said it is concerned at reports of mandatory redeployment of obstetricians during this period. Have you heard similar concerns about midwives being redeployed?

Gill Walton: We have. We have had some concerns, and in fact one of the very early Royal College of Midwives campaigns was about ring-fencing all maternity staff, because maternity services are an essential frontline service. I know of some midwives who have been redeployed because they have dual skills; they may be nurses as well and have HDU/intensive care skills, but there are not many.

We are more concerned about obstetricians and anaesthetists being redeployed, because, inevitably, that affects what midwives do and how, as a whole maternity team, they can safely care for women. Ring-fencing maternity services and maternity services staff is a really important issue during this crisis, now and in the future, and it is a key thing that we all must be mindful of.

The RCOG and the RCM have worked closely together—side by side—during this pandemic, to make sure that we are working together, and with others, to provide the best advice and support that we can to maternity teams. That has been another good thing from the crisis: it has brought us close together, which is good.

Q6 **Laura Trott:** To pick up on a point you just made about anaesthetist cover, we hear anecdotally from a number of individuals that that seems to be something that is coming up. I noted that, in a letter to chief executives on 29 April, the NHS said the priority is to make sure that there are sufficient staffing levels, including anaesthetic care, going forward. Is that something you think has suffered during the pandemic, and what effect do you think it has had?

Gill Walton: It has got better. In the initial days and weeks, when there was fear and confusion, and people were trying their best to make plans, there was some impact on epidural services, for example. I have not heard in the last few weeks from our members that that has continued to be a huge issue, and certainly care in labour has been more or less business as usual. I think access to pain relief and access to care in maternity units was initially an issue, but I have not heard in recent weeks that it has continued that way.

Q7 **Laura Trott:** That is very promising. Do you feel that there is a perception within maternity units that anaesthetic cover could have been one of the first things to go, because it is voluntary, or do you feel that there has been an emphasis on trying to make sure that that provision has been there throughout?

Gill Walton: I think there is slight confusion there because anaesthetic services—epidurals and anaesthetic for caesarean section—are not voluntary.

Laura Trott: I completely agree.

Gill Walton: For women who require epidurals for pain relief, sometimes because their labour is complex, it is not voluntary. We need to be very mindful of that and make sure that NHS trusts understand how essential it is that anaesthetists are maintained in the maternity team from a safety perspective.

Q8 **Laura Trott:** I absolutely agree. Do you think there is that understanding within NHS trusts on a uniform basis?

Gill Walton: It is getting better—as long as we all keep saying it. The RCOG and the RCM have been clear right from the start about highlighting the importance of maintaining a safe maternity service—all aspects of it—emphasising that it is a frontline service, that it cannot be stopped and that maternity services are looking after women with Covid and Covid symptoms; they do not go to another area but stay in maternity services because that is the right place for them to be. Keeping maternity services in the bundle of essential services that are protected is really important.

Q9 **Laura Trott:** Absolutely. You say in your submission, rightly, and you referred to it in answer to my first question, that maternity services should be ring-fenced. Overall, is your impression that they have been ring-fenced?

Gill Walton: Overall, they have, but going back to what we said at the beginning, there have been issues with obstetricians, particularly junior obstetricians, being moved. When junior obstetricians are moved, it means that midwives have to start doing the jobs that they previously did, which then depletes the workforce. The whole maternity team needs to be ring-fenced because they all work together with women and families, with their safety at the centre.

Q10 **Dr Davies:** First, I declare an interest as a member of the Royal College of GPs.

I want to talk about mental health, because clearly pregnancy is a very stressful time for women and their families. What do the panel feel the provision of mental health services looks like in the current scenario? Are there big gaps? Also, are there things to learn from this for the future?

Gill Walton: I can only talk about perinatal mental health. We have had reports from our members that women have become more worried. A lot of women get anxious in pregnancy anyway and I think the pathways for advice and referral have got better over recent years. During the pandemic, women have become even more anxious because pregnant women have been put in the vulnerable group, so there has been an increase in referrals to perinatal mental health services; we know that.

We are trying to bring some of the support and care back to the midwife. Every woman has a midwife, and midwives have training in supporting women who have anxiety and apprehension. They have the ability to refer onwards if they believe that a wider mental health team would be of assistance. We need to go back to those clear pathways. We need to start with women who are feeling anxious being able to pick up the phone and call their midwife, so that the midwife can make an assessment for onward referral or support if necessary.

I cannot answer about the wider perinatal mental health services; it is probably too early to say what impact there has been, but definitely the message is that the first point of contact for all pregnant women who are feeling anxious in pregnancy, particularly during the pandemic, should be their midwife.

Q11 **Dr Davies:** Indeed. There are big concerns in general about domestic abuse. How do you feel that fits into the scenario?

Gill Walton: We already know that, unfortunately, domestic abuse increases during pregnancy. We know as well that in the general population it appears that during lockdown domestic abuse and control issues have increased. That makes us very anxious about pregnant women, and it is the same advice: the midwife is your conduit for support. Because we think that midwives are able to contact women more through telephone and virtual support, it might improve access to a midwife for women who feel they are in danger and at risk. A midwife can support them and point them in the right direction so that the women get help.

Q12 **Dr Davies:** The other thing that strikes me as important during labour is to have a partner there, someone to support you. To what extent do you think that has been possible in recent weeks? Are there ways in which it can be made easier—for instance, through regular Covid testing—and how much do you think that is already happening?

Gill Walton: Right at the beginning of the pandemic visitors to NHS hospitals were banned. However, there was good support for a partner to be with a mother in labour because of the psychological support that gives. It also improves the experience of women and makes sure, especially if it is the other parent of the baby, that they have that experience together.

I am delighted that that was not changed and that women could take a partner with them in labour, unless the partner had Covid symptoms. So we then urged women to choose somebody else, to have a shortlist of people who could go with them in case their partner had Covid or Covid symptoms on the day of being in labour. It is essential that women have somebody with them in labour, and on the whole, apart from the initial days of confusion, that has happened. That has been good.

There has been huge disappointment when partners were not able to go to scans, to be in antenatal areas or induction areas or to be available in the post-natal ward. In normal times we encourage all of those things, but to keep other women safe and to keep staff safe, it has been important to support only coming in with your partner in labour. I think, on the whole, that has happened.

Q13 **Dr Davies:** Claire Murdoch, do you have any perspectives on those issues?

Claire Murdoch: There are a few things I would like to say about perinatal mental health services. The first is to echo the point about the work that midwives themselves do around supporting women who experience common mental health problems. Since last year, the entire country has been covered by specialist perinatal mental health services. Three years ago, only 40% of the country was. It is one of the areas where we have seen the map turning green and we should all be proud of that.

Secondly, we have protected specialist perinatal mental health services throughout the entire period. They have been open for referrals and they have been there to support our fantastic midwifery and primary care colleagues. It is worth saying that we have a year-on-year trajectory, so that by 2023-24 we will be seeing 54,000 women a year in those services. When we started a couple of years ago, the target was 13,000. We were on track to hit this year's 30,000 women a year, so we are seeing very positive momentum there.

Of course, like other services, we have moved to more virtual consultations, both with midwifery and primary care colleagues and with women and their partners, but we have been very much open for business and are supporting women, either through pregnancy or in the post-partum new baby period.

Dr Davies: Thank you.

Q14 **Chair:** I would like to bring in Dr Marshall from the Royal College of GPs to give a general practice perspective on maternity issues.

Professor Marshall: The role of the general practitioner in maternity care is at the beginning and the end of the process. The days when general practitioners used to be very involved in antenatal care or intrapartum care are largely long gone.

At the beginning of the process, women tend to book with their general practitioner; they come along and say that they are pregnant, and we then refer them to midwifery services or to obstetric services, depending on their risk, and that process has continued as is. At the end of pregnancy, GPs are very involved in six-week checks and we see that as being a really important part of our role. It is an important opportunity to develop a trusting relationship with the mother, to support the mother, to screen the mother, particularly for depression, as James suggested—

post-natal depression—to support the mother and encourage her to get her children immunised, for example. That is an important role as well.

At the moment, we do not have data on whether women are presenting later, either with pregnancy or for post-natal checks. Gill might have some data on the former, but we do not have any in general practice at the moment.

Chair: Thank you very much indeed.

Q15 **Sarah Owen:** I have two questions, the first relating to mental health and the second around the guidance that Gill mentioned earlier. As of last month, we were supposed to have the six-week maternal mental health launch. Has Covid-19 coronavirus impacted on the launch of that? How have midwives who have identified patients with perinatal mental health issues fed into it, and how is it going to be delivered in this continuing crisis?

