HOUSE OF COMMONS

Health and Social Care Committee

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

Thursday 14 May 2020

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Watch the meeting

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

Questions 71 - 118

Witnesses

I: Chris Hopson, Chief Executive, NHS Providers; Richard Murray, Chief Executive, The King's Fund; Nigel Edwards, Chief Executive, The Nuffield Trust; and Dr Jennifer Dixon, Chief Executive, The Health Foundation.

Examination of witnesses

Witnesses: Chris Hopson, Richard Murray, Nigel Edwards and Dr Dixon.

Q71 **Chair:** Good afternoon and welcome to the House of Commons Health and Social Care Select Committee. This afternoon we are focusing in our inquiry on the longer-term impact of coronavirus on all the other things the NHS has to do. We have an array of expert witnesses, some of the best experts around in NHS policy, and we are very delighted to welcome them to the Committee this afternoon.

From NHS Providers, we have the chief executive, Chris Hopson. We have the chief executive of the King's Fund, Richard Murray, the chief executive of the Nuffield Trust, Nigel Edwards, and Jennifer Dixon, who is the chief executive of the Health Foundation. You are all extremely welcome and thank you for the written submissions that you made to the Committee ahead of this afternoon's session. Thank you, too, to many other organisations and members of the public for their written submissions; we have had nearly 300, which is vastly more than we normally get. We are very grateful for all of those and they will feed into our inquiry.

This is a two-hour session and we are going to focus on three different areas. The first is the impact of coronavirus on normal NHS services for patients and what the NHS is going to look like in the next six months and in the next year for patients—how it is going to be different and what the issues are going to be.

Then we are going to look at issues for NHS staff, including PPE and testing, but, more broadly, all the issues for NHS staff. Then we are going to use the fact that we have these experts with us this afternoon to think about some of the longer-term lessons that the NHS needs to learn from coronavirus—the potential changes in structures and in the way we have done things for a long time. We are going to spend some time on that.

In case anyone was wondering, in next week's session, on Tuesday morning, we will be asking similar questions about the social care system. We are not neglecting the social care system, but we think that there is so much to go through with the social care system that we need to do it in a separate session, so we will be focusing on that on Tuesday next week.

The first of our three sections is to do with how patients are going to find the NHS changed by coronavirus as we come out of lockdown and start to move into more normal service. The first thing I want to talk about is the question of patient safety and how we stop hospitals becoming places where the virus is transmitted, and try to maintain NHS services with the social distancing that is required.

I am going to start with Dr Jennifer Dixon, if I may: you are very welcome, and thank you for joining us. You talked this morning on the "Today" programme about how one of the factors is patients worrying about whether they should come in for treatment because of the risk that

they could potentially catch the virus in hospital. Later this morning, we heard that A&E attendance in April more than halved compared with normal levels. Some of those people might not have needed to come in—those whom doctors sometimes call "the worried well"—but other people will definitely have needed to come in: they might have had a cancer that needed to be picked up or something like that. How do we resolve the issue of patient safety and social distancing, and how is that going to affect the experience of people using the NHS?

Dr Dixon: First, clearly there is a massive coronavirus pandemic going on and therefore infection control is going to be No. 1 in many a mind of health service managers, doctors, nurses and other staff, both in hospitals and in the community. Patients will see a lot of attention to that, not just people wandering around in PPE but a lot more cleaning and a lot more testing. All that activity will slow things down. I do not think anyone can pretend that the NHS can operate as fast as it normally does, because of the need to deep-clean much more, and to test people and so on.

It is very important, as the NHS switches back to non-Covid care, particularly elective care, that the NHS separates Covid patients from non-Covid-type patients and has areas of the facility that are just dealing with presumed non-Covid and elective care or cancer care, or whatever it is. At the moment, many hospital facilities and others are working out how to separate such patients—for example, having particular hospitals that are Covid-free, particular wards that are Covid-free and particular levels of buildings that are Covid-free. Patients will see that.

They will be tested quite significantly before they go into hospital. A testing regime is going to be implemented, and is already there in some places, whereby you will be tested 14 days before you have elective care, you will have to be isolated and you will be tested again coming into hospital. There is going to be a testing regime that patients will see.

The bottom line is that all of that will be very visible and, hopefully, very reassuring for patients, but it is going to slow things down a great deal, not least because of the cleaning and all the rest of it, as I described. Hospitals and other facilities will need to reconfigure themselves in ways that they have not done before, which may also slow down the flow of patients. I think that may reassure patients somewhat. The estimates could be that elective care may not get up even to something like 70% capacity, but maybe around that figure. These are bald estimates at the moment, and it entirely depends on what happens with the next wave, if there is one, of a coronavirus outbreak.

Q72 **Chair:** On that point, perhaps I could bring in Nigel Edwards from the Nuffield Trust. You have talked of a mountainous backlog, and we have heard predictions of a waiting list of 7 million people. What do you think the size of the waiting list will grow to and how on earth are we going to tackle it?

Nigel Edwards: It is a very difficult question to answer. Could I add a few things to Jennifer's point? There will be a lot of patients who cannot be tested before they attend. It is going to be very difficult for us to go back to anything like the model of care that we had in accident and emergency departments as well, because most of them, before the crisis, were running at well above their design capacity, so we need to manage that activity in a very different way. Perhaps we might come back to that later; I have some suggestions about that.

On the waiting list, between 1.5 million and 1.7 million people a month start a new pathway, or at least they did before March. We already see in the March data that the numbers of patients starting new pathways and being referred have fallen very significantly, and of course that is going to be very much more the case in April and May. Various hospitals I have been speaking to say that they have been managing to do maybe 15% to 20% of their elective work, so the maths of that are pretty brutal. It probably means that 1.2 million to 1.3 million people each month whom you would expect to be added to the pathway have not been. They have not been referred yet.

One of the worries is that at the moment general practice is holding a very large amount of risk back from the hospitals, and at some point that is going to be released. Patients seem to have been restrained from going to hospital, and there is concern that we have a slight backlog of people who need tests. Some of them need tests that create aerosol, which therefore means very enhanced PPE or extensive testing before they are seen.

Given that hospitals are having to take beds out to make space, and they have staff who cannot work on frontline duties and we do not have the testing or PPE in place to restart elective work as quickly as perhaps one might like, we probably have another couple of months of restricted activity. It is hard to do the mathematics, but it seems very likely that we will have doubled the waiting list to over 8 million by the late autumn.

Q73 **Chair:** Can I ask Richard Murray of the King's Fund about cancer? At a recent session, Cally Palmer, the NHS England cancer director, said that cancer referrals were down by nearly two thirds. My local trust told me that last week in 30 appointments for cancer investigations the patients did not show up because they were obviously worried about catching the virus and did not want to be in a hospital environment. Do you think, on that basis, that we are likely to see, very unfortunately, a spike in cancer deaths because we have not caught the numbers of cancers early that we would normally have done?

Richard Murray: It is certainly the case that the number of urgent cancer referrals has dropped very sharply, from about 40,000 a week to about 10,000 a week by the middle of April, but they are rising again quite quickly; they have doubled to around 20,000. People who manage to get through and get referred are being seen quite quickly, as long as they show up, because cancer was never one of the services that was

supposed to be put into a delay or a shutdown. It was not a routine service that the NHS tried to slow down.

The key to avoiding a spike in cancer mortalities later in the year, next year and the year after is how quickly those referrals pick up again. They definitely declined for a bit, but in most cases of cancer a clinical delay of a couple of weeks is probably not going to be that severe. What matters now is how quickly they go back up again.

As Nigel and Jennifer said, once they begin treatment for cancer, people are often immunocompromised. They are at risk from coronavirus, and other infections too, as they begin to move through the treatment. We might find that people are beginning to get through to treatment, but it is naturally slower simply because of the additional precautions we need to take because of coronavirus and ongoing risk. At the moment, as long as referrals pick up again, at least diagnosing them, we may manage to avoid the worst of a big surge in cancer deaths.

Q74 **Chair:** That is potentially very encouraging. Lots of members of the Committee want to ask questions, but I want to ask Chris Hopson something first. Chris, your organisation represents all NHS hospitals. What are they telling you about the challenge of the backlog and how we keep both patients and staff safe while we are dealing with it?

Chris Hopson: Chair, we also represent community mental health and ambulance trusts. Our trusts are telling us that they think the next phase is going to be more difficult. That might be a slightly surprising thing to say compared with the phase we have just gone through, but I think what they are saying is that they have two or three things going on. Remember that they were already struggling to keep up with the rise in healthcare demand before we went into coronavirus. We had 100,000 staff vacancies, and capacity had not kept pace with demand because we had been through the longest and deepest financial squeeze in NHS history, so there was a real sense that we were behind the curve in keeping up with demand.

Going forward, I think we will see significant amounts of extra demand for treatment. To give two or three examples, we know there is going to be more demand for mental health services, for example, for those who have suffered the economic, social and loss of life consequences of Covid. There will be significant rehabilitation needs for patients who have been discharged from hospital having recovered. Dealing with the 2 million shielded patients will be quite complicated, because the type of interaction you can have with those patients is going to be difficult.

Trusts are saying to us that they can see more demand of a complex type than perhaps they had before. Then they are saying—in a sense, the triple whammy—that they are going to have their capacity constrained. We have already talked with the other witnesses about the fact that, for example, if you are going to create a Covid and a Covid-free area, it is probably, in lots of hospitals, going to reduce your capacity.

