HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond, HC 320

Tuesday 16 June 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Sarah Owen; Dean Russell; Laura Trott.

Questions 119 - 178

Witnesses

I: Dr Katherine Henderson, President, Royal College of Emergency Medicine; Professor Derek Alderson, President, Royal College of Surgeons of England; Mick Armstrong, Chair, British Dental Association; and Rob Martinez, patient who has been in need of joint replacement surgery.

II: Daloni Carlisle, cancer patient; Dr Charlotte Augst, Chief Executive, National Voices; Sir Robert Francis, Chair, Healthwatch England; and Dr Layla McCay, Director of International Relations, NHS Confederation.

Examination of witnesses

Witnesses: Dr Henderson, Professor Alderson, Mick Armstrong and Rob Martinez.

Chair: Welcome to the House of Commons Health and Social Care Select Committee, where this morning we are focusing on what the new normal will look like for the NHS post lockdown and what the impact will be for patients. We are going to hear from a wide range of witnesses, including experts, senior doctors and patients.

I start by introducing our first panel. A very warm welcome to Professor Derek Alderson, who is president of the Royal College of Surgeons; Dr Katherine Henderson, who is president of the Royal College of Emergency Medicine; and Mick Armstrong, who is chair of the British Dental Association.

Before we hear from them, we are going to talk to an NHS patient about his experience during the pandemic. Rob Martinez is from Bracknell. He has been waiting a long time in a great deal of pain for joint surgery. Rosie Cooper is going to ask him a few questions.

Q119 **Rosie Cooper:** I would like to begin by thanking you, Mr Martinez, for joining us this morning. I have read a little about the wait you have had. Would you like to describe your experience in accessing medical services during the pandemic and the impact it has had on you?

Rob Martinez: Thank you very much for this opportunity this morning. I will give you a brief diagnosis of my condition and take you through the journey of the knee pain I have had through the pandemic.

I am waiting for replacements for both my knees. I also have an underlying health issue. I have lymphoedema in my legs, which I contracted from previous surgery about seven years ago. I already have significant pain and swelling in my legs, accompanied now by the fact that my knees have basically perished away as well.

I started to get knee pain about two years ago, so I have been on this journey for two years. I was referred to the NHS waiting list in October last year. I got notification in March this year that I was going to have my first knee replacement done on 17 April. Unfortunately, that got cancelled towards the end of March. In the meantime, I had to take early retirement because I was in too much pain between the two conditions. I was having difficulty walking, so that came to a halt.

During the pandemic, I have had to use the medical services of my local GP, but not so much my local hospital until yesterday, when I actually contacted them. At the local surgery, they have been absolutely marvellous. I have had two appointments during the pandemic and a telephone consultation. To be fair, they were working better during the pandemic than they were prior to it. I was absolutely amazed at how quickly I got appointments and got through on the phone. Generally, I cannot say anything bad about the doctor’s surgery.

However, with regard to my local hospital there is a slightly different story. The last I heard from them was in March, when they phoned me with the bad news that my operation was being cancelled indefinitely. I have heard nothing from them since. Yesterday, in preparation for today, I thought I would give them a call to see if they could give me some idea when I might be getting my surgery.

To my shock and horror, I was given some pretty bad news yesterday, which has put me in a bad place now. I have been told there is zero chance of my first knee replacement being done this year. I was pretty shocked at that, considering that I had an operation date of 15 April this year. I find it hard to believe that, even when things get back up and running again, it is probably not going to be until next year that I have my first knee replacement. I am a little bit puzzled by that.

I explained that I was in a lot of pain. I was told that, when surgery is reinstated, it will be done on a priority basis of urgent cases and that if I felt I was an urgent case I should go back to my GP and ask him to contact my consultant for me to be considered as an urgent case. On hearing that yesterday, I immediately phoned my surgery and was very lucky to get a call-back in the afternoon from my doctor. When I explained it all, he was absolutely horrified and quite angry about it, saying, "This is ridiculous. This is not necessary. This is just wasting GP time. You have already been referred to the consultant. He knows how bad you are. You already had an operation in place. This is not necessary." He is actually going to take it up himself with the consultant.

I have continued to get worse, pain-wise. No medication whatsoever works for me, so I am getting nowhere. In relation to the physical impact it has had on me, obviously I have ongoing pain in my knees. I have difficulty climbing stairs at home, and anywhere else. I have pain when walking and sleeping. I basically have pain all the time. No medication that I have been on has helped me at all. I also now have pain developing in my left ankle, which I have been to see my GP about during the pandemic. I am awaiting a blood test because there is a possibility that I now have arthritis in my ankle as well.

Turning to the emotional impact it has had on me, my life feels very much on hold at the moment. It is really frustrating. It affects me; I am frustrated and anxious. My family and social life have been affected as well. It is having an impact on my mental health. It is the not knowing. It is as though my whole life is on hold. I am just getting worse, to be honest. I would like to get my life back again. That is what I want.

With regard to how things could have been dealt with better, was it really necessary for every hospital to be closed to surgery, which I assume is what has happened? Could there not have been a small number left open that could continue surgery? There is obviously a massive backlog, let alone the backlog that we had before the pandemic. I had already experienced a massive delay, and it is now going to be far worse. I would have liked to have some updates from the hospital. There was nothing. There was no offer of pain management. There was nothing whatsoever. I had no updates at all until, as I say, I rang them yesterday.

I have concerns that my health is going to get worse before it gets better if the delay is much longer. I know myself that things are not right, and the pain has got worse during the last couple of months. I very much want to say a great thank you to the arthritis charity Versus Arthritis because they have helped me tremendously through the last 12 months. Without their help, I think I would have been in a worse place, to be honest. Their support has been fantastic.

I would very much like to get a true reflection, if possible, of what I am expected to have in front of me now as a true delay period. Is it going to be next year, as they seem to be forecasting from my local hospital? I want to get at least my first knee replacement done this year, if it is possible.

That is me in a nutshell at the moment.