Related to that is a question about health visitors. My baby was born 12 weeks ago, and I was very lucky to see my health visitor face to face; it might have been one of the last cases she had before the pandemic hit. My concern is that in 2015 there were 10,000 health visitors; in 2018, that went down to 8,000. How is it that we are able to deliver these services with fewer health visitors and possibly an increase in demand in services and a different way of working? I will come back to my second question in a follow-up if I may, Chair.

Gill Walton: Congratulations, Sarah. I cannot answer all of that because I do not know about the health visitor situation acutely, although there is an impact, obviously, on midwifery.

Going back to the six-week check and making sure that all mothers access that check between six and eight weeks—Martin may have some points on this as well—we absolutely support that visit, and midwives signpost women to make sure that they book for that appointment and get it. They will obviously continue to support women who have significant mental health issues for much longer than women who do not, so it might stretch many weeks.

What is important is the ongoing support of those women through general practice, and wider perinatal mental health services. We supported the maternal six to eight-week check; it is important for the mental health check. What I do not know, because it was launched at the beginning of this crisis, is how GPs have done with that. Martin might have some answers.

There has been a huge reduction in health visitor numbers, and we have seen the impact on midwifery support, particularly in the early post-natal period, for women who have problems and need advice and more support. It is about the availability of health visitors to do that. Going forward, it continues to be an issue in the post-natal, early parenting period, not just for normal parenting but around mental health, and the

whole team needs to work together to ensure that women get the very best support.

Q16 **Chair:** Thank you. Martin, do you want to come in?

Professor Marshall: As far as post-natal checks are concerned and screening for post-natal depression, there is a key role for general practitioners. One advantage that we have as GPs is that we know the mothers, so we know their premorbid situation, if you like; we know what their personalities were like and we can see when they are struggling, so that is a really important role for general practice.

I agree entirely with Sarah Owen on the issues around health visitors. Health visitors traditionally have been a major part of the primary care team and community services, and in many parts of the country their numbers have been decimated. They are greatly missed, both for maternity care and indeed for care of older people as well.

Q17 **Sarah Owen:** Gill, you mentioned the recent changes in the pregnancy healthcare guidance, and many of those were welcome. I raised that at the last Health Committee. What we have seen is a multi-agency response to bringing the guidance together. If Covid-19 coronavirus is going to be with us for the foreseeable future, would it be better to have the multi-agency guidance pulled together by perhaps Public Health England or NHS England for the long term?

Gill Walton: At the beginning of this crisis, it was essential that the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the RCPCH—the Royal College of Paediatrics and Child Health—pulled together to start producing some guidance at speed. The most important thing was to pool our knowledge, resource and expertise to look at the evidence and to produce guidance. Most of that guidance has been used and referred to by PHE, the NHS and actually across the world. I found recently that other countries and the WHO are using that guidance.

The evidence is the evidence, and it is important that people come together to interpret evidence to make it simpler for clinicians and the general public to see, use and understand. It has been an essential part of the crisis for people to come together to produce joint guidance and to keep updating it. Everybody has been honest that they only have the evidence that they have today, and when something else comes to light tomorrow, that evidence needs to be looked at and new guidance needs to be written; I think we are now on version 8 of the joint guidance. It is about making sure that it is a live, iterative document, using the best evidence at the time, and written in a way that people can understand and use.

Chair: The last question in this section, before we move on to cancer services, is from Rosie Cooper.

Q18 **Rosie Cooper:** Exactly what impact has there been on choice for

mothers—home births, choices in hospital? What has Covid meant to those families?

Gill Walton: I think home birth has been the area of maternity services that probably faced the biggest impact, because home birth services have been disrupted. There have been lots of reasons for that. Some services have had huge capacity issues with staffing. In London at the peak of the staffing crisis, there were 40% shortages of midwives, so heads and directors of midwifery had to make decisions about how they kept women and services safe.

The other impact has been the availability of paramedic ambulances. Staffing numbers in paramedic ambulances were reduced, so the decision to suspend home births because of midwifery capacity and paramedic capacity had to be made. Ultimately, that really upsets women who have chosen home birth as an option, and it is something we would all support as a safe and viable option for women.

The other issue, which goes back to how the NHS steps up services, is that there are other factors in how you provide safe home birth services; it is not just staffing. It is also the opportunity for midwives to risk-assess the home they are going into, and sometimes in labour they do not have much opportunity to do that. The risk assessment of the home, whether the mother or anybody else living in the household has Covid or Covid symptoms, is key, and so is the availability of PPE in the community setting, which has been an issue for midwives.

If they cannot do a risk assessment, do not have the right PPE and then do not feel safe to care for women in a home situation, that all has to be taken into account when decisions are made to step back up to delivering a home birth service. We know that that has been a thing that has hugely upset women, and midwives, but it is about making sure that everybody is safe—the women, the families and indeed the staff caring for them. It will continue to be an issue while services are being stepped up.

Q19 **Rosie Cooper:** How quickly can we address those choices in the future, as we come out of lockdown?

Gill Walton: It goes back to what we were saying in our submission: it will rely on the right number of staff, the capacity of paramedic ambulances, the availability of PPE in a community setting, training and education for those staff to use it safely, and testing—not just testing for patients going into acute services, but testing of women in the community who want to have their baby at home. That has to go into the priorities for testing, as well as acute services. All those things need to be in place for maternity services to offer home birth safely as a maternity choice.

Q20 **Chair:** Thank you very much, Gill. There may be lots of people watching this session at home, and I wondered whether you had any direct message for pregnant women or even new mums—there may be one

sitting in No. 10 Downing Street, who knows?—who would like to hear from you. Is there anything you particularly want to get across during this pandemic crisis?

Gill Walton: The key message is that maternity services are open; midwives and obstetricians and the wider team want to hear from women, particularly if they are worried; and they must access their normal appointments, either virtually or in person. It is really important that women tell staff if they or any of their family have Covid symptoms, so that we can protect staff.

I want to end by saying thank you to the maternity teams. They have been amazing. Despite a pandemic crisis, there is still joy; there is still joy of babies being delivered, and people appreciate that. Next Tuesday is International Day of the Midwife, and our members have told us that they want to celebrate the joy of birth and midwifery, so that is what we are going to do. Big thanks to everybody.

Q21 **Chair:** Thank you very much indeed for your time, and we certainly echo the thanks to all the midwives and everyone working in maternity departments up and down the country. Thank you for that.

We are going to move on to the next part of our discussion this morning, which is about regular NHS services and how they have been affected by the coronavirus epidemic. As I mentioned earlier, we have as one of our witnesses Dame Cally Palmer, who is the national cancer director for NHS England. I had the great pleasure and privilege of working with Cally when I was Health Secretary. We are very grateful to you for giving up your time this morning.

Could I start by asking you a few data questions so that people can understand what the score is? I hope we gave you some advance notice that I was going to ask you these questions. First, Dame Cally, what is the latest data on the national reduction in urgent two-week cancer referrals as a result of coronavirus?

Dame Cally Palmer: In the week commencing 20 April, for the urgent referral pathways—the so-called two-week wait pathway—there was a reduction of 62% on pre-pandemic levels. We had just under 15,000 people booked for an appointment, and clearly it is very important that we address that 62% reduction because early detection is vital for improved survival.

Q22 **Chair:** Does that mean that, theoretically, we could be missing up to two thirds of the cancers that we were catching before?

Dame Cally Palmer: No, I do not think that is the case. There is roughly an 8% conversion rate for urgent referrals, and I know some modelling has been done by Cancer Research UK. It is important to state that urgent referrals and urgent cancer treatment is continuing. Obviously, we need to tailor that to the patient's individual risk, but it would be wrong to make a mathematical calculation on that basis. It is very important that we get people coming forward, but to translate that into

misdiagnosis and poor survival would not be a responsible position at this point.

Q23 **Chair:** It is too early.

Dame Cally Palmer: Yes.

Q24 **Chair:** What about the drop in chemotherapy appointments?

Dame Cally Palmer: Broadly, chemotherapy appointments are running at about 70% of normal levels, and we think we can step them back up very quickly because, of course, they use different facilities and workforce, broadly, from surgery and the other resources required to respond to Covid-19. Chemotherapy is running roughly at 70% of normal levels. People are being careful about making sure that they manage individual risk for patients. That is not about absence of treatment capacity; it is more to do with making sure that we manage risk for individual people.

Q25 **Chair:** Could I ask you about the UCL analysis that you will have seen earlier this week? Basically, it says that, when you combine the impact of late diagnosis with the higher vulnerability of cancer patients who are immunosuppressed, there could be an additional 18,000 cancer deaths. Bearing in mind what you have just said, we do not want to make the mistake of overpredicting numbers, but do you think that could be a ballpark number as to what we could be looking at in potential additional deaths?