We are going to have to get PPE and testing in better places than they currently are in order to restart. The bit we need to remember is that we are going to be asking trusts to deal with all of that alongside treating a stream of Covid patients. We do not know how big that stream will be, but we are also going to be asking trusts to retain surge capacity, so that if lockdown, when we start to ease it, does not quite work in the way we all want it to, there is the capacity to deal with the further, famed second spike.

Trusts are saying to us that that is a complicated mix of things to do. They are also nervous that there are some quite high expectations of how easy it will be to deal with all of that. They say to us that they think it is important that the NHS should be clear about the priorities for the most important things to do and that people should have realistic expectations about how fast, how quickly and extensively we can do all that alongside restarting services.

Chair: Thank you. A lot of people want to come in with questions. Dr Luke Evans is going to talk about A&E and how we get that service back and running.

Q75 **Dr Evans:** This is a question for Chris and, probably, Richard. Regarding the A&E figures, we have seen a drop of about 50% in attendance. Can we dig into that a little bit more to know whether people are still turning up with accidents and emergencies or whether we have had a drop-off? Are the number of strokes and the number of heart attacks still there? Is there a happy middle? Has A&E always been misused by the public or has it now found a shift back the other way, and is there a happy medium somewhere in the middle? Is there anything with regards to the figures on that and the implications for future policy?

Chris Hopson: I can tell you what I thought was a really illustrative anecdote from a chief exec I was speaking to last week. He said that his A&E attendances had dropped by 60% and he was really concerned about that. The words he used were, "If they drop by 30%, I wouldn't be so worried because we know"—exactly as you were suggesting, Dr Evans—"there are a number of cases that traditionally have come to A&E that do not necessarily need to be there." But his view was clear: if they are dropping by 60%, there are definitely some people who ought to have come along to accident and emergency who have not come along.

What is important to recognise is that there is a sort of perception that all that the NHS has been doing over the last 12 weeks is coronavirus. The reality is that we have been continuing to provide emergency care. To give you another personal anecdote, somebody very close to me broke their hip, unfortunately, over the last three weeks, but they were able to get a hip replacement within 24 hours, and it was done to an incredibly high quality in the way you would expect.

What has happened is that the NHS has managed to retain and continue to provide care in the most important and most time-critical emergency

services, but we now need to restart the full range of emergency services, and it is going to be complicated and difficult.

To give you one illustration, I think one of my colleague fellow witnesses was saying that we should think about how busy our accident and emergency departments have been. Imagine trying to do social distancing in some of those accident and emergency departments. We need to try to be sure that, as we restart services, we get to, hopefully, a reasonable level of demand, but we are going to have some very big challenges. Trusts tell me they are particularly concerned that if we try to go into winter with the existing situation alongside coronavirus patients, we are going to face some difficult problems.

Q76 **Dr Evans:** Richard and then Nigel, do you want to answer that? Then that is my question done; thank you.

Richard Murray: There is some sign in the data that some of the patients who were less ill and were showing up at A&E are the ones who have gone. The biggest declines are in places like walk-in centres and urgent care centres. I am sure that a lot of those patients are using NHS 111 and NHS UK, so there may be a positive story about people's willingness to look at self-care and manage their conditions themselves.

The worry comes more in some of the anecdotal evidence. We have heard from a number of NHS Providers staff about seeing patients with heart rupture. This is something that happens after someone has had a heart attack and not had treatment, and they have shown up at A&E a couple of days later. Consultants working on stroke wards say that they are quieter.

There could be a positive piece that we want to try to retain about more appropriate use: "Don't go to A&E," or indeed to walk-in centres, but I am afraid there is going to be a tail of patients who should have shown up at A&E and are now beginning to appear in the system. Obviously, it is much more difficult to treat if you have left it too long and it may, unfortunately, explain some of the excess deaths that we have seen.

Q77 **Chair:** Nigel, do you want to respond to that?

Nigel Edwards: I agree with all of that analysis. We can see some data on it in the Public Health England syndromic surveillance data that shows a drop-off that should not have gone away in both A&E attendances and indeed contacts with GPs for conditions.

Without virtually duplicating emergency capacity, most hospitals I know and have looked at do not have the physical space to do social distancing in their EDs when we return to anything like normal levels of work. I am of the view that we should probably consider the type of approach that is used in Norway, Denmark and the Netherlands where you do not go to the ED unless you have had a referral from the equivalent of a 111 service or a GP, or the ambulance service has decided to take you. There

are ways of dealing with the homeless and people who do not have telephones.

Those systems work very well and people have got very habituated now, it seems, to using the phone as a first line of contact for healthcare. It would mean bolstering the 111 service and putting more general practitioners and experienced nurses on that frontline, but it is something that will be well worth considering. Without that, we will have to create a very large amount of additional physical space, which people now already have, but it has to be staffed and is generally using space that is required for other clinical purposes.

We are going to need to do some pretty imaginative thinking in that area, and we should look abroad to some of the countries that have managed to put a bit of a lid on the level of attendance and improve the appropriateness and timeliness of the service. It is now much easier to get seen in a Danish or Dutch emergency department than it was a few years ago.

Q78 **Dr Davies:** A worrying article published in the *BMJ* yesterday suggested that only one third of excess deaths in the community in England and Wales can be explained by Covid-19. How does the panel react to that? Does it reflect reductions in the use of unplanned care, and what steps should be taken urgently?

Dr Dixon: Can I add one sentence on the previous question? It is going to be extremely important to look at where all the drop-offs have happened with respect to the lower use of care during this period. We do not have access to data at the moment for the most recent period; nobody has—except perhaps people right in the system—so we are relying on anecdote, and a very fundamental issue for the Committee to think about are the data flows in real time when you are trying to assess what is going on. What is available and what is not is an important issue.

Our analysis is exactly the same in the question about the excess deaths; clearly there is a large number of deaths, particularly in care homes, that are three times the normal rate and are not at the moment classified as being Covid. We do not know at the moment what those excess deaths are due to, whether they are actually Covid but not classified as Covid, or whether they are indirectly related to Covid because of some sort of blockage or access to care that has resulted in a person's demise.

It is an issue not just in this country but in many other countries; they are seeing excess deaths. We think excess mortality is a more accurate explainer of what is going on in the Covid impact than the Covid number of deaths that have been analysed and produced by the Department of Health.

Q79 **Laura Trott:** Chris, in your report, you talk about a new normal for services in the coming months, and potentially years. What is that going to look like for maternity? Mothers are looking to understand when the

provisions that have been put on them, which have been incredibly difficult for many—not being able to see partners after birth and not having the choice of how and where they want to give birth—will be lifted. When can you see some of those changing?

Chris Hopson: It is a difficult question to answer because what must be paramount in people's minds is patient safety, particularly in that area. We know that some really difficult changes have had to be made—for example, in terms of provision of home birth—and a narrowing, in a sense, of the choices available.

At the moment, each trust is in the process of working through in a systematic way how they can restart the full range of services as quickly as possible. Each trust, in a sense, will have a slightly different profile depending on, for example, what staff are available and what physical capacity is available. Understandably, people want the answer to the question to be, "We will get back to normal as quickly as possible," but until we are sure how much coronavirus-related demand will need to be treated and how much surge capacity needs to be kept over to deal with any potential second spike, and until we can be certain that, for example, the personal protection equipment that is needed is available and the testing capacity is there as required, it is very difficult for trusts to answer that question.

One of the things I feel we have learned significantly from the first peak is the sense that coronavirus has hit different parts of the country in very different ways. We found it incredibly striking talking to, for example, London chief executives and chief executives in the West Midlands, about the degree of pressure organisations were under, and then when we were talking to chief executives in the south-west we got a very different picture. Part of the issue is that it is very difficult to plan how you restart services, if you have that degree of differing impact of the virus on different parts of the country.

Q80 **Laura Trott:** Is there anything specific that could be given to trusts to help them increase that capacity? You mentioned PPE and testing, obviously, as two key things, but is there anything else, specifically on maternity, that you think is required to help trusts start to reopen those services, or is it inevitable that there will be uncertainty and it will be on a case-by-case basis?

Chris Hopson: As I was saying earlier, there is a real issue, isn't there, around prioritisation? If the NHS cannot do everything in this next phase, what is going to be helpful is being clear about what the priorities should be. Our sense is that it should not just be something that is decided by the NHS. There should be an element of public debate about it. It is the public's service; they pay for it, so our sense is that that needs to be fed in.

The one thing I probably have not talked about, Laura, which feels to me quite important, is recognising staff. When I said to a chief executive

yesterday, "I'm going in front of the Select Committee tomorrow. What does it look like for you?", the three things they said were, "I can't really restart services until I have more than two days' supply of PPE and until I can be certain that I can get the rapid turnaround of testing that I would need. I am not there yet."

The third thing they said was, "I've got a really tired group of staff who worked incredibly hard over the winter period. I've now asked them to do extraordinary things over an extended period, over the last kind of 12 weeks—real pressure. They have deferred leave; they have done some extraordinary things. I've just got to give them a break." We are going to need to find a way of enabling them to rest and recover, and get the support that they need, particularly *[Inaudible]* provision of care. Therefore, again that is going to vary trust by trust.

Chair: Thank you. Rosie, Barbara and Sarah all have questions about the backlog and capacity and how we deal with it. I am very keen to make sure that we have time to talk about staff issues, staff testing and PPE, which is in the next section, and the longer-term legislative changes the NHS might want, so could I ask everyone to try to be brief in their questions and answers?