Q120 **Rosie Cooper:** Thank you, Mr Martinez. You describe a really poor set of conditions as regards communications, except with the arthritis charity. How do you think it could have been handled better for you inside the NHS?

Rob Martinez: I cannot complain about the doctor's surgery side of things because they have been marvellous. They have been there for me, but on the NHS side of it, with the hospitals, I think they should be in contact with people, to keep them aware that they have not been forgotten and that things will eventually come back again. They could have given a phone call or an update, but it went completely silent. It is almost like, "Is this going to happen? Isn't it going to happen?" You were left in the lurch. They could have helped by being in contact with people.

Q121 **Rosie Cooper:** You describe poor communication. Certainly, you are not describing to me patient-centred care. They might be medically ready, but you, as a whole person, have not been taken along on that journey. I know and appreciate what you are saying because I have had two knee replacements. It is a difficult place to be if you are in pain and nobody is talking to you. Is there anybody you could have turned to other than your GP? You have nobody else to go to?

Rob Martinez: No. It is something that you obviously discuss with family and friends, but they are in a small minority. Unless you have this pain, it is hard to really understand it.

Q122 **Rosie Cooper:** I meant within the NHS. Do you have somebody in the hospital that you can go to?

Rob Martinez: I am not aware that I have, no. To be honest, it is difficult even to get through to my consultant. It is usually his secretary. That is the only person I have managed to get to speak to. No, there is no one I am aware of that I could have contacted at the hospital. Getting ideas for pain management from the arthritis charity has been of help, but not from the hospital, no.

Q123 **Rosie Cooper:** That is a very sad reflection on where we are with patient-centred care. From your comments and observations today, Mr Martinez, I think we take the fact that medically we can deal with it, but if we do not keep you informed, we make life very difficult for you. It must be hard to make choices based on not knowing.

Rob Martinez: Yes, I totally agree. If I had had the odd phone call just to say, "Look, we know you are waiting for an op but you have not been forgotten. This is the latest update," it would have been nice. It went so silent. I was so close to having it, and then it was cancelled. It was absolutely devastating the day it got cancelled. It would be great to get the feeling that it is going to happen and when it is going to happen. Could they have helped me along over these two months? It is exactly two months. It is a shame that they did not communicate.

Rosie Cooper: I hope you get your operation very soon.

Rob Martinez: Thank you very much. I appreciate that.

Q124 **Chair:** Thank you, Mr Martinez. We may come back to you later in the discussion, but we really appreciate you giving your time to the Select Committee this morning.

I turn now to the most senior surgeon in the country, Professor Derek Alderson of the Royal College of Surgeons. I should say that he is not responsible for your care, Mr Martinez, but he is responsible for all the surgeons in the country. Thank you for joining us, Professor Alderson. What is your reaction to Mr Martinez's story?

Professor Alderson: I feel desperately saddened to hear Mr Martinez's story. Of course, I am very sorry about the way things have worked out for him personally. What he describes is not atypical, and that is the real sadness.

Numerically, in the NHS at the moment, people waiting for joint replacements probably constitute one of the largest, if not the largest, group of patients who are waiting for unacceptably long times for their surgery. In April this year, we saw 1 million fewer patients than in the corresponding period last year. Over 1 million people have been on our waiting lists for more than 18 weeks. That is a long wait, typified by orthopaedic patients expecting to have a joint replacement, who are in pain and increasingly dependent on painkillers, increasingly disabled and who really need the surgery. We know that it makes such a difference to the quality of life for orthopaedic patients to have new joints, so I feel saddened to hear Mr Martinez's story, along with all the other patients with other conditions who have had their surgery postponed for long periods of time at the moment.

Q125 **Chair:** You described in your evidence to the Committee that the NHS is effectively functioning at the moment as a Covid-only service. As a result, it has been reported in the *HSJ* and other places that waiting times are increasing by one week every week. Is that the kind of thing you expect to happen?

Professor Alderson: That is the kind of thing that is happening, but it is not of course what I would like to see. The longer we are unable to restart scheduled surgical services, the worse the situation is going to get. That is why we have made such a call to establish Covid-lite sites, which was what Mr Martinez was implying. Maybe some hospitals could be created where there is minimal risk to the patient—we cannot say zero risk—of contracting Covid if you go into that hospital for a planned operation.

We believe that at the moment anyway, and for the foreseeable future, the capacity within our NHS resource alone is insufficient for us to be able to get surgery started again and maintain a sustainable and resilient service as we move into the winter. That is why we believe it is essential that we retain access to independent sector facilities for NHS patients, so that people can be operated on by priority and by clinical need. It would be no bad thing if there were provision made at least to understand how we might retain access to the Nightingale units in a worst-case scenario second wave flu epidemic.

Q126 **Chair:** Would you explain what a Covid-lite site is? What does having a Covid-lite site involve?

Professor Alderson: A Covid-lite site would ideally be for patients like Mr Martinez, who require planned or scheduled surgery—what we sometimes used to call elective surgery. We would expect patients to self-isolate before they came to such a hospital. We want them to be asymptomatic. We want them not to have a temperature. We need them to be tested shortly before their surgery. We need the staff to be tested on a regular basis, probably a couple of times each week.

We need facilities so that if patients are unwell, post-operatively, we can test them again. We need to create zones within the hospital in which we can create a traffic flow for surgical patients that minimises the risk of the staff and the patients in that zone coming into contact with Covid-positive patients. That might be operating theatres, recovery areas, access to critical care or diagnostic facilities.

The logistics are quite considerable. That is why it was very easy to stop elective surgery, but it is not quite so easy to get surgery started again. We did a poll of surgeons last week, and a quarter of surgeons said that they have no access at the moment to Covid-lite facilities.

Q127 **Chair:** That makes very good sense, but is it the college's view that the Government and NHS England are taking too long to set up these Covid-lite sites?

Professor Alderson: I think the logistics of trying to set them up are quite complex. Obviously, the arrangements to maintain NHS facilities in the independent sector expire very soon. We believe that the Government need to commit to maintaining those facilities. That is the kind of environment up and down the country where, for instance, Mr Martinez's elective orthopaedic operations could be undertaken.