Dame Cally Palmer: Again, it is important to be careful about the basis of that modelling. What the UCL team was principally looking at was the impact of Covid on cancer patients and comorbidity. What they were not really looking at or evaluating in their modelling was lack of access to treatment capacity resulting in cancer deaths. It was much more to do with the relationship between Covid-19 and patients who are more vulnerable because they have cancer. While that was interesting and useful modelling, you cannot relate it to absence of treatment capacity.

Q26 **Chair:** None the less, even though it is not to do with not being able to get treatment, there could be thousands of additional cancer deaths because of the combination of coronavirus and cancer.

Dame Cally Palmer: It is really early to make those assumptions. It is very important that we do proper modelling and use that to manage our response in the restoration of all cancer services. It would not be the right thing to make that assertion at this point.

Q27 **Chair:** Can we go back to the question of the immunosuppression of people with cancer? It is vital, as normal services start to resume, that people do not catch Covid in a hospital environment. Thinking about the normal chemotherapy wards or the normal interactions someone would have if they were going in for radiotherapy, are you going to be introducing social distancing inside hospitals to try to reduce the risk of

anyone getting infected while they are having their cancer treatment?

Dame Cally Palmer: The key thing to manage the restoration safely of cancer treatment, beyond the essential and urgent treatment we are doing currently, is to make sure we can maintain what we call locally Covid-light or Covid-negative environments. Between NHS capacity and independent sector capacity, it is making sure you can segregate workforce and available treatment space, so that patients can be looked after safely as we move through.

We have to work on the principle that Covid is here to stay for some time in some proportion, so the key is making sure we have designated treatment capacity that is Covid-light or Covid-negative. That is very important for cancer patients. That is indeed why we developed the cancer surgery hubs across the country in this first phase, to make sure that patients can be treated safely through those hubs. With that, of course, goes pre-op testing—testing of staff and testing of patients—to make sure that we can maintain that capacity safely for all our patients going forward.

Q28 **Chair:** Professor Karol Sikora has been expressing concerns about access to proton beam therapy, and you kindly responded to a letter that I wrote to you expressing some of those concerns. For the record, can I confirm that proton beam treatment at the Christie is being made available to all children who would benefit from it when it was clinically appropriate?

Dame Cally Palmer: Yes, that is absolutely correct.

Q29 **Chair:** Thank you. The last question from me is a slightly more general one. When you were not thinking about coronavirus, you were spending a lot of time thinking about how we are going to increase the proportion of cancers diagnosed at stages 1 and 2 to 75% by 2028, which would go a long way, if not entirely, to closing the gap between our cancer survival rates and those in France and Germany. Do you think coronavirus could knock that off track, or are you still very hopeful—it is a long way off—that we should be able to meet that target?

Dame Cally Palmer: I am very hopeful, because what has been amazing through all the difficulties and challenges of this period is the way people have adapted models, both in diagnostics and treatment, to manage patient pathways efficiently. We need to keep some of that learning going into the future, so I am still optimistic that we will meet those targets over the term of the long-term plan because it is crucial for our cancer patients.

Chair: Thank you very much indeed.

Q30 **Amy Callaghan:** Thank you, panel, for answering our questions today. I have two general questions around cancer care and then one that is more specific to young persons' cancer and the supportive care that they receive. First, what guidance is being provided for patients eligible for cancer surgery who test positive for Covid-19 on how long they may have

to wait for their surgery to be reconsidered?

Dame Cally Palmer: We have issued a series of guidance to the system, both primary care and secondary care, particularly on managing coronavirus during this period and surgery for patients. Essentially, for cancer surgery, we are prioritising the most urgent treatments and making sure that when treatments are either rescheduled or changed in some way—in some cases people have, say, radiotherapy rather than a surgical procedure—we encourage both the clinical teams and the patients to have a dialogue about those treatment changes so that people feel supported and they have proper information about their treatment pathway.

We are also safety-netting patients. When they have to be rescheduled—if, for example, their surgery or the procedure is either not super-urgent or when it is considered, on balance, to be too risky to bring them in—we make sure, both through GPs in primary care, and through patient tracking in secondary care, that we safety-net everybody so that we can reschedule them and we do not lose people to the system. We have issued a series of guidance to both primary and secondary care about the management of those pathways. We have also been working very closely with cancer charities on messaging to patients to try to ensure that people talk to their teams or to their GP if they are worried.

Q31 **Amy Callaghan:** How does NHS England intend to deal with the backlog of pancreatic surgery cases, particularly in cancer alliances?

Dame Cally Palmer: A letter has just gone out to the system to talk about the next stage of restoring and recovering cancer treatment. The important thing about that is to create, on a longer-term basis, the role of cancer surgery hubs and designated diagnostic capacity, so that we can manage any pent-up demand and manage patient care safely. The key point about the cancer hubs, apart from designating safe capacity that is Covid-light or Covid-negative, is making sure that we prioritise CCU beds, in-patient beds and theatre sessions to make sure that we can deal with that demand as we move through the next few weeks.

Q32 **Amy Callaghan:** That is really helpful. Moving on to cancer in young people, Teenage Cancer Trust has heard from young people with cancer that aspects of their supportive care have been disrupted, and that includes both access to mental health services and fertility preservation. What can be done to ensure that young cancer patients can access those non-emergency but often life-changing services during and after the Covid pandemic?

Dame Cally Palmer: Through the national team we are working with the cancer charities, including Teenage Cancer Trust. We have a call every fortnight with over 50 charities, including all the children's and teenagers' charities, to talk about messaging, and about where patients go for support, if they are not accessing as they should be doing the wellbeing and support for them as they go through their treatment. There is a lot of

work going on with all the cancer charities about messaging and about making sure that people know where to access support and help. It has been heartening to see how the cancer community is operating together to support patients and get information out. That has been a really important thing in managing that part of our work.

Amy Callaghan: That is much appreciated, thank you.

Q33 **Dr Evans:** I have a few questions around modelling particularly, which you have mentioned several times in your answers, Dame Cally. I am very pleased to hear that cancer treatment is all about modelling and what is going to happen in the future. I spoke to my trust and CCG yesterday, and they are looking at how to model versus Covid capacity and normal capacity, and what to do around it. Can you talk me through what conversations you have had with the Government about how you are being used to model what is going on?

Dame Cally Palmer: The main conversations are through the cancer alliances rather than directly with Government, and actually working with all the cancer alliances and with clinicians at the major cancer providers to think about how we structure and segregate Covid-negative and Covid-positive capacity. What has made that manageable in terms of modelling and providing that capacity for patients is to have a central clinical triage point, to think about prioritisation, and matching the patient, the available capacity and the clinical team. That sort of central triage is really important. In my local cancer alliance, we have had 30 clinicians across 10 hospitals dealing with the prioritisation of patients and the placement of patients. Having IS capacity is crucial because it means that we can manage.

In my own organisation at the Royal Marsden, we have managed to have less than 20% of our facilities for Covid-positive patients, meaning the rest of those facilities plus the IS capacity can be used by all the teams around west London for urgent cancer surgery. We are working across wide boundaries, managing clinical teams and matching patients and clinical teams to available capacity through that central triaging system. Modelling is important to make sure that we have the right capacity going forward. In my local alliance, we have had about 500 patients going through for cancer surgery in the last three weeks through the hub.

Q34 **Dr Evans:** If I can top and tail that, are you getting any more data, which is so important? Across the world, people are trying to work this out, and any more information that can improve the modelling can help. So, from the top down, are you getting anything from the WHO, or indeed across the world, to help your modelling? From the bottom end, the regional aspects are trying to work out what they should be doing and saying, "If we get sight of modelling, we are going to be able to give much better, more reactive and proactive responses in dealing with things like cancer, and Covid treatments as well, as capacity is going to flux up and down."

Dame Cally Palmer: We have been doing some modelling and providing data for all our 21 cancer alliances nationally; we have been doing modelling with them. We are working with academic groups on modelling what we should expect to see over the next few weeks so that we can make sure that the service is set up to respond properly. In terms of service models, the cancer hub model is very much drawn on information from intensivists in Milan, Italy and, actually, China. If you want to keep cancer treatment going, the crucial thing they taught us, which we were then able to follow quickly, is to designate clean cancer capacity, particularly for surgery, because that is the draw. A lot of cancer patients require critical care post-operatively and it is exactly the same resource that is required to treat patients with Covid.

Q35 **Dr Evans:** There is one final question from me, and it is a completely different topic. There are good-news stories to come out of a crisis: in GP work, telemedicine is really important, and we have just heard that in antenatal care we are getting more contact. Are there any good-news stories on the cancer side where you have gone, "Gosh, we really want to hold on to this going forward"?