Q81 **Rosie Cooper:** Perhaps we should have started with that little recommendation before we began the session.

Leaving that aside, I would like briefly to refer to the impact on patients in both complex and simple ways. The delays in diagnostics, and indeed in some treatments, are quite pronounced. In my area, a gentleman requires some dental treatment and is in real pain. He has been told that his only choice is to go to a centre, where the only choice he will have is extraction—no treatment, just extraction. If he turned up with a broken leg, he would not be offered an amputation, so there are some real quality problems there.

We have talked in the last few weeks about delays in diagnostics and about cancer treatments, where chemotherapy is not possible because of immunosuppression, or perhaps surgery cannot go ahead because the ICU beds are in demand for Covid patients. An area that we seem to have neglected dramatically is radiotherapy. It looks like the NICE guidance has been taken absolutely literally in some areas of the country, and treatment is delayed, postponed or cancelled altogether. Yet at the very same time I am hearing stories of great advances in treatment, where you can treat early lung cancer with one radiotherapy treatment instead of the 20 that it used to be.

With that great disparity across the country, what advice could the panel give to the Secretary of State to enable all those patients who are paying their taxes to be treated equally in these very troubling times? Perhaps Nigel could start.

Nigel Edwards: It is not as if we started the situation with everyone being treated equally before, is it?

I am not entirely sure I know an easy answer to that. One of the problems with setting central direction in this area is that everyone has a different starting place, and there are an awful lot of tricky trade-offs that will need to be made locally. Chris has sort of answered the question; there are a whole number of areas where we are going to need to make difficult decisions about who gets treatment and what sort of treatment is available.

This situation is very familiar to me from my work in middle-income countries. We are experiencing what it is like to be in a middle-income country healthcare system, unfortunately, with the expectations, regulation and standards of a high-income country, which is a very difficult place to be. We are going to need to be very clear about what are the standards, where are the trade-offs and what basis should be used to make those decisions.

I would suggest, as another middle-income country insight, that it is probably better to set the standards and principles, and then have the decisions made locally rather than trying to do them from the centre. We have learned that our system is so big that it is not possible to make these types of very complex ethical decisions from the centre.

Q82 **Rosie Cooper:** Currently, we have some radiotherapy services that have staff not at work; we have machines not being used for five hours a day. This is not about more investment; it is about using what we have.

Chris Hopson: When we speak to chief executives, they are clear about the need to treat as many patients as they possibly can, but they are working under a set of constraints that we have simply never seen before. For example, we have already talked about the need to create—in fact, all hospitals now have them—green, amber and red zones: green zones where they know they have Covid-free patients, amber zones for patients who are waiting for tests to return and red zones for patients who they know have Covid. That is having very significant impacts on physical capacity.

You have already referred to this. A trust I was talking to the other day had 50 operating theatres and it is now operating out of 10. It is now ramping them up and it was telling me that it was going to get to 15 this week and 25 by next week. Wherever you look, because of the impact of this virus, we simply do not have the capacity available to get through patient treatment at the volume and speed we have done before.

It is a really difficult thing to say, because our chief executives and all their teams know that their job is to provide service to the people who are paying for the NHS, but the difficult reality is that we are simply not going to be able to do as much as we have traditionally been able to do, for a period of time. Trusts will do everything they can to treat as many patients as possible, but we have to be realistic about the impact that the virus has had on capacity in the NHS.

Q83 **Taiwo Owatemi:** My question is directed at Chris and Nigel. The NHS is going to have a backlog as a result of the pandemic. One of my constituents was due to have dental surgery in April but has not yet been told when it will be rescheduled. How is the NHS going to cope with the additional backlog that Covid-19 has created, and what could the wider health implications be for the population?

Chris Hopson: The way trusts tell us they are going to tackle that backlog is that they will prioritise on the basis of clinical priority, using a well-known NHS prioritisation mechanism: they will identify which patients are in most clinical need and work through them in that order. They will try to do their very best to ensure that they mitigate the consequences for individual patients, and they will obviously do their very best to communicate as quickly and effectively as possible to those patients to tell them with as much certainty as they can when they can expect to receive treatment. That is what I meant about managing expectations.

What our trust chief executives are really nervous about is the perception that we can just get the NHS going straightaway at maximum speed, that there has just been a 12-week gap where, effectively, we have been focusing on Covid, and we can now restart everything at full speed and it will all be fine. The reality is that this is going to have a significant impact for a period of time.

Q84 **Chair:** Nigel, do you want to come in on that one?

Nigel Edwards: I will talk about dentistry briefly, if I may. It has not received a lot of attention, but it is a real problem because virtually everything that is done in dentistry generates an infection risk, and we have not given dentists a good answer about how on earth they will run their businesses in a safe way in the future.

We are going to have a very major problem of long-term dental morbidity as a consequence unless we can find an answer to that. There is a limit to what hospitals can do on that, but at the moment we are unclear about how to safely run a general dental practice. There is no sign of them opening. We do not really know what prevention and control of infection measures they are going to need to take to make it work. It is something that the Committee might want to keep an eye on, and it is something that is worrying me a lot.

Q85 **Sarah Owen:** I was going to ask about capacity and the staff testing needed for Covid/non-Covid areas, but I will change that to this question for Nigel and Chris. Were any of you or your organisations consulted before the Government's change in message from "Stay at home" to "Stay alert and go back to work"? What impact do you think that quick change of message will have on patient services and capacity, and, as Chris just said, perhaps expectation management as well?

Chris Hopson: We were not consulted, and we would not necessarily have expected to be. This is in a sense a top-level Government and public

health-type communication, which we would not necessarily as providers expect to have been consulted on.

The real issue for us in the NHS is how lockdown easing is going to work. The word picture that we try to have in our minds is the concept of a rather uncertain tap. What we are going to try to do in lockdown easing, effectively, is turn the tap on and hope that lots of water does not rush out, and that, if too much water does rush out, we can quickly turn the tap off and be certain that the water does not flow.

The answer is that it is not going to work like that, in our view. It is very difficult to predict exactly how lockdown easing will work, which is why we need to ensure that it is done in a very careful way, otherwise we risk the second spike. We need to recognise that it is difficult to predict what the impact of lockdown easing measures will be.

We have all said right the way from the beginning that one of the things we must take account of is protecting the NHS and ensuring that we do not get a volume of demand that we cannot cope with. In looking at lockdown easing, that feels to us to be a very important set of criteria to think about when you are working out how to ease lockdown.

Q86 **Chair:** Nigel, I think you were going to come in.

Nigel Edwards: I do not think I have anything to add. I would not have expected to be consulted. I agree with what Chris said. I will let us move on.

Chair: Thank you. We will move on to some of the non-hospital services and community services, particularly around mental health and the role of the third sector. I welcome a new member of our Committee today, Barbara Keeley, who is joining us for the first time. You are very welcome, Barbara. Do you want to ask your question?

Q87 **Barbara Keeley:** I have a couple of questions, because one is about children's services. The first is about mental health services, on how effective remote services have been and on the decline in referrals. Services have been shifting to the phone rather than being face to face, as IAPT services might normally be. I have a concern that before the pandemic some patients were kept waiting for long periods of time, perhaps just having a cursory call with a mental health professional first. How can services make sure that that does not happen, that the phone services are not just used, effectively, to cross somebody off a list?

I think we will face a very high level of mental health issues related to the crisis itself, but we know and have been hearing about people holding off and GPs perhaps not referring people. Is that decline in referrals going to lead to more people reaching crisis point in the months ahead? I guess the fear is that we are building up a hill, or a mountain, of mental health issues that we are going to have to deal with in the months to come.

Richard Murray: We are hearing about the decline in referrals. You would expect that, because it is not only that GPs have sometimes tried to hold off referring patients, but patients are not showing up at GP practices either—certainly not through the period of peak stay-at-home concern around the coronavirus. You would expect that to lead to a backlog of problems developing in mental health, because with mental health, just as much as in other services, the sooner people get help, the better the chances are that they will recover and the better they do.

The challenge, I think, is that mental health did not start from a very good position.

Barbara Keeley: No.

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

There may be some lessons from the reskilling and retraining that has been done with many staff in the acute sector, and to train them up very quickly to be able to help deal with some of the critical care. We might need to draw on those same skills, the same experience, to try to build up a bit more resilience in the mental health services as well.

Q88 **Barbara Keeley:** There is a slightly different impact in terms of CAMHS. We were talking about a drop-off in referrals. YoungMinds has just published a survey that shows that, among parents whose children had been receiving mental support, 25% of those children had not been able to access treatment but still needed it. That is almost a denial of treatment, if you like, rather than just people not being referred.

What can we do to prioritise during the rest of the crisis—however long it lasts—mental health support for our vulnerable children and young people? There is evidence that the pressures and the anxiety will play very hard on children and young people.

Chair: Can I suggest that Jennifer comes in on this?

Dr Dixon: It is a very real issue. I do not have anything specific on that area. There are a number of areas where there is going to be a huge backlog and there are going to be groups that have suffered as a result of the lockdown.

How we get a grip on which areas are the most vulnerable is a key point, especially if we leave a lot of local restart decisions to local individuals and local groups. How are we going to monitor that the country is offering decent services across a range of areas, including this area, and that it does not just get lost in a gap? That is the standing-back question to ask, and it relates to the previous question. The restart could be a

recipe for very lopsided care in different parts of the country, because of different choices made locally, the different backlog locally and the different Covid load in different parts of the country. To be able to spot that is going to be very critical, and I do not feel at the moment that we have the mechanism to do that or, indeed, to question some local priorities that are being made.