Q128 **Chair:** I am sure that lots of members of the Committee are going to have questions for you. I have a quick question for one of the other witnesses, Dr Katherine Henderson, president of the Royal College of Emergency Medicine.

Dr Henderson, you have said a few very interesting and quite forceful things about A&E provision. One of the things you said is, "Going back to how we used to operate is not an option—patients will die if we do." What permanent changes would you like to see to A&E services?

Dr Henderson: The reason we said that was that the old way of doing things involved emergency departments having elastic walls. We were able to have an infinite number of patients. We were never able to say, "We are full. We are at capacity."

We now need to recognise that we cannot do that in an era when we need to keep patients safe. The patients who need to be able to come to an emergency department to get emergency treatment are some of our most vulnerable and are most at risk if they pick up Covid. If we cannot have space to put those patients in, we are going to cause enormous problems and harm to patients. We need to be able to have some way of stopping those elastic walls and knowing who is coming, to make sure that the right patients come to the emergency department and that there are other routes of access to care for urgent patients who do not need emergency care.

What we are talking about is having a contact point before the emergency department, such as 111, which has done amazing work during the Covid pandemic and has had much more clinician input. Prior to Covid, there was not so much clinician input, and therefore people were not necessarily confident that they would get the advice that they needed. The 111 service has to be supported to have access to alternatives. There is no point in going to that triage point if the only triage options are nothing or A&E.

During the pandemic, as Mr Martinez was saying, primary care has been functioning incredibly well and has risen to the challenge of technology. Having 111 able to use access to primary care, and to use access, potentially with booked appointments, to urgent treatment centres and potentially booked access to same-day emergency care or hot clinics from specialists, would mean that a patient who has a known problem could go through to a hospital, or maybe not even come to the hospital but get the advice they need.

Q129 **Chair:** To be clear, you are saying that the only way we can keep A&E departments safe and not go back to crowded A&E waiting rooms, which would obviously be very dangerous, is to move permanently to the system they have in some Scandinavian countries of "call before you walk", where people either call 111 or go online before turning up at an A&E.

Dr Henderson: Yes, that is what we are saying, or of course dialling 999. There is going to be no change in the provision of 999 access to emergency departments, nor would there be a scenario that we could envisage whereby we would be turning away people who are in desperate need of care. Some people do not have access to smartphones. They are not going to be able to ring 111. They are homeless; they are in domestic violence; or they are very vulnerable.

We are absolutely dedicated to still being the safety net for patients, but the problem beforehand was that we had become the safety net for the system. We were becoming very crowded and we had people in corridors. The idea that you could have a vulnerable 80-year-old with a hip fracture in a corridor next to someone who might have Covid is just impossible. We cannot let that happen. We need to find a way of making it possible for people to get the care they need where they need it, which does not always necessarily require going to the emergency department.

Q130 **Chair:** Lots of Committee members want to talk to you, but first I will bring in Mick Armstrong from the British Dental Association. You heard Mr Martinez's story. From the perspective of a dentist, are you hearing lots of similar stories?

Mick Armstrong: Thank you for this opportunity, Chair. Yes, of course we are, because primary dental care has been virtually non-existent during the pandemic. To relate to two points earlier, dentistry is often seen to be outside the NHS, but for Mr Martinez it is important that he is free from oral infection so that it does not interfere with his surgery. That is one part where we can help.

There is no reason for dental pain to be treated at A&E. We could certainly take some of the workload there once we are back up and working. Dentistry was not in a great place when we started. We have access problems, which had been raised in both Houses and at the previous Health Select Committee. We have widening inequalities, rock-bottom morale and recruitment and retention problems. The pandemic has made that much worse. The effect on general practice, NHS and private, has been devastating and is probably existential. The effect on oral health has been catastrophic.

I am also a frontline clinician in West Yorkshire. We have cancelled 8 million courses of treatment nationally. Our practice alone has cancelled 6,000 appointments. We will be cancelling another 3,000 until September just to deal with the urgent case backlog. Twelve thousand dental practices in the country have been effectively replaced by 500 urgent care centres. They have done a sterling job in treating the most urgent, but it is clearly no replacement. The knock-on effects—

Q131 **Chair:** What is the solution? What is not happening that needs to happen, in your view?

Mick Armstrong: As we go back to work, we are still bedevilled by having the correct PPE consistently and widely available. The protocols that are in place severely limit our capacity to treat patients. We would normally offer 150 appointments a day in our practice. We are now offering 10 to 15, simply because of the extra cross-infection controls that are needed. We need some relief from that. Testing and vaccine: everybody needs the same solutions, but I cannot see capacity improving within the next six months unless that happens.

Chair: We have lots of questions on the basis of that.

Q132 **Paul Bristow:** Mr Martinez, you said that you took early retirement because of the pain that you suffered, and let me express how sorry I am for your experience. But would you have carried on working if you had had the operation in a more timely way?

Rob Martinez: Yes. I think there were still a few more years in me to be able to do so. Yes, definitely.

Q133 **Paul Bristow:** You would have been paying tax and doing all the things that contribute to the economy.

Rob Martinez: That is right. I am 63 now. I took early retirement at 60, so I was short by about five or six years.

Q134 **Paul Bristow:** Professor Alderson, we have heard a lot about the more routine NHS procedures like hips, knees and cataracts that have probably been delayed. Is that it, in your mind, or have there been more complex cardiac and aortic surgeries delayed?

Professor Alderson: No. I think you have hit the nail on the head. We described a series of priorities. There are operations that need to be done urgently—those that need to be done within 72 hours. The next category of operations are those that we believe, in general, could be delayed, with proper patient selection, for up to one month. In that category is a substantial proportion of patients who have cancers and, for instance, as you mentioned, cardiac surgery. They could be patients waiting for a valve replacement.

We said quite clearly that, if we were not able to meet the target of dealing with those patients within one month, the consequences would be serious. Of course, the consequence for some patients is the risk of dying if they do not get their new heart valve, or, for a person who has cancer, that it advances in stage so that their chances of being cured are substantially reduced by delay. That is a real issue for us, and it is the point Mr Martinez raised. We now have a large backlog of patients in that category when you look across the totality of surgery.