Dame Cally Palmer: Yes. The first thing is on setting up the cancer alliances. We have been trying to flex demand and supply for a while and we are doing it now across organisational boundaries in a way we have never done before. In my own hospital we have had about 10 different hospital surgical teams operating, because it is the cancer base, and very good feedback. I had a lovely letter from a patient this week saying it was brilliant: "I had St. George's surgeons working at the Royal Marsden theatres with follow-up in my local community. It was seamless and it was brilliant, and it meant my surgery could go ahead."

The way in which the central triaging has worked for patients and the flexing of demand and supply across a wider catchment beyond organisational boundaries has been great. The clinical relationships are amazing; normally, people stick to their knitting in their own organisations, and they are absolutely not doing that.

Some of the work we are doing to modify patient pathways, particularly telemedicine for out-patients—modernising the way we run out-patient models—has suddenly happened. We are doing stratified follow-up now much faster than we thought we would so that patients can be supported at home rather than having to come in for umpteen follow-up appointments. We were partway down that pathway, but it has kind of happened overnight.

I thank all my colleagues, both our supporters from the cancer charities and NHS staff: they have been absolutely amazing, very flexible and courageous in the work they have been doing to change models and deal with what they need to deal with.

Taiwo Owatemi: I only have two questions to ask. *[Inaudible]*

Dame Cally Palmer: I cannot hear.

Chair: We are struggling to hear you, Taiwo. I will move on to Rosie Cooper and come back to you, Taiwo, when we have, hopefully, got the sound sorted out.

Q36 **Rosie Cooper:** I would like to ask Dame Cally this. The Prime Minister yesterday gave a commitment that people would get the cancer treatment they need. To quote, he said, "Let's be absolutely clear about that." We know that has not been the case for the last six weeks and we were struggling before that. I heard the comments you have made about sending letters out through the system, but what is NHSE doing to assure—not just reassure, not warm words—that the PM's commitment will be kept?

Dame Cally Palmer: It is not about letters and guidance, as you rightly say. That is only a tiny part of the whole picture. What is really important is the work we are doing with all our cancer alliances to look at how we step up cancer services. We have twice-a-week calls, and we are working with the alliances on how we get patients through the system and how we restore cancer surgery that has been delayed. We have been prioritising patients with urgent and life-threatening conditions, and now we need to restore it for patients with less urgent surgical conditions. We have a programme of restoring that surgery.

As I said, for chemotherapy and radiotherapy we think we can step back up to normal levels very quickly. We are working with the alliances and assuring ourselves about the numbers that are going through. The first treatment figure, I think in west Lancashire, is at 86%. The figure for patients going through first treatment is 86% of pre-Covid levels, so we have a way to go, but we are determined to make sure that we have a restoration programme in place.

Q37 **Rosie Cooper:** The *HSJ* reports today that restarting services is going to be much more complicated than stopping them, especially with the lack of rapid testing and tracking, and that will hamper those efforts. An additional part to that is, how will workforce shortages affect our ability to deal with the backlog?

Dame Cally Palmer: We have obviously been dealing with and contributing to the NHS People Plan in the medium term, but short term with the workforce it is very important. The letter that went out to the system yesterday talks about prioritising designated diagnostic capacity for cancer and hubs for cancer. There is a huge amount of work going on, as you know, to bring returners back, to accelerate students through the system and to make sure we have the workforce more generally. In cancer, the designation of priority capacity for cancer patients, both for diagnostics and for treatment, is clearly going to be very important.

On cancer surgery, I think we can step back up with the available capacity and the hub model that has been established. It is working in 14

out of 21 cancer alliances, and the rest are ready to go. With cancer diagnostics, we are going to have to work on modified pathways to ensure that we can get all patients back through the system. As you say, that is going to be more complicated than just turning it off. We are doing essential cancer diagnostics, but we need to make sure that we have protected capacity for endoscopy and other cancer diagnostics going forward.

We have also bought in about 35 CT scanners, which are very important for cross-sectional imaging in cancer. We have additional independent sector capacity in CT scanning. We bought in 35, and I think we are due another 35. Workforce is key. Workforce is prioritised, and we will be working more efficiently with modified pathways for diagnostics and treatment to make sure that we can get those patients through.

Q38 **Rosie Cooper:** Radiographers report that unused machine capacity has increased fivefold, with some machines not being used for six hours a day, and a third of frontline staff felt that they did not have the appropriate levels of PPE; one radiographer said that street cleaners in China had more PPE than they did. Do you think that radiotherapy has been overlooked in the crisis, and that lives could be saved in the longer term if we could use the machines more?

Dame Cally Palmer: I do not have concerns about radiotherapy, actually; I am more worried about cancer diagnostics and stepping those back up. Radiotherapy is a very precious but very specialised workforce, and radiotherapy, broadly, is running at not much below normal levels. For imaging, I think we have the available workforce and now the available kit, so I think we should be okay. I have not heard about the thing you have just reported on, the down-time of machines—that is new—but I will look into it. It has not been reported to me as an issue in getting treatment and diagnosis back up and running.

Chair: Thank you. I would like to move on and try Taiwo again. Taiwo, have a go and see if you can ask your question.

Q39 **Taiwo Owatemi:** Thank you, Chair. I only have two questions. The first question is on clinical trials. What challenges are clinical trials teams facing, and how are they adapting to ensure that patients' treatments are not affected during this crisis?

Dame Cally Palmer: With clinical trials it is important to say that at the moment recruitment to new trials has stopped but existing trials are still running. My assessment would be that we can get clinical trials up and running again by mid-May, so I think we can move on R&D. Initially, we were concerned about footfall and about managing risk for individual patients. Existing trials are running, with support in place from the normal research teams. It was access to new trials and recruitment to new trials that was halted. We think we need to turn that back on in the next phase.

Q40 **Taiwo Owatemi:** One of my constituents highlighted that she was concerned that her trial had been delayed by a month. I want to confirm if that was true, and what we are doing to ensure that those treatments continue.

Dame Cally Palmer: If someone is on a trial, their treatment should not have been paused unless there was an individual clinical assessment that it was too risky for her to come in. If it was about risk to the individual, that might have been a reason why she would have been paused. If not, her treatment should have continued as normal on a trial, if she was already on the trial.

Q41 **Taiwo Owatemi:** Thank you for clarifying that. My next question is about radiotherapy. Due to the outbreak of Covid-19, some cancer patients are unable to have surgery or chemotherapy. What assessment has the NHS made of using precision radiotherapy treatments to improve the outcome for cancer patients?

Dame Cally Palmer: We had done a lot of work nationally in investing in precision radiotherapy, pre-pandemic. What individual clinical teams are doing, including an assessment through some of the hubs where they are looking beyond surgery, is looking at what treatment modality would be right for individual patients. We are finding that, rather than having surgery, someone might have radiotherapy instead. There are substitutions where that is felt to be in the patient's best interests, but I think precision radiotherapy is continuing and is clearly a very important part of our treatment for patients.

Q42 **James Murray:** Thank you very much for your answers so far, Dame Cally. I want to ask one question, with potentially one follow-up. We focused quite a lot on talking about treatment, and I know that the cancer hubs are being developed to offer safe locations for cancer treatment. I would like a bit more information from you about when we think screening and diagnostics will all be fully resumed too.

Dame Cally Palmer: As you know, there has been no national instruction to pause screening, but I think there has been local decision making about levels of risk for patients. What is incredibly important is to make sure that rescheduled screening takes place. In particular, I am concerned that we get bowel cancer screening back in place. We are doing treatment for fit positive patients currently, but it is important that we make sure that screening methodology is available in the normal way. Things like bowel cancer, as you may know, are very slow growing, so if there is a four-to- six-week rescheduling, it should not affect survival, but it is very important that we continue our big screening programmes for cancer.

There has been no national instruction to pause, but various decisions have been taken about resource and risk to individuals, so we need to get that turned back on. It is a priority, and a letter has gone out to the system to confirm that.

Q43 **James Murray:** Once screening programmes are restarted, you would assume that there would be some pent-up demand because of the reduction of services in the meantime. I would like to ask, first, whether you have done any estimates about the extra funding or resources that will be needed to ensure that pent-up demand can be met.

Secondly, when the Health Secretary talks about non-Covid NHS services being restored according to local Covid-related demands on the system, how do we make sure that you are restoring other services so that areas with a high level of Covid do not miss out?

Dame Cally Palmer: We are assessing the resource requirements now. We are thinking about the next stage—phase two—restoring screening and cancer treatments beyond where we have been for the last four to six weeks. We are working out the resource required for that now, including the extension of things like the IS—independent sector—capacity and what we need to make sure that we can resource that demand.