I am sorry that is not specifically on YoungMinds. It is a more general point about monitoring what is happening, particularly to vulnerable groups.

Q89 **Dean Russell:** Building on Barbara's previous question on mental health and the backlog, one of the things that has been very clear during the crisis is a level of anxiety and an impact on the mental health of many people that they probably have never experienced before. There is that impact. If people's elective surgery is delayed, and things have been delayed when they might be in pain, for example, that is also going to affect their mental health.

I wonder whether, moving forward, every time somebody has a physical health check-up, say, or sees their GP, there should be, as standard, a mental health check-up and questions asked of patients—everyone who is seen—around issues such as loneliness or anxiety levels, so that we can get a much better view of what is happening in people's minds and the mental health issues that are happening. We could then provide greater support and identify those who are going to be in need of that. I wondered, Chris Hopson, if you have a view on that.

Chris Hopson: One of the things that is worrying our chief execs, as I have already said, is the fact that we are expecting to see, and in fact are already starting to see, significant increases in mental health demand. That is very clear, and there are two obvious sets of people who are likely to need greater mental health support.

If you look at past evidence when economic impact has hit, you see that there has been a direct mental health consequence. There will be people who suffer from the economic consequences of lockdown, and from the social consequences in that they have not been able to go about their ordinary lives and are now cooped up in quite confined spaces. There are also people—one hears some difficult stories—who have been involved in loss of life of relatives. You can see that there is a group of people who will need extra mental health support.

We also know that there are some really big issues for our staff, if you look at what has been happening and the pressure and intensity there. I was going to do a Jennifer stand-back question as well, which is that we know that one of the problems in mental health has been the inability of funding to actually reach the frontline of mental health. We have been increasing mental health investment, but our mental health trusts have been saying very clearly that the extra money has not been reaching them on the frontline.

At the moment, nobody is talking about money because, effectively, the Government are saying, "Look, whatever the NHS needs, we will ensure gets funded." But when you are talking about the kind of expansion of mental health service that we are going to need, over probably the medium term, one of the important questions that our trusts are beginning to ask is, "Okay, we are going to need to fund this beyond the end of Covid. How is the funding for that going to work?"

I think, Dean, you are right to identify that one of the things that would be helpful, given the much wider prevalence, is to ensure that we have mechanisms to identify mental health need. There were some questions, particularly in the children and adolescent mental health services that Barbara was talking about, that we perhaps were not getting right because of capacity constraints. There is a set of difficult questions.

Q90 **Dean Russell:** Would you agree that, if every appointment in terms of physical health with GPs always came with a mental health check-up, that would make sense?

Chris Hopson: My immediate reaction to the question is that it seems really sensible, but my immediate question is: do we have the capability to deliver that on a consistent basis? We do not represent general practice and we know that general practice has significantly improved its capability in this area, but at the moment, to be able to make that promise, which is clearly one that I think everybody would reflexively want to endorse, you need to think about what capacity and capability would consistently be needed. That is quite a long way from where we currently are.

Q91 **Amy Callaghan:** I am going to move on to a question about the third sector. Dr Dixon, how important has the role of the third sector been in delivering core services, and do you believe that those organisations are able to access sufficient financial investment from the Government to combat the strain on their services?

Dr Dixon: That is a great question; thank you. Recent analysis I saw from the third sector itself—charities and the voluntary sector—is that its finances would take a £4 billion hit, and the Government have made available about £750 million to try to make up the slack. There are many thousands of charities and small voluntary groups locally that provide masses of care throughout the country, particularly to vulnerable groups. Everybody realises that the sector is highly vulnerable and that there is going to be wreckage as we go forward, which will in fact backwash against the NHS as well if you do not provide the services that have been in place.

How to shore up the sector is critical. There is, helpfully, some work that is currently being done to analyse the numbers and types of providers, as well as the income and economic loss, so we should get a better picture over the next few months about where in the country there are organisations that need to be shored up and should be supported. We are

in the dark at the moment; all we know is that it is a significant problem and there is a significant chance of irreparable wreckage. We will have a better view later in the year. For the moment, the immediate assistance is not quite enough for the voluntary sector as they themselves calculate.

Q92 **Chair:** Thank you. We have been hearing from some of the experts this afternoon that normal NHS elective care may only be able to run at 70% of capacity, waiting lists may double and we may have to radically change our A&E model. We are going to move to our second section. We have been focusing to date on the impact on patients. The next section is on how the NHS is going to feel different for the staff who work in it.

I want to start with what has probably been one of the two big issues of the whole of the Covid pandemic—PPE. Chris Hopson, you have estimated previously that trusts are getting through 80,000 gowns a day, and there was that crucial weekend when we were worrying that trusts might run out of gowns. Have we cracked the PPE problem yet? Is it an operational problem or a procurement problem? What are your members telling you now about where we are with PPE?

Chris Hopson: In terms of our members, which is the 217 trusts, there were three questions. First, was the pandemic stock reserve correctly configured for a respiratory type of pandemic, as opposed to a winter flu-type pandemic? The answer was it was not, and therefore we have had shortages of gowns and visors.

The second issue was that there was a significant distribution problem right at the beginning, when, effectively, the distribution logistics chain got completely overwhelmed. To be fair, our view was that NHS England and the Government, with the help of the Army and the national logistics industry, managed to overcome most problems relatively quickly for the 217 trusts we represent. I recognise it is a very different picture for the 58,000 GP surgeries, care homes and hospices in the voluntary sector.

Where we are now is that, with the notable exception of gowns, where there is a particular issue I want to focus on, the situation has got better. But gowns are a good example of the constraints we face. Because of the shortages of gowns, trusts ended up having to use the very high, top-end maximum *[Inaudible]* gowns, which are normally kept just for surgery, in environments other than surgery.

What we have found is that there are sort of enough around at the moment to restart surgery, but there is not a sufficiently reliable and consistent flow to guarantee that, if you restarted surgery, you could carry it on. Our trusts do not want to say to patients who have been waiting, "Yes, we will definitely schedule your operation," and then find they cannot follow through on that operation because of shortages of PPE.

We are getting there, and everything that we see in terms of the social operation, NHS England, the supply chain and so on is doing the best that

it can, but as you know, Chair, there is a global shortage of PPE. We are competing with lots of other countries, and we find that as deliveries come in from overseas they are not in the volumes or the quality in which they were ordered.

If everything had arrived that had been ordered, and if everything had arrived to time and to quality, we would not have the problems that we have. The problem at the moment is that you cannot guarantee the time, the quality and the quantity, and, although it is not quite as hand to mouth as it was three or four weeks ago, it would be a brave person who said at this point, "We are out of the PPE woods. It is all fine." It is still very much a work in progress.

Q93 **Chair:** I am sure there are going to be other questions on PPE, but can I ask you about the other really big issue on testing? You will be aware of the Cambridge University study of staff at Addenbrooke's that showed that 3% of the staff working in the hospital there were carriers of Covid without knowing it, asymptomatically. Do you think we are going to need to move to routine weekly testing of NHS frontline staff if we are to be able to reassure patients that hospitals are clean of Covid?

Chris Hopson: Yes, we are, and it is not just NHS staff; it is care home staff, I would argue. That is something we know we need to do. We are looking at the moment at how you might do that on a progressive basis, as I think you would want to focus first on those who are most important in restarting emergency services.

Our trusts are telling us at the moment that they cannot guarantee sufficient reliable and consistent access in a timely way to the tests that they need. If, for example, you want to restart emergency services, you absolutely need to know that all the staff involved in that process will be able to get a test, and have it done and turned round sufficiently quickly to guarantee restarting services. Trusts say to us that there are still significant problems of laboratory capacity and access to reagents and chemicals.

That is why the point we have consistently made over the last two or three weeks is that it is not just about the capacity; it is not about 100,000 tests on 30 April. What actually counts on testing is whether everybody who needs access to a test can get it reliably and consistently. That is as much about geographic access—whether you can get the test close to where you need the test to be performed—and as much about who you are prioritising for tests as it is about capacity.

To be honest, our view and the view of our trust leaders is that we are still a long way from where we need to be to have a testing regime that is reliable and consistent, which enables us to restart services in the way we need to.

Q94 **Chair:** On a slightly different topic, Richard Murray, you said in December 2018 that one of the biggest health policy failures of successive

Governments was a lack of workforce planning. I guess that was directed as much at me—as Health Secretary for some of that time—as at others. Looking forward to the People plan, which we were promised before and obviously has been a bit delayed because of coronavirus, are there any big changes you think need to happen in the People plan to take account of what we have learned with coronavirus?

Richard Murray: I think there are. There are some big changes on the positive side about the use of technology and the ambition for how quickly you can move to digital routes. We need to know that they provide fair access, but I think there is more optimism about the speed with which you can move.

There is a real point, as I think Chris mentioned, about the exhaustion of large groups of staff. The People plan offer is to improve morale, to do more on CPD and to provide a better offer to our staff so that the NHS is the best place to work. We need to make sure that we can say that without slightly cringing and wondering how the message will go down. The People plan has to build from what their experiences have been through Covid. We have to make sure that we make a generous offer to staff under the People plan, while on the other hand not making such ambitious offers about restarting services and what the world is going to look like that we are once again setting up too much pressure on the staff we have.