Then there are people who we think need operations in between one and three months. Again, there are patients with some cancers where we believe it is relatively safe to delay for that length of time. Already those backlogs are beginning to get very close to or beyond the time limits we set, so there is a very strong sense among the surgical community that we have to get on and develop Covid-lite sites in order to start that type of surgery again safely.

In the era when the pandemic was at its height globally, and patients could not be tested and there was a mixed set of patients, 50% of patients who had surgery at that time developed serious pulmonary complications. The global mortality among those patients was nearly 40%. It is devastating if you have to have surgery with some degree of urgency in an environment like that. We simply cannot advise our patients to have surgery under those circumstances. That is why so many people are fearful of coming to hospitals at the moment.

Q135 **Paul Bristow:** Professor Alderson, you have made that point very clearly, and I share your concern. One of the biggest challenges we will face in our NHS related to Covid-19 will be managing the restart and dealing with the backlog.

We have talked a lot about Covid-lite sites. Let us be absolutely clear. We have also mentioned the independent sector a couple of times. The NHS struck a deal with private hospitals to cope with the Covid emergency with ventilators, beds, ICUs, and so on. Are you saying that a similar deal—a comprehensive long-term deal—with the independent sector would, in your mind, be necessary to clear the backlog and get the NHS back up and running?

Professor Alderson: Absolutely. Remember that before we went into the Covid crisis we still had very long waiting lists. We have had recent winters where we have had to suspend some forms of elective surgery because of flu epidemics. We must build some resilience into our system in the face of a pandemic that is not over and where there may be outbreaks or second surges—and, of course, we have our usual winter viruses to take care of.

Our bed base and our total workforce were short. I am not just talking about surgeons but everybody who contributes to care in a hospital. We need expanded facilities. In the short term, the only way we can see that is through using the independent sector. We still need to retain as much of our expanded workforce as we possibly can, bearing in mind that people have worked very hard for some months and are getting tired.

Q136 **Paul Bristow:** Absolutely. It is about clearing the backlog and getting people like Mr Martinez treated and back to work, hopefully, and paying tax and so on. If we do not do that, how long do you think it will be until we return to pre-Covid levels of elective activity?

Professor Alderson: We must bear in mind that, to begin with, we have to restore confidence among the public that they can have an elective operation safely with excellent results, as they enjoyed before the Covid crisis. That means we still have to put in some extra precautions until we can establish that we have been doing elective surgery safely. Even if we can get going again, it is slightly unrealistic to believe that we can get going at full speed very quickly.

Dealing with the backlog is not something that is achievable simply in weeks. We have stopped for 12 weeks, but we cannot catch up in 12 weeks. That, to my mind, is completely unrealistic. It will certainly be many months. It may take us a few years to catch up, and we have to be able to sustain that effort. We need a programme for the recovery of surgery and the sustainability of surgery, and we are probably looking at four or five years to have a resilient system and take things forward in the best possible way.

Chair: Four colleagues want to ask questions about Dr Henderson's evidence on A&E.

Q137 **Dr Evans:** Dr Henderson, please pass on our thanks from the public to all those who work in A&E for what they are doing.

I would like you to comment on two things. First of all, on the A&E stats, we have heard that the percentage of people turning up to A&E has dropped by about 60%. Was that people using it as an accident and emergency, and is there any evidence that people were staying away from hospital? Do we know that now? The second thing is whether the RCEM has a position on the 2-metre rule and whether it should be relaxed.

Dr Henderson: On the A&E stats, we are not as far down as 60% now. Last month, type one departments were only down 30%. Type three departments, which deal with lower risk presentations, were down about 60%. Our type one departments—our majors departments—are increasingly busy every month. Comparing May and April, another 200,000 people were coming back. People are coming back to emergency departments.

That is good, but we are in an odd balance of trying to work out how we communicate how the service is going to work. We only have weeks to get it right. We want people to have confidence that they can come to an emergency department with an emergency and be safe. We want people who are having heart attacks and may be ignoring the symptoms, or ignoring their early stroke symptoms and saying, "I won't go because I'm worried about picking something up," to come back to the emergency department. What we do not want, and we cannot have, is people coming when there are other places in the system that could provide them with the care that they need. Some of that care might not even need to be face to face.

It is a difficult message and balance. We do not want to drive inequalities to become worse, because we know that in the 10% most deprived areas patients use A&E departments twice as much as they do in the 10% least deprived areas. In other areas, we have always been a safety net for deprived patients.

If we put in place complicated arrangements that require a mobile phone, we may make those health inequalities even worse. We must have a whole-system view. How do we make sure that patients are at the heart of it, where they can get advice and the care they need, but at the same time make sure that the patients who come up to the A&E department are safe from harm and crowding departments?

As we were saying before, we did not start the pandemic in a great place for EDs. Emergency departments were at their most crowded and most stressed and with the most long waits there had ever been when we went into the pandemic. The pandemic has cured crowding for now, but the risk is that it comes back and we do people harm.

The 2-metre distance is not my area of expertise. I know that we will try to maintain it for the moment.

Q138 **Dr Evans:** I wondered if the college had a position. You said you had elastic walls. A 2-metre down to a 1-metre wall makes a big difference in a tight ED department. I know from when I worked in EDs how tight they can be. I wondered if the college had a position on that yet, or is it still being reviewed?

Dr Henderson: No, we do not have a position on it. We will follow national guidance, but the patients who are coming into A&E departments are ill. That is why they are there. Therefore, maintaining a distance that keeps everybody else safe seems a sensible idea.

Q139 **Dr Evans:** Thank you. One of the big things is that training has been put on hold. It is very difficult in a pandemic. How are you trying to get people trained to carry on with no career progression?

Dr Henderson: Thank you for bringing that up. It is one of the slightly hidden parts of the whole pandemic. Trainees have been in a very difficult position, with a lot of people being incredibly flexible about what they are doing and stopping their normal training.