The letter that talks about the priority for cancer diagnostics and cancer treatment went out this week. That is going to be important. At the moment, we are looking at the resourcing required to make sure we can have a unified restoration and recovery programme to pre-pandemic levels at this point. The short answer is that we are working on the money at the moment. It is under way.

Could you remind me of your second question, please?

Q44 **James Murray:** It was on the comments the Health Secretary made earlier this week around non-Covid services being restored according to local Covid demands on the system; it would vary by local area depending on what the Covid demand is. How do we ensure that people who live in areas where there is high Covid demand do not miss out on non-Covid services being restored?

Dame Cally Palmer: We are making sure that we have capacity that is modelled across all our cancer alliances. Our 21 alliances across the country are looking at what the requirements are for restoration of activity and how they can manage the segregation of Covid-positive and Covid-negative capacity between their local NHS hospitals and their access to independent sector hospitals.

The important thing is to make sure that we have understood what the requirements are and that they have plans in place. We have sent out and discussed principles with them for making sure that those hubs are fully operational and that we can start to manage the diagnostic pathway for the restoration of cancer treatment.

Q45 **James Murray:** So, just because a particular area has a high level of Covid, they won't miss out on the restoration of non-Covid services.

Dame Cally Palmer: No, they absolutely will not. It is very important that we look at unified access and equality throughout the system, and that we have the capacity, the workforce and the pathways in place to do that. The neat thing is that by having cancer alliances, which include secondary care clinicians and primary care, we have systems to look at how they are going to manage that in each community. There are some local differences in how they want to set the hub up, but the principles are the same for the work that has to go through, which is to restore and then to recover to pre-pandemic levels.

Q46 **Chair:** Thank you very much for those answers, Dame Cally. Just as we did with maternity services, I wonder whether you have a message to cancer patients. One of the most worrying things that can ever happen to you is to have a cancer diagnosis, but to have it at the time of a pandemic is doubly or triply worrying. Is there a general message you have?

Dame Cally Palmer: Yes, thank you, and thank you to the Committee because this raises the focus.

It is incredibly important, if people have signs or symptoms that they are worried about, that they come forward. You will be treated safely. It is very important that you do so. Please do. Staff are there to look after you. It is very important that cancers are detected early, because that gives you absolutely the best chance. Giving people confidence and reassuring them that they should come forward is really important. That is the key message, so that we can give people the best outcome.

Q47 **Chair:** Thank you very much indeed. That is much appreciated. We are now going to move on to the third area of focus this morning, which is the impact of coronavirus on mental health treatment. We are very happy to have with us the national mental health director for NHS England, Claire Murdoch, someone else I was very lucky to work with when I was Health Secretary.

There is obviously a huge number of areas one could focus on when it comes to mental health—children, adults and frontline staff. There are mental health issues that were pre-existing when the pandemic struck, and mental health conditions that have been precipitated or caused by the pandemic.

Claire Murdoch, I want to start by asking you about young people's mental health, which I know you are particularly passionate about. Obviously, a lot of referrals to CAMHS previously came through schools. Have we seen a reduction in CAMHS referrals as a result of the lockdown?

Claire Murdoch: It is really good to be here today talking about mental health, so thank you very much.

We have seen a reduction in referrals to CAMHS services. It is important to say that CAMHS services have been open for business throughout the pandemic. They have focused on maintaining care, treatment and access

for those known to us, and emphasising that, yes, we want to see new referrals. Clearly our referral routes have been disrupted—schools, somewhat in primary care and A&Es. There are various routes by which youngsters might come to us.

What have we done to try to counterbalance some of that during this period? I pay tribute to my mental health colleagues, whose work has inspired and awed me over the last few weeks. One of the things we have done to try to help counter any difficulty in new referrals coming through is to move at pace to bring forward from 2023-24, which was in the long-term plan, all-age 24/7 crisis services.

On 3 April, I wrote to my colleagues across the country: "Please bring those plans forward from 2023-24 to now." We did the same for adults. We were due to have country coverage by this time next year for adults 24/7. Within a matter of weeks we have what I think is probably 98% of the country now covered with those 24/7 services. It seemed to us to be important to anchor that—

Q48 **Chair:** Is that adults and children?

Claire Murdoch: That is adults and children, all-age services, and for older adults. We looked at our long-term plan and re-ordered priorities in the context of Covid.

We are concerned about the drop-off in new referrals. We urge everybody to come through the emergency routes or primary care if they do not know where else to go. We are giving new referrals a big focus currently.

Q49 **Chair:** What sort of drop have you had in referrals? Can you give us a ballpark figure? Cally was telling us that chemotherapy is down 30%.

Claire Murdoch: It is ballpark, because we are not seeing the data yet. We are still living in the midst of the crisis, as you know. We think it will be somewhere between 30% and 40%. There are some areas of the country that say they have not seen a drop-off at all. Other areas say there has been a greater drop-off.

We are trying to understand whether there has been a correlation between a drop-off in referrals and the intensity of the virus as it has moved to different parts of the country. One of the things we are hearing is that there has been a change in behaviour. Everybody is hunkering down; home feels safer. People are not wanting to go through the usual referral routes or perhaps think that we will not be there. We are trying to understand why there is variation across the country, as far as we can understand it.

Q50 **Chair:** Sticking with young people for a moment, Claire, I heard that the raw data for suicides shows that, sadly, there was a spike in the first two weeks of April. This is just raw data, so you cannot over-interpret it. In terms of under-18s suicides, it may be two or three times higher than this time last year. Do you have concern about suicides? Is there

anything you can do to try to head that off?

Claire Murdoch: There are a couple of things. There is absolutely no evidence currently that we have seen a spike in suicides or self-harm. That evidence does not sit there yet. I checked this last night with our national and international experts. We absolutely have not seen that.

We are working with Public Health England on realtime surveillance. They have rapidly been developing a tool and a process for gathering information from various sources to see whether we are seeing an increase in self-harm or suicide among youngsters. That realtime surveillance piece is incredibly important.

That said, we are pretty certain that levels of distress, anxiety, worry and depression will have increased for children and young people during this period—there have been various studies—as we have seen for adults as well. Everybody is more worried. Lots of people are sleeping less. Lots of people are worried about all kinds of things, but it is very important that we do not succumb at this stage to a narrative about massive spikes in suicide. It is important that we are very responsible in how we understand the evidence.

It has been important to us to open those 24/7 services across the country. We are working closely with schools. Even though they are not open, they know the families and youngsters they are most worried about. We know that they are making every attempt to stay in touch with youngsters they are concerned about, as are local government and as are we.

Q51 **Chair:** If there has been an increase in distress, are you planning for a surge in referrals after lockdown is lifted?

Claire Murdoch: Yes. To go back to the long-term plan, on average we are seeing about 370,000 children and young people a year, and we had intended in any case to increase that by an additional 340,000 a year, almost a doubling of access. We had plans in place to increase the workforce. In fact, the children's workforce has increased by 20% over the last two years anyway. We have seen 750 new mental health support team therapists recruited, trained and in place, with more in the pipeline. What we are going to do is adapt our long-term plan, which is a good one, and make sure it stands solid at the moment.

I wish the world were watching this Select Committee; I am sure they will be, Chair—

Chair: They may be.

Claire Murdoch: Let's hope they are, because a really key message to anyone listening is that we are recruiting. We have been recruiting throughout this pandemic, and that has not stopped. We have great employment opportunities in mental health, including in children's services. We are adapting and strengthening our long-term plan now.

We are working with national and international academic experts, the Department of Health and Social Care, Public Health England, service user networks, the third sector and others to take an expert look now at what we might anticipate by way of need coming through over the next few weeks and months. In fact, we know that with trauma in particular it will be years.

We know from our Grenfell experiences that not all need for clinical services materialises at the time. Indeed, there is a very long tail on demand in trauma. Currently, we are working with national and international experts to help us model what, in addition to the long-term plan growth, we need to factor in. Some of that will not just be about the NHS. There will be big factors that affect how not just children and young people's mental health fares over the next few years but all our mental health, whether it is employment or the economy.

Might I say that I find the rather binary discussion about whether it is health or whether it is the economy to be somewhat frustrating? We know that there is a big correlation between economic prosperity, employment and so on, and good mental health. We are modelling it through, but meanwhile we are driving the implementation of our long-term plan very hard indeed.

Q52 **Chair:** I want to ask you about another group, moving on from young people. We have been very conscious of the stress that frontline staff have been under and, indeed, the trauma that they have been under on occasion. Are you planning for extra help for staff with PTSD and other conditions that may emerge as we go through this crisis?