We should also look at how we can draw in staff from the private sector. That is one place where we can increase capacity. Standing slightly back, the People plan is a plan for the health workforce. If there is one thing that Covid has taught us—I know you will be discussing this next week—it is to be very careful about thinking about health on its own. The social care workforce needs just as much attention as the health workforce.

Chair: Sarah Owen has some questions on PPE, testing and BAME staff.

Q95 **Sarah Owen:** Thanks, Chair. Actually, you asked my question on testing and staff testing, so I will move on to PPE.

Whether it is the NHS trusts or ambulance services, or even councils like Luton that I speak to, the issue of PPE is still continuously raised. They have supplies for immediate need, as Chris said, but that is only weeks; it is not long term. They say that one of the problems is that they do not have the same type of PPE or the same supplier; they are still spending a lot of time trying to source PPE, which means that fit-testing has to be carried out multiple times. Roughly, what would your suggestions be to improve the supply to staff of continual PPE now and in the long term?

A related question is that, as we know with most forms of protection, if it does not fit correctly, it is next to useless. One frontline NHS worker said, "PPE is designed for a 6-foot-3 bloke built like a rugby player." I have heard anecdotally from a number of sources that there is a problem fitting the FFP3 masks for certain ethnicities, such as east Asians in particular. Nurses like my mum, for example, struggle to try to get the

FFP3 mask to fit and it has failed a number of times. What are we doing to ensure that our staff are properly protected with PPE, especially the female BAME workforce and pregnant workers?

Chris Hopson: Sarah, if I may say so, that was a spot-on question. There are two or three things. The first is that I talked about the distribution overwhelm. The answer that the Government and NHS England adopted, which seemed to us to be the right one, was effectively to take the pallets of equipment out of the national stock reserve, and then proactively deliver them to trusts.

In the vast majority of items of PPE, there is probably not an issue, but you are absolutely right to identify that with FFP3 masks there is a problem. There were six different mask types sitting in that stock reserve, and trusts found that one day they were getting one type of mask delivered, the next day another type of mask and the next day another type of mask. As you said, that then meant they had to do fit-testing because each different mask required a different fit test. There were other problems along the line—for example, insufficient fit-testing liquid.

The trusts have, in a sense, had to make do and mend in going through that fit-testing process. It can take up to 30 or 45 minutes per person per mask. You asked, "What would be the answer?" The answer would be to get to a stable distribution system in which there was sufficient stock of all the different types of masks, so that trusts could say, "Okay, I just want to have type A because that is what we are used to using, and that is what all our staff have been fit-tested in." Of course, that completely depends on our ability to source sufficient stocks of the different types of mask. At the moment, because of the global shortage, we are reliant either on what sits in the pandemic stock reserve or on what we can bring in from abroad. It is an imperfect situation.

You are absolutely right, Sarah, to identify that one of the consistent issues that is raised with our trust chief executives is that some of the different types of mask do not fit particular types of face. You are right to identify that that has been raised as an issue particularly for certain groups of black and ethnic minority staff. I had heard that east Asian nurses in particular were finding that some brands of mask did not fit in the right way. I have heard variants of your anecdote about some of it being built for 6-foot-3 rugby players.

What trust chief executives have been doing, where they have those particular problems, is trying to source the right type of mask. We have heard that, if that has not been possible, there has been an appropriate discussion with the member of staff to say, "Actually, since we cannot provide you with the correct PPE, should we look at redeploying you to an area where that particular form of PPE is not needed?"

One of the descriptions that we have used is that our chief executives are literally multiple problem solvers. Almost all they have been doing over

the last 12 weeks is identifying an important problem, doing their very best to solve it and trying to get a robust solution. They want to stop being constant problem solvers and get to a reliable and consistent flow of the right type of PPE. I am afraid that is probably a few weeks away, depending on which particular type of PPE you are talking about.

Dr Dixon: I have nothing to add to what Chris said, except the obvious point that it raises very big questions about sourcing essential supplies in this country and the planning and logistics of distribution. I am sure the Committee will return to that and it will be a major feature of its report.

Chair: Rosie Cooper also wanted to talk about PPE.

Rosie Cooper: Most of my questions on PPE have been answered, so may I go on to testing?

Chair: Please do.

Q96 **Rosie Cooper:** The question I am going to ask is about the fiasco that is testing. Virtually every NHS chief exec across the country describes pillar 2 testing as a car crash.

I would like Richard and Nigel primarily to answer whether they think that all those delayed tests, or those taking longer than the specification in the Deloitte contract, should be registered as clinical incidents. That is what happens when X-rays and CT scans are lost. Why is this any different? It is a fiasco.

Richard Murray: Without having sight of the contracts or the arrangements themselves, that is a very difficult question to answer, particularly where commercial arrangements have been made. Contract monitoring and what the responses are might be appropriate.

My only worry is that, at least in some cases, other organisations have attempted to step into the fray, so to speak, and tried to provide what capacity they could in what they also saw as an emergency. In that case, to some extent, some of the slightly more aggressive contractual routes would not be appropriate because they could simply switch the machines back on again and turn them back to the uses they had already. For me, it depends on what the nature of the arrangement was.

Clearly, it is not acceptable. I would not want to lose your point, which is absolutely right. If you are doing testing, it is absolutely essential that the results come back and are available both nationally and locally, or else we are never going to get on top of the way coronavirus is evolving both within our institutions and in our communities.

Nigel Edwards: I have nothing to add other than that they need to be quicker, to make elective surgery and a number of other activities work and to be able to test the staff. I was talking to the chief executive of a teaching hospital in Portugal where they are testing their staff much more than weekly. Some of them are being tested daily. We are way behind

where we need to be. I cannot really comment, as Richard was saying, on the contractual issues. They are clearly very serious, though.

Q97 **Rosie Cooper:** Everybody seems rather nervous about tackling the fact that private companies have been given contracts, but they are failing. People are being offered tests, but the closest I got yesterday was a choice between 50 and 100 miles locally. That is the choice that was offered. Local authorities are not involved. Those people do not have a clue what is going on, and everyone seems to be stepping back from addressing the elephant in the room.

The little testing that is going on is costing a lot of money, and we are not hearing the results. It is not being treated in the same way—as a clinical incident—as it should be. Who is going to pick up that responsibility? The panel is representative of the people who are trying to administer that. Surely they are as worried as the chief execs I talk to.

Nigel Edwards: There is a more general point about the underuse of the expertise of public health directors and the infrastructure of local authorities for testing and tracing that that comment elicits. We have been very concerned about the extent to which we seem to be relying on a vertical programme to do testing and contact tracing. One might reflect that some of the other attempts to do things by big vertical programmes run from central Government have not been brilliant in a number of areas. We should look very seriously at the role that local government could play.

There is an issue with commercial performance, but my experience of most of those types of failures is that there is often fault on the part of the commissioner as well as the companies delivering it. Without a much bigger investigation of what has been going on, it is quite tricky to get to the bottom of it, but there clearly is a problem.

Q98 **Dean Russell:** I am very conscious from speaking to many people across the NHS that black, Asian and minority ethnic groups seem to be impacted quite heavily within staffing and across the community. It is not just the nurses and doctors; it is the porters and cleaners, across the whole range of staff. At the very frontline—those dealing with Covid cases—full PPE is being provided. When we get to people who are cleaners and porters, doing the sorts of jobs that can be dangerous in their own right, depending on which wards they are in, what sorts of things do you think should be looked at to make sure we are protecting those groups, who may be more vulnerable?

Secondly, is there any more evidence about why they are more vulnerable? More broadly, there has not been much discussion about male versus female or people who are overweight, who also seem to be particularly targeted by Covid. I am interested in your thoughts on that in the round. How should we tackle it, and is there any evidence that we are starting to see around those particularly vulnerable groups?

Richard Murray: I will take them in reverse order. Why are BAME staff and citizens more vulnerable? I wish there was an easy, scientific answer that we could base action on. We certainly know that they are. There is an ongoing debate about whether it is a collection of risk factors and incidences of things like diabetes, or whether it relates, sometimes at least, to living in bigger households. Either way, we know that the end result is the same; they are at higher risk. That then feeds back into the point around other staff in the hospital sector. It also plays into staff working in social care, whether it is in care homes or in domiciliary care.

Unfortunately, it ratchets up the requirement for PPE and testing, to make sure that if we are testing all the clinical staff—the nurses and doctors—we are also treating porters and cleaners. You cannot run a hospital without them. They move in and around the wards, care homes and people's homes providing social care in exactly the same way. It makes the ask bigger, but you are absolutely right that they are providing essential services. They are at risk and, equally, they can transfer the virus themselves.

Q99 **Taiwo Owatemi:** My question is directed to Dr Dixon and Richard Murray. In a survey of over 2,000 BAME NHS staff, 50% stated that there was a culture of discrimination within the NHS. They felt that they were unable to speak up due to the lack of BAME representation in leadership roles. Currently, only 6% of NHS leadership positions are BAME staff. As the NHS plans for the long term, what practical steps are being taken to ensure that there is diversity in leadership positions across all professions?

Chair: Who wants to come in first?

Dr Dixon: Richard can comment on leadership, and then I can say something about BAME groups more generally.

Richard Murray: It is an excellent point. In some ways, the things that we have seen around coronavirus and the unequal way it has hit the population are exactly reflected, I am afraid, in very long-standing issues around culture and inclusion within the NHS.