There has been a lot of training around Covid and a lot of intensive care skills. Doctors have been redeployed to emergency departments and have been absolutely fantastic at doing that, but we have had to cancel exams. You cannot do face-to-face exams. If you have an exam system that is an exit exam, you cannot progress your career unless you have that exam. That is obviously a huge deal, and trainees have been co-operative and fantastic during the whole of the pandemic. We absolutely have to focus on training, otherwise we will not have the next generation of doctors or consultants to treat patients and the next waves of whatever happens.

We need an appreciation of the time that is needed to make sure that trainees get trained, for the craft specialties, for example. Professor

Alderson will say that people have not been doing the normal operations they would have been doing, so they cannot get the competencies. It is important that that is an area of focus, and we are making the case for that. It is amazing what technology can do. We can do some online exams, but obviously face-to-face patient examination in an exam cannot happen for now. We need to make arrangements to help with that.

Q140 **Sarah Owen:** From what we have heard, it would be fair to say that the spare capacity that Ministers talked about was not actually spare at all. It was at the expense of people like Mr Martinez.

One of the issues that you talked about with Covid-clean or Covid-lite facilities was whether the patients themselves are clean, but I want to ask about staff. How often will staff working at Covid-clean or Covid-lite sites have to be tested? We had thousands of staff shortages before the pandemic. Will we need an increase in the number of staff if we are to have separate facilities? What impact will it have on staff who are shielding?

Professor Alderson: You have described some very real problems. It is absolutely essential to regain public confidence that we are able to test our staff regularly. We feel that probably, in a pragmatic sense, it should be about twice weekly, bearing in mind that we know that the tests are not perfect.

As regards the workforce, there is a critical issue. It is everybody who is concerned with delivering surgical care—theatre nurses, ward nurses, porters, physiotherapists, and so on. In different parts of the country, we were desperately short in each or every one of those areas at different times. Maintaining our existing workforce and trying to get the people who have come back to understand that we are a long way yet from getting out of the crisis are important messages to get across.

If we are to try to function on more sites, you have to split your teams. That again has a workforce implication. The logistics are complex. That is one of the reasons why we are struggling to get going again, but it is absolutely vital.

Dr Henderson: We have the same issues. We cannot build confidence for patients coming into hospitals if we cannot be sure that we can protect everybody. We must make sure that staff are not carrying the virus, because asymptomatic spread is a worry, and staff-on-staff infection is a worry.

We know PPE works. When you have full PPE, the chances are much reduced of picking up the problem, so we need to make sure that we have hand sanitiser and face masks for patients, and if we start having visitors back into hospitals. We need to make sure that in areas where staff are not face-to-face clinical—coffee rooms or the seminar rooms where we do our training—they manage to social distance and that everyone is washing their hands, wearing face masks and that all of those things are happening. That is a real problem.

The productivity of everything drops in this situation. Putting on and taking off PPE takes time. It adds time to every single encounter. It also adds to problems with communication. We did a quick survey of our members and fellows, and 97% of them said that it is more difficult to communicate wearing PPE. Even doing simple things like having a conversation takes longer when you are wearing PPE. Wearing a face mask all day is tiring. It dehydrates you. You feel tired by the end of the day. People get skin problems from wearing a mask. It is very uncomfortable. All of that adds up to a productivity issue, so the workforce are a real concern.

We want to retain people and make it possible for them to stay in the system. Obviously, young trainees are not travelling abroad so much this summer, so I think we will have a good number this August. My worry is when we get round to the next part of the year. When we get to February, we may lose a lot of staff. The other thing is people towards the end of their career and near retirement. Will it be, "I've had enough. I can't be doing with this. This is not how I thought I was going to be spending my day and I am now going to retire earlier"? We have a real worry at that end that very experienced people may feel that it has been great to deal with the crisis but the aftermath is just a bit too much to take forward.

Q141 **Sarah Owen:** One of the ways that wards are plugging the gaps is through agency staff. Do you know if there has been any communication at all around trying to keep agency staff working in either dirty or clean areas, Covid areas or non-Covid areas? That is an issue of concern.

Dr Henderson: In emergency departments, we use agency staff. In my experience, it tends to be agency staff that we have always used, and they tend to be loyal to that department.

Talking about "clean" and "dirty" is a bit difficult. I would tend to try to avoid doing that. The reality is that everywhere is going to be at risk. Some places are going to be lower risk. We would be very lucky to have anywhere that was Covid-zero. Everybody needs to recognise that there are risks. We need to make sure that all the staff we use are well trained, understand the risks involved and have had risk assessments so that they can feel confident to be at work. I am not aware of anywhere that has said that they are not going to be using the staff they have previously been using.

Q142 **Laura Trott:** Dr Henderson, you described in some detail an outline of what a new system for A&E might look like, with all the supporting services. Can you give us a bit more idea of the changes the Government would need to make, or systems they would need to build in a few weeks, for that to happen?

Dr Henderson: Work is already starting on that, thinking about integrated care systems whereby a patient would contact a service to get advice as to where they need to get help. Most of the time that is going to be primary care; it will be problems where they speak to their own GP and get advice.

Things do not necessarily come up in a planned way. That would be an example where we hope that we could encourage patients to use a beefed-up 111 service. In the past, we know that people have not always had confidence in the answer they were hoping for when they rang 111. That is one of the issues we would need to see.

One of the things is around technology. We would need to be able to track what is happening to patients. In the past, it has been very difficult to do that. It has been difficult to know whether a patient has followed the advice of 111 or chosen to do something different. We would need to link up the system to know whether, if 111 says, "We will get this appointment for you at primary care," the patient actually goes down that route, or whether they end up going to an emergency department. The technology involved in doing that would be part of it.

In primary care, they need the capacity to manage patients. We think that they probably do and that they are keen to do it. There are some concerns that they may need to think about that very carefully. We need to think about booking into urgent treatment centres, and maybe even EDs for particular time slots, for somebody who needs to go to an emergency department. They may need an X-ray of a potentially broken limb.