Claire Murdoch: We absolutely are. As with everyone else, I pay tribute to NHS care staff and other frontline workers across the country. I have worked in the NHS for 37 years and I am very proud of the health service, but I have never seen anything quite like this.

Staff are coming to work and delivering high standards of care when they may be frightened for themselves, their families and communities, as well as being very worried about their patients. We know it has been a high-stress environment, and we are planning for wellbeing, resilience and mental health support for staff right now. In fact, we are delivering a lot more right now.

I am keen to emphasise three things. First, all the evidence shows that the best thing you can do for staff mental health right now resides within teams and how teams operate, with good supervision, good debriefs at the end of every shift, remembering to think about what went well and remembering to help staff go home at the end of a shift having talked about anything they are concerned about. It is about making sure they are getting sleep, rest and down-time. We are trying to reinforce good team behaviours. The military are very good at that, and there is a wealth of international expertise.

Secondly, all trusts and organisations across the country are investing more in their occupational health and mental health support. We know that there has been an increase in staff accessing those services. Thirdly, we have invested in national 24/7 helplines with the Samaritans and the third sector. You have to keep thinking about those three tiers or levels of support.

The last thing I would like to say, which is very important, is that last year our IAPT services—psychological therapy services—saw about 1.1 million people. We have committed in the long-term plan to see an additional 750,000 people a year by 2023-24. Again, there is a big growth area in counselling and support for the population.

Over the last six to eight weeks, thanks to my team, colleagues across the country and Professor David Clark, we have been looking again at the training of IAPT therapists and running online sessions for them. The last one was last week; 1,500 therapists were online being taught how to re-gear their treatments around PTSD and some of the fall-out from Covid. We are running that webinar teaching session throughout May and June. We have put seminars online through the future forums platform that we have established. We are looking at re-gearing the services we have, both for staff and the wider population.

Q53 **Chair:** Lots of colleagues want to come in, but I must ask you about funding. In the long-term plan, mental health funding is going up an additional £2.3 billion a year by 2023-24. I want to check that that is still the case and that we are on track to do that. Maybe you think you need additional funding because of the coronavirus impacts that you have just been talking about, but, most importantly, is that funding still on track? How are we doing on the mental health investment standard, which says that the proportion of NHS funding going into mental as opposed to physical health will continue to increase year on year?

Claire Murdoch: First, on the principle of the investment standard, the commitment to higher investment in mental health and the investment standard, whether it is from Government, Simon Stevens or Julian Kelly—the finance director in the NHS—stands rock solid. We have been meeting it in the last few years, so there has been an upward trajectory in investment.

We have not seen the year-end accounts for the financial year just ended, nor will we for a few months. I think accounts are laid before Parliament in September. Obviously, we have had the interruption of the last six weeks. What we know is that, in planning this year, there is the out-turn of last year plus a 2.8% inflationary uplift for contracts this year, plus whatever the gap was between that 2.8% and what we needed to do to meet the investment standard. Julian Kelly and Simon Stevens wrote reiterating that in planning this year.

I speak constantly with my chief executive colleagues. We meet weekly virtually during this period. I am not aware of any funding flow problems

whatsoever. Quite the opposite. The Government promised that if we needed resource during this Covid period to help us adapt to the crisis we would receive it. I have not heard from any chief executive that that has not been the case for mental health as well.

Chair: That is very encouraging. Four colleagues want to come in, and I would ask you to be fairly brief because we have to finish at 11.30, and I want time to ask Dr Marshall some questions as well. That was directed to my colleagues, Claire, not you.

Q54 **Dean Russell:** I had two broad areas of questions that I promise to keep brief. The first one, around staff, has been covered in part. One of the things I am very conscious of is that there are real, serious levels of anxiety for staff and for their families.

One of the things that has happened in my constituency in Watford has been fabulous. Watford football club, luckily, is next door to the hospital. It has set up a sanctuary where staff can go throughout their shift and during their breaks to get support and respite from it all. Has a similar facility been looked at for rolling out across other hospitals in the UK, especially during the current crisis?

As part of that, longer term, I want to get a sense of how you are supporting the families of staff. Their anxiety levels for their family member who is going in every day to the hospital must be incredibly high. Our doctors and nurses are incredibly brave, but so are the porters and the cleaners. I want to make sure that they are all covered.

The second broad question was around tackling specifically the impact of loneliness. I know it has an impact of the equivalent of 12 to 15 cigarettes a day in terms of smoking. It has a real physical health impact. I think that in this society loneliness should have no place to hide. Looking forward, how are we dealing with that and its impacts during this time?

Claire Murdoch: First of all, in terms of staff, NHS trusts across the country are looking at creating sanctuaries, whether within the hospital or through partnership with others. One of the best things we can do for families is to have our staff going home from work saying that they felt well supported, they had good access to things like PPE and they felt safe and listened to. That is incredibly important.

The narrative is about our NHS and other heroes at the minute. They are heroes; they are courageous because they are coming to work when they are frightened. We need to be sending them back home to their families so that their families know we are looking after their loved one—our employee and colleague—and that they have the right access to PPE. We have been focusing very hard on that.

We have not set up a bespoke service for families, but I reiterate some of what I said earlier about mental health services. They are open for business. Primary care is open for business. If families are worried, they can make contact with GPs, mental health services and others, but the

best thing we can do is send our colleagues home with the support, PPE and everything else they need.

Q55 **Dean Russell:** Could we potentially look at how we can advise families on the communications bit? I think families need to be given specific advice. It is their family member—husband, wife or mother—who is going into that scenario. It is important to make sure that families are aware of that. It would heighten the anxiety for frontline staff when they went home, knowing that their families are worried about them. I wonder whether that could be something more specific.

Claire Murdoch: *[Inaudible]*

Chair: We seem to have a technical hitch. We lost you for a moment, Claire.

Claire Murdoch: We will take that suggestion away and look at whether we need to do something more systematic for families. I was saying that there are some lovely examples of trusts that have reached out to families, but I do not think it has been a national effort. I will take that suggestion back.

We know that the impacts of loneliness on physical and mental health can be severe for many. One of the good things about this crisis is that right across the country mental health services have been running their own radio stations for service users and their families to dial into. My own trust today is running its radio station programme for two hours this afternoon for people to dial into.

Trusts across the country have been running online groups, whether for people recovering from addiction, older people or people with serious mental illness. We have rapidly exploited the technology. In mental health, we have achieved in days and weeks what we were planning to do over three or four years. Although it is not a substitute for human interaction, there were many people, particularly elderly people, who were not leaving home much before and who are being given a great deal of support now through technology.

We also have a big NHS volunteering programme. A key part of that volunteering programme is phoning people every day. We are looking at who needs a call every day.

Q56 **James Murray:** I want briefly to return to the issue we spoke about earlier: mental health for young people. It is very much at the front of my agenda because in my first few months as an MP I went to a mental health summit run by young people in my constituency. It was really impressive, and they were all very clear that as well as investment in mental health services what they wanted was a clear way of accessing them.

As we discussed, there are particular difficulties with accessing those services at the moment, with many children and young people unlikely to

be at school for the time being. Could you give us a bit more detail about what you are learning from the current situation about improving access to mental health services for young people in the future?

Claire Murdoch: One of the things we were working on and that is absolutely central in our long-term plan was improving access. Indeed, we were setting ourselves some ambitious access and waiting time standards that we were piloting across the country. We have all heard the stories of youngsters sometimes having to wait 18 weeks or longer to access care. We were trialling, and still are, four-week access time standards. In fact, we think that, where referrals have been made, access has happened a lot more quickly because we are able to see more people through digital routes.

I mentioned the 24/7 all-age services, with children and young people very much included, that we have set up and that have gone live pretty much across the whole country, with two trusts still to go in a few weeks' time. They were not due to be live until 2023-24 and they are live now. That is because colleagues in particular have been concerned to make access easy.

We are working with the third sector. There are lots of routes to us, whether it is through the Children's Commissioner and her team or YoungMinds and others. We are working closely with other agencies so that if they pick up youngsters they are worried about in primary care they know how to divert and refer to us.

We had good momentum around trying to improve access. It was at the heart of the long-term plan for children and young people. We have brought forward by three years our 24/7 crisis and emergency services pretty much countrywide, or soon to be, and we are working closely with other colleagues on the referral routes to us.

Q57 **Taiwo Owatemi:** I have two questions. One is on capacity post-crisis and the other is on the elderly population. As you are aware, post-crisis there will be severe implications for our population's mental health. This is due to the lack of social interaction, and of anxiety, bereavement and trauma support during the crisis. Is there capacity post-crisis for all the new patients you expect to be diagnosed? Is enough support being given to grief counselling? Is there capacity for the NHS to work alongside religious organisations and charities to provide counselling for those patients?