The main theme at the moment is around the workforce race equality scheme. There is a whole set of practical things that can be done to try to make sure that appointment panels are configured correctly. We know that if there are no BAME staff on appointment panels it is much more likely that BAME staff will not get through them.

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

and more resourceful in trying to overcome some of those long-standing inequalities.

Dr Dixon: I have a few points about the differences in health and how Covid has affected different groups. The best study that I have seen shows a fourfold difference between black ethnic minority groups and deaths from Covid compared with the white population. If you adjust for everything the researchers were able to adjust for—for example, poverty, socioeconomic group or self-reported health—that difference of four times halved. Even if you adjust for everything you possibly can, you still get double the risk of death from Covid. No one truly understands that, but it is possibly related to exposure in the way Richard was referring to.

We know that the risks for death from Covid are being male, overweight, age, BAME and pre-existing conditions. Making a wider point, Covid has exacerbated existing inequalities that we know exist in the population. Maybe now it is time for an inequalities strategy, off the back of Covid, to try to address some of those issues more purposefully than we have been able to do over the last 10 years.

Q100 **Taiwo Owatemi:** Following up on health inequalities, as we all know, many BAME people tend to live in communities that are poorer. The data shows that Covid-19 has a higher death rate in poor inner-city communities. What is being done to ensure that one's health is not dependent on where one lives?

Dr Dixon: I am afraid your health does depend on where you live; we knew that before Covid. Covid, as you exactly point out, is making things a lot worse. That is why we should have a purposeful inequality strategy to reduce the gap between rich and poor and different ethnic groups. The gap has been widening over the last 10 years. You will remember the Marmot report that was published just before the Covid outbreak. You can bet that Covid has made that gap much wider.

As a society we need to think about how that is addressed going forward. It is something that should be firmly on the Government's agenda.

Q101 **Dr Evans:** I have two questions. The first one is for Chris and Nigel and is around staff and litigation. As someone who has practised as a GP for a long time, I know you practise defensive medicine. You are very worried about the fact that you could get struck off if you make a bad decision. Telemedicine has made that even more difficult, through the fact that you are trying to make an assessment over the phone regarding whether or not you think a person has pneumonia, Covid or something else.

Do you have any thoughts on protecting your staff and how to deal with that, going forward? I know that the MDU is very concerned about it. Both in your role practically and as a think-tank, what are your thoughts?

Chris Hopson: *[Inaudible]* concerns our chief executives and concerns the clinical staff for whom they are responsible. We have already had several conversations with our colleagues at NHS England and

Improvement to ensure that people are not *[Inaudible]* and that we recognise the situation we have been in. When you talk to our chief executives, they say, "We have had to do some really difficult things at incredibly high speed and we have done them in the best way we possibly can."

There was some very helpful work just before the crisis hit. A whole load of pathways were redesigned at incredible speed. We need to recognise that lots of decisions were made at real pace, and that therefore we need to appropriately support staff who made those decisions.

When I talk to chief executives and say, "What worries you about the coming period?", there are people who are worried, exactly as you say, Luke, and concerned that they may be on the end of some vexatious litigation. It is something that we are all going to have to manage appropriately in the NHS, recognising that it is right that people are held to account. If you are providing healthcare, there is an element of being held to account.

I fear that there is quite a lot of use of that famous new piece of equipment called the retrospectoscope, where people will, with hindsight, say, "Well, actually, if we had been there, we would have done it this way." We all need to recognise that decisions were made at pace, and people tried to make the best decisions, in line with the guidance available, but inevitably chief execs say to us that they will have got some things wrong.

Q102 **Dr Evans:** I would like to hear Nigel's point on that. My final question is for Richard. PCNs were brought in, and you guys have done a lot of work on PCNs and their impact. We heard in the last session, with the RCGP, that they seem to be quite useful in this case. Do you agree with that statement? Going forward, how do you think that is going to help in looking after the care sector? That is more of a policy-based question.

Nigel Edwards: I do not have a huge amount to add to what Chris said. There is a distinction to be made about the judgments that people have made during the crisis, but, if we move forward to a model in which people have to do more consultations by video and telephone, there are some issues about that. There is some evidence that GPs doing telephone and video consultations become more risk averse, order more tests and are more likely to prescribe antibiotics. They may well make mistakes.

I made a comment earlier that in the future we may have to hold ourselves to account on standards that are not achievable in the environment in which we will find ourselves. That will be a challenge, particularly when things start being taken to court.

My comment on PCNs is that, from the ones I have spoken to, they appear to have played a very useful role. They will be extremely important in the future as one of the mechanisms to help to deal with the

problem of how we are going to manage the level of demand we have with significantly reduced capacity.

Richard Murray: Some of the primary care networks have definitely managed to play a big role for general practice. The example of care homes is a good one; we have seen some that have reached into care homes and tried to provide a lot of support. My only caveat would be that those are new. Some primary care networks that are a bit further along the path were a federation before, when there had been some previous network in place. Yes, it is easier. We have to recognise that some existed almost more on paper than they did as real decision-making bodies. They are not an organisation even where they are stronger.

There are optimistic signs about what they can do, but there is a note about pace. The evolution of primary care networks across the country is very varied, reflecting the fact that formally some of them are barely past their first birthday.

Q103 **Barbara Keeley:** Going back to PPE, Chris has described the problems with getting PPE for the NHS, the global shortages and the logistical problems, but we should say, and hopefully accept, that it was much tougher for social care. Not only did the same factors exist, but in social care they were competing with the NHS. I found, liaising with care homes in my constituency, that that was a real issue for them, particularly for homes that were not in a chain. There were some advantages for homes that were in a chain of other care homes because they could get into mutual aid arrangements.

As we look at the issues you talked about, Chris, in terms of how we can stock the NHS—I can see that that is a big enough problem—we should not be doing it at the expense of getting the PPE that is needed to the care sector. Even though we keep mentioning care homes, there is care beyond the care home sector. There are still real issues with PPE out in the community.

Chris Hopson: You describe that really well. When we have been talking to those in NHS England and Improvement and in the Government who are responsible for the distribution and logistics of PPE, they recognise that it has not been done satisfactorily and has taken a very long time. I do not think that we are there yet.

When we talk to them, we get the sense that there are 58,000 different institutions. You made a good point about the difference between those in chains and those who are single operated. I want to reassure you that, wherever possible, trusts have been doing their very best to try to support social care. One of the advantages of the STPs and ICSs—the local integrated care systems and sustainability and transformation partnerships—has been that by bringing health and care together they have proved, with the local *[Inaudible]* community, cases where social care has been able to say, "Look, we are really short" and the hospital or the community mental health or ambulance trust has been able to say,

"Well, actually, as it happens, we can help." Wherever possible there has been that mutual aid. That is something we know any subsequent public inquiry is going to have to look at, because it has not been done correctly and properly.

Q104 **Chair:** We are going to move to the third and final section. We have just had a very good discussion about NHS staff, the issues for BAME staff, and PPE and testing. In this final section, we are going to look at what lessons the NHS needs to learn for the future as it puts coronavirus behind it. I heard an interesting statistic yesterday. Pre-coronavirus we used to do about 200 video consultations a day in the NHS. Now it is 6,000 video consultations a day, so there will be lots of changes.

The Government have promised an NHS Bill to support the NHS 10-year long-term plan. There is the opportunity for primary legislation to support some of the structural changes that have been happening in the NHS in recent years. Chris Hopson and Jennifer Dixon, what legislative changes do you think will be most helpful in the NHS Bill that the Government are due to bring before Parliament later this year?

Chris Hopson: It is a bit difficult to tell at this point exactly what lessons we might learn. I would probably point to two areas where we will need to think carefully.

First, this has shown that we probably do not have the national architecture right. Testing is a very good example. We counted seven or eight different central Government or arm's-length bodies that were involved in the co-ordination of testing. I do not think anybody could sit here and say with a straight face that that was, first, the right number or, secondly, that accountabilities and responsibilities were clear. There will be a question around what the arm's length body architecture looks like and what the relationship is between other parts of Government and those arm's length bodies. That would seem to me to be one question.

The second is that, as you know, before we went into the coronavirus crisis there was a developing debate about what the relationship should be between STPs and ICSs and individual trusts. The observation I would make, channelling what our members have said to us, is that it is very clear that what has happened, as we have gone through the crisis, is that individual trusts—acute, community mental health and ambulance trusts—have come to the fore to deliver that operational response.

There is an interesting question that needs to be asked. Everybody is saying that STPs and ICSs have had an important role to play in bringing health and care together, but they also allow horizontal collaboration between different trusts. An idea that some were trying to push was that you could simply have accountability and statutory responsibility held at the STP and ICS level, and that trusts could somehow fade away. It seems to me that the crisis has shown that it is the frontline delivery of care that counts, and we need to be very careful about having leadership,

management and statutory accountability moving too far away from frontline care.

If you move to a 44 STP and ICS system, and they are the only institutions that have statutory accountability, that does not feel to me to be the right answer. It will inject an interesting element into the debate about what the relationship should be between STPs and ICSs and, on the other hand, with individual trusts going forward.

Q105 **Chair:** Chris, you sometimes do surveys of your members. One thing that would be very helpful for our inquiry would be if you were able to survey them on those issues—the structural changes that they think should and should not be considered—and on some of the earlier issues we have been talking about, such as PPE, testing, how patient services are going to resume and how we are going to deal with the backlog. When you have that survey, maybe you could bring it back to the Committee. It would help us enormously if you felt able to do that.