Organisations like hospital trusts need to be working to find alternative access points—what is called same day emergency care. That is for a patient who has an urgent care need but could be brought in at a particular time of day to see a particular team, and not via the emergency department in a queue, potentially.

Reorganising it is quite a lot of work. Some of it is pre-hospital. Some of it will be working with the ambulance services so that they have help, when they get called to somebody, to access the same services as 111. Ambulance services have been doing a lot of "treat at scene" during the pandemic, and it has been very successful. It seems that the concept of providing care in the community is a goer. Potentially having services that could go out to a patient rather than the patient having to come in is another aspect. There are a lot of things but they all have to be done rather fast, and that is the problem.

Q143 **Laura Trott:** Is that something you think should be a long-term solution for how emergency services should work?

Dr Henderson: Yes. Emergency departments and emergency care doctors and nurses are trained to deal with the most acutely ill and the most acutely injured. That is what we are good at. What we are not so good at is being a rolodex for a specialty patient who needs advice from their own care team. We are not so good at primary care. Primary care is a lot better at primary care than emergency medicine people.

Q144 **Laura Trott:** What have been the barriers to that happening in the past? As you say, there is a lot of sense in that system. Why has it not happened before now?

Dr Henderson: It has been difficult. Primary care has not necessarily had the capacity. They need input to make that possible. We have not focused on getting 111 as robust as it needs to be, and appreciating the need for clinical input—having clinicians available to give advice to the people who are answering the phones, so that you get a robust disposal decision, as it is called. That is a realisation that Covid has given us. There are huge advantages in there being people who can give good, sensible advice to somebody who understandably is worried about risk and has defaulted to the safest option, which is to go to A&E.

Q145 **Dean Russell:** My question is about the learnings from the past few months. I have been volunteering at the local hospital, and I see how quiet some of the wards are because of the Covid crisis, in particular A&E. Seeing it with one person in sometimes, or even empty, has been quite an unusual sight.

What are the two or three key lessons? I am sure one must be the fact that perhaps previously some people were using A&E as a sort of 24/7 GP surgery, rather than going to the GP first. Where do we go from this, moving forward?

Dr Henderson: A&E departments have been quieter. They have seemed quiet because they have had enough space, they have had enough staff and they have not had so many patients. That sounds like a service that is functioning properly. The idea that we have all been sitting around not doing very much is not true. We had a huge surge of Covid patients that we had to deal with. Then we had a drop-off, but we maintained a lot of our redeployed staff, which has meant that we have been able to provide an extremely timely service to the patients who have appeared.

If you have departments that are big enough, and you have a big enough workforce and you are not overwhelmed by patients, you can provide a very good standard of care. That is one thing we have learned. Possibly a lot of us knew that already.

The second thing we have learned is that multidisciplinary working has been transformational. We have been able to get teams working together. We have managed to unlock conversations and pathways that have been hideously difficult to get agreement on because we just had to do it. The need of the Covid pandemic to make sure that patients are kept safe has made it possible to break down those barriers. It is important that the resetting that goes forward, and the real difficulties that other specialties will have with getting their services back up and running, does not mean that we go back to silo working.

The demise of silo working has been one of the most positive things that has come out of this. Although training has suffered, we have managed to deliver a lot of training. We have managed to do an awful lot of teaching. We have embraced Zoom as a way of doing meetings. I have had more staff and multidisciplinary staff at my mortality and morbidity meetings than I ever had pre-Covid because people can zoom into meetings. That is the way we did it, rather than expecting people to turn up in a single place. Understanding that doctors, nurses and other staff can usefully do things from home, and that we can trust them to do that and take part in service development, audit and all those other things, but they do not necessarily physically need to be in the hospital, has been revelatory. We have had an awful lot of good work out of that.

Q146 **Dean Russell:** This is on the communication side of things. I am aware that there have been patients who should be going to A&E, especially with stroke, heart attacks and so on. Do you think there is a communications piece, moving forward, to get people to go to places other than A&E when they perhaps do not need to?

Dr Henderson: As I said, getting the balance right is complicated. We need the emergency cases to come back to us, but it is quite clear that the public are thinking hard about where they are going to get care. The problem is that some of the patients who really need to come to us are not coming. Sadly, we have seen the number of people presenting intoxicated going back up; the number of people intoxicated on drugs and alcohol is going back up. We had seen a 60% decrease in alcohol presentations. It is possibly not the patient group that we are keenest to see back. I want to see the person who is having a stroke or a heart attack.

It is trying to work out how to have a mature conversation with the public about public health matters; when to come and what the alternatives are. We must not let them down by there not being good alternatives when people have anxieties about their health.

Chair: Thank you very much indeed. We have had an enormous amount of correspondence on dentistry matters, so I am going to allow this panel to run over a little bit because I want to make sure we have a chance to ask Mick Armstrong some very important questions. Four colleagues want to ask you some questions. Thank you for being patient.

Q147 **Rosie Cooper:** Aerosol-generating procedures are the basis for most dental procedures. When do you think we can get back to providing basic dental treatment? We have been closed for five months. Some patients have been abandoned part way through treatment. Most of Europe has opened its dental practices. Why haven't we? Is the problem contractual or clinical? For example, my bridge is broken and I do not want the urgent care centre offer of extraction or extraction. That is a medieval approach to dentistry.

You may wish to comment on dental leadership, which I consider to have been woeful. Dentists and patients feel abandoned. Do you know the whereabouts of the chief dental officer, who is reported missing?

Mick Armstrong: I am not going to make this a personal thing. It is more systemic as regards leadership, so I will come back to that.

Regarding AGPs, we could do them now if we had the correct protective equipment. The problem is that, because an aerosol is potentially one of the most dangerous procedures, we have to do them in very small numbers. You can probably do one in a surgery about once every 90 minutes, as the current guidance suggests. Our first priority is to maintain the safety of patients and the safety of our staff, so unless something intervenes to shorten the time for the number of AGPs that will be done, opening up normal dentistry will be very difficult. It is still going to be very challenging to get the output up from 10% or 15% of what it was.