Chair: Were those both of your questions?

Taiwo Owatemi: No. My second question is on the elderly population.

Chair: Do you want to do that one as well?

Taiwo Owatemi: Given the fact that the elderly population were the first people to be isolated, and potentially will be the last to come out of isolation, what long-term support has the NHS developed to provide proper support for the elderly population, especially those suffering from

loneliness, isolation and bereavement?

Claire Murdoch: In terms of capacity, there are two things. First, we are adapting our long-term plan, which was going to see an increase in any case of 2 million people a year by 2023-24 being seen by mental health services. The £2.3 billion additional investment was going to have us seeing 2 million more people a year. Our first priority is to make sure that we deliver on that. I go back to my points about recruiting staff and developing our service models. We are in our second year of the long-term plan and we were on a good trajectory for the 2 million more. Now we need to make sure that we have adapted that plan, and we are driving it very hard to help with the capacity issue.

The second thing is that we are working closely with communities, the third sector and others around capacity. The mental health support will not all be about an NHS service. It will be about communities. The one thing that Grenfell taught us, which we are now sharing with the rest of the world—not as the NHS alone but with community leaders who have worked with the NHS in that patch—is how you build resilience within communities. The NHS is there sharing expertise, but—guess what?—often the real experts are communities, religious leaders and others. That has to be a central plank of both the long-term plan and recovery.

Thirdly, you asked about capacity. The truth is that we do not yet know what additional demand there will be as a result of this dreadful pandemic. We fully expect that it will increase significantly, for example through bereavement. We know that post-traumatic stress disorder is prevalent among those who have been on ventilators in intensive care and loved ones who perhaps lost dear ones they could not be with at the end of life.

I come back to the expert group that is being led by the Department of Health and Social Care, with Public Health England, communities and the third sector. We need the best modelling and evidence possible to tell us what in addition to the long-term plan—the £2.3 billion and 2 million more people—is going to be needed to see our citizens through what is undoubtedly going to be a challenging time for them.

We know that things like employment are good for your mental health. Economic prosperity is good for your mental health. Some of that modelling is going to have to be iterative. We are going to have to draw on best evidence from elsewhere in the world, such as the experience from SARS disease and studies in Canada, as well as from the Manchester bombings and from Grenfell. We have to keep evaluating and re-evaluating that over the next however long it takes to understand what we are dealing with.

I am so glad that you mentioned elderly people. We often talk about a golden thread. I like to talk about the silver thread through everything we are doing and thinking about. I, too, along with my colleagues and the people of this country are concerned about the multiple, compounding

factors on our older population. They have been hit very hard by this pandemic and those they love have been hit hard by this pandemic, and we are asking them to socially isolate.

We have to challenge ourselves on the prejudices we have about older people and technology. I know plenty of older people who, if their grandchildren are in Australia, have learned how to use Skype, for example. Whether it is prejudices about digital, or ensuring that they have iPads and technological know-how, I sense that we are going to be doing a lot of digital training with older people, or the third sector groups are, to help them stay connected to the world.

We have recently run a campaign with Age UK. Another prejudice we have is that older people do not benefit from talking therapies. All the evidence shows that they absolutely do, so our IAPT services and Age UK have been working together to make sure that, first and foremost, we need to connect older people and have them clearly in our sights as a silver thread. Secondly, we need to ensure that when they need access to good evidence-based talking therapies they have that access and they are referred. All the evidence shows that they respond really well to that.

Chair: You have been very comprehensive in your answers, Claire, Thank you for that. Last but not least in this section is Sarah Owen.

Q58 **Sarah Owen:** I have a question about dementia and mental health. A large number of people in care homes have dementia, but many people are cared for in the community. Two thirds of carers were already reporting severe loneliness, as reported by the Alzheimer's Society, before the pandemic. Because of the loss of routines during the pandemic, they report worsening symptoms. Given that there is not going to be any respite for carers, particularly those caring for loved ones at home, and there will potentially be an increase in symptoms, what long-term care will be available for at-home carers, particularly of people with dementia and Alzheimer's?

Claire Murdoch: Thank you so much for that question. I have talked about how proud I am of NHS and other frontline staff. You are quite right to put absolutely to the fore the vital role that carers have always played, now more than ever.

Some of my previous answer about connecting people digitally to support groups and chat groups, and a bit of peer support for carers, is going to be important. I would like to see carers having greater access to talking therapies if they need them.

Every cloud has to have a silver lining, and the volunteer force we have marshalled is one. We have to take a legacy from this dreadful pandemic and build on the strengths, with volunteers being able to provide some respite as we get through this. We are training our staff on how much more we can do digitally for people with dementia during this period. We know that NICE has changed its guidelines. Professor Alistair Burns, our

clinical lead, is working with professionals and carers right now to look at how we can flex and change our offer, both to carers and to people living with dementia in the community. Our long-term plan is great, but we need to tweak it and adapt it for a world where Covid will be with us, we suspect, for some time. Carers are very much at the fore.

Q59 **Chair:** Claire, thank you very much indeed. That is very helpful. Many congratulations on getting the crisis care helplines up and running. That will be very good news for a lot of people. Thank you for your comprehensive answers on a whole range of mental health concerns that people have.

For the last, but absolutely not the least, part of the session, we move to Dr Martin Marshall from the Royal College of GPs. A lot of colleagues want to come in, but I want to ask one question, following Sarah Owen's question just now about dementia care. GPs have an absolutely crucial role in dementia diagnosis, but, as most of the memory clinics are closed, are you worried that people are not getting diagnoses at the moment, which could mean they are not getting the additional care they need?

Professor Marshall: Yes, that is a very real concern. It is relevant to dementia, but it is relevant to many other conditions that we are looking after. Particularly in the early days of the crisis, a lot of services that we wanted to refer to had shut down, regrettably. They are opening up and it is getting easier for us. By and large, dementia services are still quite difficult. They are not regarded as a priority, however important they are to the patients we serve. We are looking forward to them opening up, as and when that is possible.

Q60 **Dr Evans:** I should declare that I was a member of the RCGP and have been an AiT rep for several years. In light of that, I have been contacted by AiT reps who are particularly concerned about the ST3s who are due to finish. Could you explain the role you have played with the GMC and the AiT reps and the RCGP on getting people qualified, both protecting the public but also allowing people to take their jobs in August?

Professor Marshall: This is a very significant issue for all of us. We had to postpone the exam back in the middle of March because of the crisis, particularly because of social isolation. That left about 1,400 trainees who were expecting to qualify in August at least initially unable to do so. We have been working very hard with a range of different partners. That is not just college business. The college sets the exam, but we have been working with the General Medical Council, which sets the regulations, the education bodies in all four countries and the Government to try to find a solution. It looks as if we are about to do so, which is great.

We hope that the majority of the 1,400 trainees who need to qualify and get into the workforce in September will be able to do so. There still will be some who will not be able to, particularly those who, for example, have health problems or who simply do not feel ready to sit the exam

when their training has been changed so dramatically over the last two or three months. We hope that we are going to get there with a solution.

Q61 **Dr Evans:** Would that be an outcome 10? Do you have a date for when it is likely to happen? People have jobs starting, technically, in August, and they are very concerned about whether they are going to be able to take up those substantive posts.

Professor Marshall: We are very aware of that. The majority of people who want to take up posts and who have posts to take up will be able to do so. What we have to do as a college, of course, is recognise the needs of the service and the needs of the trainees, but most importantly our job is to protect the public and make sure that doctors are safe when they become independent practitioners. That balancing is difficult, and there are many different cogs that need to work together. We have a meeting this afternoon, and we are confident that we will be able to come up with a solution that satisfies the needs of most trainees but, most importantly, satisfies the needs of the service.

Q62 **Dr Evans:** Can I flip it on its head? From the top end, we have had over 5,000 retired GPs coming back to help the service. Have you put any work or effort into making sure that, if they so choose, they can stay on to help increase GP numbers?

Professor Marshall: We know that there has been a massive workforce crisis in general practice and that a lot of people even in their mid and late 50s retired simply because the job became quite undoable for many people, with the bureaucracy and increased workload that they had to face. It has been extremely gratifying to see a number of the people who left, often in frustration, a job they love wanting to come back to support the service during this crisis. We are looking at ways of supporting them and getting them back into the service. We would love it if we could create a general practice that makes it attractive for them to want to stay on, because we need experienced clinicians.

Q63 **Dr Evans:** I have one last question on the wider nature of thinking about when we start to get back to normal. The PCN and the DES that was put forward with the service spec is warmly welcomed in the principle of what it is trying to achieve, but not so much in the implementation. Does the College have a position on where that should go, both now and forward, in implementation? Should there be any changes, considering the workload that may well now be developed because of the coronavirus outbreak?