Chris Hopson: Yes, we would be very happy to do that. We will talk to both you and the Clerks about exactly what areas to cover and how quickly we might do it. Yes, we would be delighted to do that.

Q106 **Chair:** Thank you. Jennifer Dixon, could I bring you in on that point?

Dr Dixon: On the legislative changes point, I think my comment will probably be unhelpful. I think it is too soon even to consider any legislative changes for the NHS. What I would do is focus entirely on social care and try to sort that out and reform it in the way the Government want, and use legislative time for that.

I would pause on any further legislation for the NHS until there has been a proper analysis of what has happened with the pandemic and we can discuss the wider learnings. For that, I would return to Don Berwick's very interesting report from 2013, "A Promise to Learn – a commitment to act." That was a very open, no-blame, no-fear approach and inquiry to understand some key elements of what has happened, and therefore what needs to be done and what would be helpful with respect to teeing up the NHS in a slightly different way.

A lot of the learning may well not need legislation. I would pause on the NHS and go straight to social care without delay.

Q107 **Chair:** That is very clear. Richard Murray, you told the Committee last year that, if the Government really wanted to integrate health and social care, legislative changes would be needed sooner rather than later. Is that still your view? Should that be one of the priorities? Are there other things that you would think about?

Richard Murray: The measures that were in the original legislative proposals still look helpful. They are slightly technocratic and probably not the stuff of a march down Whitehall, either for or against, but they are still useful. They were built up from a lot of engagement with NHS

leaders, and I still think that they look acceptable. They do not set out a blueprint for the future of the NHS. They are probably a "nice to have" rather than something truly essential.

What we have seen through coronavirus, echoing something Chris was leading towards, is that even despite the lack of legislation it has not stopped NHS trusts working together. The idea that you would use legislation to downplay the role of trusts and increase that of STPs looks slightly odd, given that we certainly have not needed it over the last month or two.

Finally, if Chris does his survey with NHS leaders and asks them whether they would like a series of architecture changes in the NHS or a lasting solution to social care, I can pretty much guess at the answer. They will go for the latter and not the former.

Q108 **Chair:** Thank you. That is a very important point.

Nigel Edwards: I do not have much to add. I agree that it is too early to tell which legislative changes we need. There clearly is an issue about the confused accountability and responsibility between the different arm's length bodies and exactly what the role of the Department is. It is notable that some of the bigger problems, as I alluded to earlier, seem to be with the centrally run programmes rather than the ALB ones.

Social care is an absolute priority. A lot of our focus has been on fixing the funding side of social care. What the crisis has shown is that we probably need to look at the provider side as well and make that more robust. It is not an issue for legislation. Jennifer's point, and indeed everyone else's, about where we should put our effort is that getting the social care problem sorted out, which has been festering for a couple of decades, is absolutely the key priority. We can learn what we need to learn about what can improve and what structural changes might be needed, but it does not strike me that it is an immediate priority compared with the other things that face us.

Q109 **Amy Callaghan:** My question is probably directed to Richard and Nigel. How effective has the use of technology and digital alternatives been during the pandemic? Are there plans to ensure that that use of technology remains once we are out of the pandemic?

Richard Murray: At first sight, one of the amazing developments is the speed, and the acceptability to staff, patients and users, in how digital technology is moving forward, whether that is in general practice or for out-patients, and increasingly in remote diagnostics as well. That is great.

There needs to be a degree of evaluation to make sure that it has worked exactly and as well as we think it has done. Obviously, some parts of the population will struggle to deal with digital interactions. They may not have the kit. They may not feel inclined to use it or be able to use it in the same way. We need to make sure that it has not altered inequalities, but it should be a major plank of any recovery from Covid. We want to

keep the speed at which we have moved into the digital space. That is really clear.

We seem to have made progress in a matter of weeks that took us years before. That is something to try to keep hold of in the next months and years. Of course, it helps with our physical distancing as well if we are not actually in front of the patient. It cannot work for all things, and we need to recognise that, but retaining some of those gains should be a really important issue for all leaders.

Nigel Edwards: The telephone has turned out to be quite a useful piece of technology. It is an old one but it works rather well. Video has been employed for teaching patients how to do self-care very effectively. We have seen an upswing in the use of digital for communication between GPs and consultants. That offers some very major opportunities to build on. We are going to need to move away from the traditional model of a GP writing a referral letter, a patient being seen in a clinic and then a letter coming back, to one in which consultants, particularly those dealing with chronic diseases, work very much more closely with their colleagues in primary care. Technology offers a big opportunity to do that.

The technology has also allowed us to get a lot better at identifying patients who are at risk. People have managed to overcome the barriers created by our rather complex and arcane information governance rules. At the beginning of the crisis, there were a few complaints that vital people were not able to access the information they needed—for example, to contact shielded patients or identify people they needed to be working with— because of assumed problems with information governance. Sorting out some of that is probably one of the most important lessons. Do we actually have a system that balances privacy with the effective use of information?

I suspect that we will be able to hold on to many of the gains. People are going to have to continue to use these technologies for a considerable period of time, for the reasons we talked about earlier—the need to retain social distancing. By the time we come out of it, they will be so used to it that we will have managed to capture many of the gains.

I hope we will have discovered some new ways of using it that we had not thought of before. For example, one care provider I was talking to has a system that goes from prescription to delivery of chemotherapy without a single individual transaction involving a person, up to the point when the chemotherapy is delivered. We are going to see more of those innovative things. Rather than just substituting video for face-to-face consultation, we can use technology to completely redesign the way that some of the pathways work.

Q110 **Amy Callaghan:** I want to pick up on a point that Richard touched on. What risks do you both believe that this increased use of technology could pose to those who do not have access to, or cannot use, technology? We do not want people to be left behind as we move out of

this pandemic, or during it.

Nigel Edwards: One of the problems the NHS has is a tendency to say, "If we cannot give this to everyone—*[Inaudible]*

Chair: You seem to be freezing, Nigel. Apologies. Shall we try Richard?

Richard Murray: I can channel Nigel for a moment. The fact that not everybody can use the service, or that it may not be appropriate for patients, is not a reason for us not to do it. We need to make sure that we have other channels by which people can get easy access.

There is learning from the DWP on the benefits side about trying to go to digital first and who that turned out to exclude. Some of the representative groups from charities and patient groups already know an awful lot about what works and what does not work for different parts of the population. That is why it needs a little bit of evaluation. If it works for most people, who doesn't it work for and what do you need to put in place to make sure that they still get easy and timely access? We must not end up biasing the service towards very tech-savvy 20-year-olds who may have slightly lower health needs than other people.

Chair: It was no irony at all that Nigel's picture was frozen just as he was talking about the power of new technology.

Q111 **Dean Russell:** Following Amy's excellent question, I want to build on a similar theme. Back in April 2009, when I worked in the digital world, I wrote an article for the *Health Service Journal* called "Patients getting connected". I was talking back then about prescribing technology for patients, being able to book appointments online and so on. Many of those things have now come to the fore. However, it has taken nearly a decade.

What things are you seeing now that are shifting and changing and should not wait a decade to come into play around the technology piece? One of the aspects is around things like single customer view, so that we do not have all of those silos in the technology and data collection from patients.

It seems to me crazy in the modern world that big business can have a very clear view of an individual, based on advertising to promote products and so on, yet in the NHS and social care all of those bits of data are often siloed. I am interested in your views on that. What are the barriers? Why isn't it happening? What needs to be cleared out of the way in terms of red tape to enable us to get to a much quicker view to help patients holistically in the next few months and years rather than waiting a decade?

Richard Murray: Some of it relates to the point about IG rules. There has been a lot of nervousness around the sharing of data. I hope that what we have seen through Covid is a piece of learning that to a large extent the public do not mind, as long as they know it is going between

trusted sources. We have managed to overturn some of that and move at pace, and we want to keep that.

It is partly a technical issue. I do not think it is largely a technical issue, but there is also a question about staff and their attitudes to sharing data. I hope through what we have seen over the last few weeks that some of the views about how acceptable it is to move patient level data across the system will have changed, but, as we do it, we have to remember that some of the evidence from the United States about heavy use of digital was that it really turned staff off.

What we have found through the last few weeks is that that is absolutely not necessary. At the same time as we have been designing systems that are accessible and give us the kind of flexibility we need with patients and users, we have not inadvertently given staff a digital nightmare. As I say, there is quite a lot of evidence from the United States that it is closely linked to burn-out and lack of satisfaction with work. We have not hit that here. It is about trying to keep that learning.

Q112 **Sarah Owen:** This question is related to the point that Richard just raised around staff morale and making sure there is no burn-out, as well as, broadly, all the technology and the changes that are needed in the care system in a post-Covid world. It is going to cost money, so this is about funding. Do the panel think that the funding settlement that the Government announced to fund the long-term plan will be enough to tackle the growing backlog and to recruit the staff we will need to deliver the services in a different way, or will there need to be a new funding settlement?

Dr Dixon: We set out a while ago what we thought the NHS needed. The amount that was given—the £20.5 billion extra—was enough to keep the service ticking over but not enough to modernise. We can revisit the figures there and provide them to the Committee, but we thought that more was needed to modernise.