Q148 **Rosie Cooper:** Do you think the problem is contractual, so the 12,000 practices that you describe will not be able to function and will not be paid enough to keep going?

Mick Armstrong: That is a serious concern. The NHS/independent partnership that David spoke about exists in dentistry. Private dentistry delivers 50% in financial terms of the country’s dentistry. Private practices have had nothing. Mixed practices have had their NHS in part, but it is financially unviable to keep doing dentistry in small numbers. We will do it. We will provide what we can for our patients, but we need long-term investment to ensure that there is a service when things ease. At the moment, private practices are on the brink. Many NHS practices are also on the brink because they have lost their private support. Only 8% of practices think that they are financially viable in the long term.

Q149 **Rosie Cooper:** Are you getting any support from the Government right now? What is happening? What are we waiting for?

Mick Armstrong: You are paying our contract value monthly. That will be abated for expenses at some point, although it has not yet been agreed. But that does not make the practice viable; it needs the support of its private income in the vast majority of cases, and there is no long-term certainty that that will continue. The certainty of NHS support needs to continue for at least 12 months, and not from month to month, as is currently the case.

Q150 **Rosie Cooper:** Is there any hope you can offer patients who are desperate? We do not want everybody to go off to Europe once travel is restarted. Surely, we want a dental service to remain in this country when this is over.

Mick Armstrong: Absolutely. That is what we want. That is what all dentists want. They want to treat their own patients, but, as the guidelines currently stand, they only allow us to treat those in the most severe need, with severe toothache and swelling, or the most vulnerable people. We do not have the capacity to do what we knew as routine dentistry.

Q151 **Rosie Cooper:** You portray a very depressing picture. Are you having any real, deep, meaningful or moving discussions with the Department for Health? This cannot remain the way it is; it is a stand-off.

Mick Armstrong: The Department for Health understands very well where we are coming from. It is the Treasury that seems to be the problem. The Department for Health has started to listen of late, but we are the Cinderella service. We are not really mentioned in the 10-year forward view. You yourself asked a question about registration at the last Health Select Committee. The two most senior people in the NHS did not know what you were on about. That shows a huge disconnect in what primary care dentistry does and what politicians understand the need for the service to be.

Q152 **Barbara Keeley:** My questions are about reopening. Perhaps I could start on PPE. I have had a particularly heartfelt plea from a dentist in my constituency who has had problems with getting PPE. It is hard to get and very expensive, masks in particular. There is no access to services to fit the masks; having bought them expensively, there is no access to NHS services to fit the masks.

There is an important issue around the leadership question that Rosie just touched on. You referred to the current circumstances as an existential crisis for dentistry. Dentists in my constituency say that they need a plan. They feel that they have been left out on a limb with no support.

Mick Armstrong: Absolutely. The plan was what we were waiting for. We got one working day's notice before we were told that we were going to open. That plan had been drafted, with the help of the profession and the colleges, a while ago. Quite what the blockage was in getting it delivered, I do not know. I am told it is the system. Whatever it is, you will have to explain it to me, but that plan was ready to go probably a good week before it was actually released. It is that disconnect, the political will to communicate properly, that seems to damage us.

Q153 **Barbara Keeley:** What about the PPE? That seemed to be a very big issue.

Mick Armstrong: We need PPE for AGPs that is similar to what they have in critical care. It is hugely expensive. We are a business. We have to buy it. Pre-Covid, you could protect patients for £2 or £3. It is now over £40 per patient. We have huge expenses, but virtually no income coming in because of the reduced throughput.

Q154 **Barbara Keeley:** As Rosie said, we cannot get away from the question of leadership. There has been the whole period of the lockdown to come up with the plan, support, advice and guidance that dentists need. There is a lot of anguish out there. A lot of dentists, particularly NHS dentists, feel that they have been left outside. Your point about a Cinderella service is an appropriate one.

Mick Armstrong: That is something beyond my control. The profession is ready, willing and very able to deliver whatever you want us to deliver, but we need that plan and we need clear lines of communication and influence. If we ask for something, we expect to be heard.

Q155 **Dr Davies:** On the line of reopening services for the benefit of patients, and also the viability of so many practices, in my area in north Wales there is a lot of frustration about the chief dental officer in Wales recommending that aerosol-generating procedures should not take place possibly until even next year. Do you have any views for the rationale of the very different approaches across the UK?

Mick Armstrong: I am privy to the situation in Wales. I think initially you were very progressive and were looking long term. You seem to have fallen a little bit behind the curve now. The rationale is safety. Unfortunately, the risk is not quantifiable at the moment because the evidence is poor. I can understand people being very cautious in the way they reinstitute the move back to routine care. I am not critical; it is just variable.

Q156 **Dr Davies:** What does it mean for the viability of practices depending on private income?

Mick Armstrong: If private practices can get hold of the PPE and follow the protocols, they can carry out AGPs, and they will be able to receive fees for that. Throughput remains a problem. Where they may have seen 15 patients a day, they will see five. The only thing I can say is that they have the ability to pass on those increased costs to patients. Whether that makes dentistry unaffordable is an entirely separate matter.

Chair: Thank you. I am very sorry, but we have to move on. You have given very powerful evidence, Mick Armstrong. The thing that is particularly striking and slightly depressing is that both Professor Alderson and Dr Henderson had a solution for the problems in their fields, but you are struggling with even an outline of a plan. We will take that away.

As you know, we are in the middle of an inquiry into dentistry anyway, which we are going to come back to at some stage, but this makes it even more urgent. I am very grateful to you for sparing your time this morning. Thank you, too, Professor Alderson, Dr Henderson and Mr Martinez for sharing your experiences.

Examination of witnesses

Witnesses: Daloni Carlisle, Dr Augst, Sir Robert Francis and Dr McCay.

Chair: In our second panel, we have some very interesting experts. Charlotte Augst is the chief executive of National Voices, an organisation that represents a coalition of health charities. Sir Robert Francis is chair of Healthwatch. Of course, I know him of old because of the work we did on Mid Staffs and his very important inquiries into the tragedy that happened there. Dr Layla McCay is from the NHS Confederation, which represents a multitude of NHS organisations, to give their perspective.