Professor Marshall: We are very supportive of practice networks and primary care networks in particular. We see them as an important model, and they are working exceptionally well in many parts of the country. PCNs have actually been given a lease of life by the coronavirus crisis, because of the sharing of services across practices, particularly PCN-based hot hub centres for Covid, for example. We expect and hope that

PCNs will be more embedded in the service as a consequence of having to work through the crisis.

Q64 **Dr Evans:** You think it might be beneficial, going forward, because the previous boundaries have had to change overnight.

Professor Marshall: Yes, I think that is right. In so many ways, general practice has changed as a consequence of the crisis, and I am sure we will come back in subsequent questions to exactly how it has changed. The desire to work collaboratively between general practices, and between general practices, community services and hospital services, has been dramatic. The pace of change has been amazing and is a real testament to the work that general practices and their staff have had to put in.

Dr Evans: Thank you for all you do.

Q65 **Laura Trott:** Professor Marshall, in your answer to the previous question, you alluded to the changes that GP practices are undergoing. Many people are finding virtual consultations incredibly beneficial. What would be required for them to carry on after the pandemic?

Professor Marshall: There has been a dramatic change. Prior to the pandemic, about 70% of consultations in general practice were carried out face to face. Now, according to the data, it is about 23%. I suspect it might even be less than that. That has been enabled of course because it had to be. That is the reality of not being able to provide face-to-face care except when it is exceptionally required. Most importantly, it has been enabled by having access to the technology and the investment that has been put into the technology.

For example, in the early days of the pandemic I received a laptop fully loaded with patient software, with a VPN connection that allowed me to access safely all my patient records, and I have been able to deliver surgeries remotely. That should be the norm. The cost of that laptop would be a few days' work for a GP or a practice nurse. That relatively small investment in developing technology to allow more remote consultations is absolutely spot-on.

The future will be somewhere between where we were and where we are. I do not think that 70% of consultations had to be carried out face to face before the crisis, and I do not think 23% is right either. Maybe 50% is right. Online remote consultations are good for transactional problems, which are quite common in general practice. They are not so good for problems that require relationships or require you to understand, lay on hands or use your sixth sense to see non-verbal communication—all the things that are the essence of general practice. We need to make sure that we get the right balance. I guess that is one of our biggest challenges as we emerge from the crisis.

Q66 **Laura Trott:** The piece of technology that you described sounds ideal. How confident are you that GPs across the country have the kit they need

to continue carrying out those consultations on an ongoing basis, albeit in a balanced way with physical consultations as well, as you described?

Professor Marshall: A growing number do, but many still do not. Many do not have the actual equipment, and many of them do not have the support to set up and use the equipment, or indeed the training that is required to carry out remote consultations. It is a different style of consulting. The investment that has been made has been helpful. More investment is required. As I said, it is a fraction of the total cost of dealing with the crisis or the total cost of running primary care services. The small investment that is required could have a massive impact on our ability to provide a different kind of care for those who will benefit from it.

Chair: We now turn to another of our resident GPs.

Q67 **Dr Davies:** Building on that and in relation to telemedicine, I have seen it being used very successfully, but one of the concerns that has been raised is that there is some degree of variation as to how much it is being used and whether sometimes people are not being seen face to face or on home visits who should be. Perhaps we are relying a little bit too much sometimes on community care colleagues. Do you have any views on that?

Allied to that is the fact, anecdotally, that some of the commonest causes of death normally—heart disease and stroke, for instance—are not featuring on death certification as they might. Is there a worry that we are missing some of what is going on out there?

Professor Marshall: As far as death certification is concerned, it has been an interesting and fast-moving field because we have all been dealing with more deaths. We are preparing for a larger number of deaths, particularly in the community.

On certificates we always try to put the most likely diagnosis. If it is likely to have been Covid, we would want to put Covid. The major problem has been the lack of testing, which has meant that we have not always been able to put Covid when we think it might be likely, or maybe we have just had to suggest that it is most likely to be Covid. When more testing takes place, it will be much easier for us to fill out death certificates in an accurate way, and that, of course, is extremely important for us all.

As far as the use of technology is concerned, you are absolutely right. Some people are using it more and some are using it less. We know that there are potentially risks in not being able to see and examine patients. That is a judgment we are learning as we go along. We are making sure that we assess people face to face when they need to be assessed. Sometimes we use other services, such as referring them to hot-hub Covid centres. Sometimes people who deal with visits from care homes are making those visits instead. The vast majority of GPs are examining patients and seeing patients physically when they need to do so.

Q68 **Amy Callaghan:** I had real concerns prior to the Covid-19 outbreak that young people with cancer symptoms were not presenting to their GP, and this crisis has made those concerns even more real. What work is being done to ensure that individuals, with particular emphasis on young people, with signs and symptoms of cancer do not experience delays in diagnosis due to Covid-19?

Professor Marshall: Some of these issues were discussed in the previous section under cancer. It is a very real issue. We know that a lot of younger people do not access health services of any sort, including general practice services, and one of the issues might well have been their difficulty with making face-to-face appointments or discomfort with face-to-face appointments. One hopes that the use of remote technologies, particularly online technologies, and even the basic telephone, will improve access to young people. That will help us diagnose a whole range of conditions, not just cancer conditions, but in particular mental health conditions as well.

One hopes that the different approaches towards different modes of consultation will mean that services for people who are currently not as well served as they need to be will improve.

Q69 **Taiwo Owatemi:** Professor Marshall, given that patients discharged from hospital may need to be rehabilitated to community care, what challenges are healthcare professionals and community teams facing, and how efficient is the referral process?

Professor Marshall: The referral process has been complicated by the crisis, as one would expect, particularly in the availability of the specialist services that we need to refer to in general practice. A lot of the services that we would like to refer to simply have not been available or are only just coming back online for us.

One of the positive things that has come out of the dark cloud of the Covid crisis—another silver lining, if you like—has been better and more effective communication between general practice and hospital services. There was a reference earlier, for example, to cancer services and online consulting. In some parts of the country, there is three-way consulting between a patient, a GP and a consultant online. Those are the kinds of things that we need to build back into the service.

One of the big challenges that we have in general practice is to identify which of the Covid-related changes are good and need to be sustained and embedded into the service, and which ones are not good for patients and perhaps not good for the NHS and that we need to push back on. One of the things I am particularly keen to push back on is the administrative workload in general practice. It has been a massive problem for general practice; around 25% of clinicians' time is spent doing things that often do not add very much value.

We have seen a dramatic reduction in administrative tasks in general practice, and that has freed up space that many GPs had not seen or recognised for five or 10 years. We need to make sure that the default position is that that bureaucracy does not come back again. We need to make sure that it does not and push hard. That is in areas like contractual obligations, organisational regulation and professional regulation. I am not saying that all of those are bad things, but they became disproportionate. More opportunity to create space by reducing the administrative workload would be massively beneficial for general practice.

Q70 **Chair:** Thank you. Dr Marshall, you are one of the most senior GPs in the country. There will be lots of people at home thinking about whether they should go to their GP with a concern. You have heard the whole discussion this morning about the drop in cancer referrals and the drop in young people's mental health referrals. What message would you give to anyone at home about accessing GP services right now in the lockdown?

Professor Marshall: The message, as other witnesses have said, is that general practice is open. It is operating in a different way. We need to understand why patients are not accessing both general practice and other services. A lot of patients say that they respect the NHS, they want to look after it and they do not want to put pressure on it. That was certainly the case in the early days. Some patients are worried about picking up infections. Some people are worried about the door being closed, and some people think that services simply are not available.

The message from us in general practice is that general practice is open, particularly for significant conditions that need to be prioritised, whether they be acute health illnesses, mental health problems, potential cancer or preventive issues like childhood immunisations. Right now, during the crisis, you might not get normal care. It is very likely that you will be triaged, and it is very likely that you will receive online care, but general practice is open to you.

Chair: Thank you. That is a very clear message and goes alongside the very clear messages we had from the other witnesses this morning. This brings our session to a close.

I conclude by thanking our witnesses, Dame Cally Palmer, Claire Murdoch, Dr Martin Marshall and Gill Walton, for the helpful replies they have given us this morning. I thank the broadcasting team at Parliament and the Clerk and the Select Committee team based at Parliament for their help in preparing for this session.

On behalf of everyone, I thank people on the NHS frontline who are doing everything they can to keep those frontline services going. It is not just coronavirus but, as we have heard, cancer, mental health, maternity, general practice and a whole range of other areas as well.

Thank you, everyone, for tuning in this morning.