Capital investment in the system has been very low. We spend about half the OECD average on capital, which obviously funds some of the technology we have just been talking about. Covid has shown that we have some big infrastructure issues. Our capacity is lower than in other countries we like to compare ourselves with—in particular, the numbers of staff and beds. There need to be two big look-ats: staffing needs and capital needs going forward. Perhaps we need another beds inquiry to understand how much we need going forward, taking into account demand and technology, but also taking into account that we now need to think more seriously about having reserve capacity in the system. We would be very happy to share our analysis of that with the Committee.

Perhaps I could add one final sneak-in on the use of new technology. *[Inaudible]* Technology is great when it comes to ease of booking, ease of transactions or ease of getting your prescription. Another use of it is in the therapeutic space, which is how patients get better and their

treatment. We need a much longer look at how technology has a longer-term therapeutic impact on patients, not just for an immediate transaction but over a year, particularly for patients with chronic disease. We know that a lot of patients with chronic disease have difficulty accessing digital technology or using it or, indeed, expressing themselves other than in a face to face.

We need to revisit investment for the NHS over the coming period: staff, beds, money, capital. We also need to think very carefully about some longer-term assessments of the impact of technology on the outcomes for patients, particularly those with chronic disease and those in socioeconomic groups who may not be so used to using technology.

Chair: Thank you, Jennifer. You had the curse of Nigel Edwards: your line started to break up just as you were talking about new technology. I think we got the gist of what you were saying. If you were able to write to the Committee with the thoughts of the Health Foundation on the funding settlement, it would be extremely helpful.

Dr Dixon: Yes.

Q113 **Chair:** On the funding point, I will bring in Chris Hopson, as I know he will have views on it.

Chris Hopson: Yes. The work that Jennifer and the Health Foundation did with the IFS demonstrated that, if you want just to keep pace with existing demand, we need annual real-terms funding increases of around 3.5%, which is where we have landed up. That is very different from where we have been over the previous decade. I think it would be appropriate to say to the Chair that he had a very important role in getting us to that point.

The reality is that Jennifer's report said that if we wanted to go through the backlog we needed to go to 4% annual increases, and if we wanted to modernise the service we needed to go to 5% annual funding increases**.** At 3.5%—actually just below that, 3.4%—we are just marking time, but don't forget that the backlogs and the demands have now grown.

To give you a very simple example, before we went into coronavirus an important piece of work was done by NHS England and Improvement looking at emergency bed capacity. The conclusion that everybody had very clearly reached was that we had insufficient capacity in the NHS, and that we had effectively shrunk our bed base to too low a level, and we needed to make a significant investment in not just increasing the bed base but recognising that very large numbers of hospitals had insufficient physical capacity in emergency departments to deal with the demand that hospitals were now facing.

Jennifer is absolutely right to identify that we needed a capital settlement to address not just new hospital building, and not just backlog maintenance, but ensuring that we sorted out technology *[Inaudible]* needs like, for example, *[Inaudible].* The obvious question is that we are

clearly in a position where, if you look at the bill that is going to arrive *[Inaudible]*—

Chair: Chris, we are losing you; I am so sorry. The line is going. I am going to move on to someone else, and then I am sure we will come back to you. Four people want to ask questions, and we have to finish in nine minutes.

Q114 **Rosie Cooper:** It seems that national policy specialists believe they are good operationally. Why does one of the panel—let's say Nigel—think that local government doesn't work with local authorities and use their knowledge? There is also an impression that Government and regulators do not trust NHS leaders. Why do you think that is?

Nigel Edwards: I am not sure that I fully know the data that gives the premise for that question. I know a lot of systems where local governments and local NHS leaders work extremely well together. Where you find they do not, the reasons are often quite complex and not immediately clear.

Sometimes, it has been because local government has felt that the local NHS is basically pursuing a nationally set agenda that does not fit with its local system. I see lots of examples of skilled local leaders on both sides of that fence who have managed to find effective ways of working. We probably need to make sure that that good practice is spread.

Q115 **Rosie Cooper:** My local resilience forum is very clear that it cannot get access to the detail it needs, and it is not being consulted locally.

One final question from me. With the lack of oversight from the CQC and local authorities' restricted access to patients' families, reports have suggested that there has been an increase in DNRs in patient records—for example, people with learning difficulties and mental health issues. There is a suggestion that this has been done without the appropriate legal requirements. Are you assured that patients in the NHS and care homes are being appropriately supported?

Nigel Edwards: You are asking me a question that is some considerable way out of my area of competence or knowledge, I am afraid. I am sorry.

Q116 **Rosie Cooper:** Would Jennifer be able to help with that, or Chris, on the ground?

Dr Dixon: I am afraid I am not on the ground, like Nigel. We are in the same position.

Chris Hopson: Rosie, you have consistently pointed to the importance of appropriate governance, assurance and accountability at trust level. We are in extraordinary circumstances, but I can tell you, from talking to chairs and non-executives, that they take very seriously their role of ensuring that trust executive teams are doing the right thing, and they are doing the best they can in some difficult circumstances.

My view is that the CQC has been right to be careful in thinking about what activity it undertakes. Clearly, we are in extraordinary times, so we are not going to be able to do things in the way we have done them in the past. I assure you that things like assurance and quality control are really important to trusts. They are carrying on with those in exactly the way you would expect, but they are doing things differently because they have to, due to the nature of the response they are able to give.

Rosie Cooper: If the NHS cannot deal with it, I am sure the police and people like that will have to. Thank you.

Barbara Keeley: I agree with the points made by Jennifer and Richard about prioritising social care reform, much as it would be good to have NHS legislation. There is an important point to be made about making providers more robust.

There have been reports over the last number of days about care homes on the brink of closure. We have to take that very seriously indeed. There are things like the cost of PPE for care homes and things like funding empty care beds. The home featured in much of the media as on the brink of collapse is rated outstanding by the CQC. That is a pretty serious thing. The point they make is that they were largely nursing patients funded through NHS continuing care funding. There are some serious things to be looked at by CCGs.

The final thing, which we cannot deal with today, is that we have to address how to ensure survival and increase stability for those care homes. We must change the way we think about them. The key aspect, apart from funding, is morale and how down they feel, and how hard it is for staff after so many deaths. We will have to take that into account.

Chair: Thank you, Barbara. We have Professor Martin Green coming next Tuesday, so I am sure he can answer those questions.

Q117 **Dr Evans:** We have five minutes left, and I have a question to go down the panel. The pandemic is huge. With your organisational hat on, what has surprised you the most?

Chris Hopson: That is a really good question. Probably the thing that has surprised us the most is getting consistent feedback from clinicians that it has presented in ways they were not expecting. We were expecting much higher levels of need for ventilated critical care beds. We planned for that, but it did not happen.

The other one that has surprised people, where we are trying to do as much as we can as quickly as we can, is what we have already talked about—the disproportionate impact on black and ethnic minority communities. That really felt like it came out of left field. We mobilised as quickly as we could to deal with that, but it was a bit of a surprise. Those are the two things I can think of.

Dr Dixon: What surprised me, frankly, was that the NHS moved as fast as it did to bump up critical care and ventilation. I thought that was

extremely impressive, as was the amount of reconfiguration locally and the amount of pathway change that has happened. Collaboration nationally *[Inaudible]* has been stunning.

The logistical problems of PPE and testing have surprised me in the other direction. You would think that with a centralised system that would not happen to the extent that it has. We obviously need to deal with both of those.

Nigel Edwards: I was going to say exactly the same things as Jennifer has said, so I will pass.

Richard Murray: I agree with Jennifer, but let me add another one. Despite the fact that we saw evidence in Italy, Spain, France and others that social care was going to be the second problem for coronavirus after the hits on intensive care, we did not seem to take that on board. I do not want to lose the positive points that Jennifer made, but there is a question about how we were so slow given that we had seen what happened in Europe.

Chair: Thank you very much indeed. Last but not least, James Davies.

Q118 **Dr Davies:** To end on a positive note, we have seen many thousands of former clinicians returning to the NHS, or at least offering to return to the NHS, through the GMC and the NMC. What does the panel feel is the best way forward to keep those people engaged? Some of them have not yet been asked to help; they have not been needed. Of course, many are put off by revalidation and annual appraisals and suchlike. What is the way forward to make sure that we can benefit from their expertise?

Chris Hopson: A good question, James. All the trusts we have been speaking to have been trying to create a very wide range of opportunities. Clearly, you can engage in frontline NHS care. There are opportunities, for example, to go and support 111. One of the things I am particularly pleased we have been doing is saying, "Can we support our social care colleagues by asking the people who have returned to potentially go and provide greater nursing support in care homes?"

For me, the idea is to provide as wide a range of opportunities as possible, given that those returning staff may well want to do different things. Some of them, for example, have already said that they do not want to return to frontline care, so going to 111 to help there has been a very good use of their talents. There is a good range of opportunities for them.

Chair: Thank you very much indeed. That brings us to the conclusion of today's session. On Tuesday, we are going to focus on the social care sector. We have been focusing mainly on the NHS, but of course social care has come in. Could I ask the three think-tanks whether you would consider writing to us, either separately or together, with your thoughts on what the social care funding settlement needs to be in this Parliament if we are both to meet increased demand from an ageing population and

make sure that we properly protect the NHS through winter, and avoid the cycle of winter crises? If you are all happy to write to us on that basis, the Committee would very much welcome your thoughts.

I thank you all for the evidence you have given and for your very insightful answers. A very big thank you to Richard Murray, Nigel Edwards, Jennifer Dixon and Chris Hopson. We have really enjoyed listening to you. I thank the technical team at the House of Commons and my Select Committee team. With that, the session is concluded.