Before we hear from those experts, we are going to hear from another NHS patient. This time it is a cancer patient, Daloni Carlisle from Sevenoaks. Dean Russell is going to ask Daloni a few questions.

Q157 **Dean Russell:** Daloni, I hope it is okay to call you by your first name.

Daloni Carlisle: Yes.

Dean Russell: First of all, thank you so much for joining us today. I do not expect you to go into details of your diagnosis of course, but would you mind sharing your experiences, especially over the past few months, and how you felt during that time about your care?

Daloni Carlisle: The lockdown coincided for me with a period of quite serious ill health. I have had more contact with the NHS than I could count. I have had three admissions via accident and emergency. I have had a lot of contact with community and primary care services. Finally, there has been an issue around planned care. Shall I take you through those three areas?

Dean Russell: If you could, briefly, that would be wonderful. Thank you.

Daloni Carlisle: My experience with accident and emergency has been fairly similar to the experiences you have heard outlined today. I met very empty departments. Obviously, there was a good deal of trepidation about the known risks. I was feeling very unwell, and I needed the accident and emergency department, but was I going to be exposing myself to the virus? I went along with some nervousness, but I found that it was quite a safe environment. There was lots of separation. There was immediate hand sanitation. Everybody was masked and gloved. It felt a very safe environment.

The accident and emergency departments were very empty. There was nobody there, so I was able to get through in double quick time. When I talked to the nurses afterwards and said it was an astonishingly fast service, they said, “Yes, we are really worried because people are not using the A&E departments.” It was a very similar experience to what you have already had outlined.

Something you may not have touched on is the way in which community and primary care services have changed. I have had a lot of telephone contact. I had a really interesting experience when I needed to contact an out-of-hours GP because I had a skin rash. I was able to get through to the out-of-hours GP. She did not want to bring me into a waiting area because she did not want to expose me to any risk. We looked together at a New Zealand dermatology website. “Does the rash look like that one? Oh yes, it does.” We were able to diagnose that it was shingles. She sent a prescription electronically through to my pharmacy. From first contact to me having medication in my hand and starting to feel better was three hours, all done via the telephone.

I have had consultations with my GP by phone, and that has been terrific, and with community nurses. I also have lymphoedema, and being able to do a consultation with my lymphoedema nurses by telephone is not ideal, because there are some physical things that need to happen in a lymphoedema consultation. They need to do measurements. As a stopgap, it has been okay.

There have been lots of changes in the way I have worked with the community and primary care services.

Q158 **Dean Russell:** Have you felt that that has been, in an odd way, an improvement on the way it was pre-Covid, or have you felt there have been more challenges that need to be overcome?

Daloni Carlisle: Both. Certainly, it was much easier for me not to have to go out to a waiting-room and sit in a waiting-room at a point when I had shingles and was feeling very unwell. It was great to be able to make that diagnosis on the telephone. I felt quite safe in that diagnosis, but ideally a doctor should have had a look at that. As a way of dealing with things in a crisis, it was totally acceptable and had advantages, but I am not sure that it would be good long term.

It also depended on me having the internet. If I had not had the internet in my house, and if I was not able to pull up that website and was not confident in what I was looking at on a New Zealand dermatology website, that would not have worked. It was dependent on me being able to do that. It is a combination.

Q159 **Dean Russell:** With that in mind, are there any learnings that you think, moving forward, should be continued? That is one area where it would not work for some, but are there things, especially from a patient perspective, that you felt could continue in that way, or are there areas where you would say absolutely not and they caused you concern or anxiety?

Daloni Carlisle: I felt fine in all the contacts I had on the telephone and with community and primary care services, with the proviso that it has been in an emergency situation, in the Covid situation. Yes, some of it could definitely go on. GPs are doing telephone consultations; we all know that. Some have been fine, but we should not move everything over. There are times when you need to see your doctor. They need to eyeball you.

Q160 **Dean Russell:** We have some incredible experts on the Select Committee at the moment. The Chair will question them shortly, but is there anything from a patient perspective where you think things could be improved?

Daloni Carlisle: I am not sure. A successful telephone consultation requires quite a lot of confidence from the patient's side. You have to be quite confident in your ability to talk about what you are experiencing and your symptoms. A lot of care needs to be taken with extending what has happened in the lockdown to what might happen further on, but I am not entirely sure that anyone is really pushing for that. I do not think patients are pushing for telephone consultations. I am not convinced that doctors are either. I can only speak about my own experience. That is all I have.

Dean Russell: A huge thank you for joining us and sharing your experience.

Daloni Carlisle: An aspect that we have not touched on at all, which I think is really important, is what happened around my planned care. I started the lockdown in a clinical trial. I had a CT scan. The clinical trial showed that all my cancers were growing, and my doctors told me that I needed some chemotherapy.

I then fell into a hole where I was absolutely in limbo. I did not know, and I had no communication about, when the chemotherapy might start. For most of the lockdown I have been sitting here at home knowing that all the cancers are growing and knowing that the tumours in my lung, my liver and my spine are all busily growing, and there has been absolutely no word at all from the hospital about when some treatment might start.

I am a single mum with teenagers at home. My absolute priority is to stay alive. I cannot tell you how difficult that limbo period has been. It has been resolved. I have heard from the hospital and I have started my treatment, but because I do a lot of work with Macmillan's online community I know that there are a lot of people who are still in that situation. They are waiting to hear about planned treatment. They have been told that they need chemotherapy and other treatments, but have fallen into a hole or limbo and have no word about when their treatment might go ahead. They are in an absolutely terrible situation. I do not know if you can imagine how hard that must be.

Dean Russell: I cannot, actually. Thank you so much for sharing that story.

Q161 **Chair:** Thank you, Daloni, for sharing that with us. We may well come back to you. We can completely understand how distressing it would be not to know what the score is with respect to your treatment.

I would like to bring in Charlotte Augst from National Voices. You heard from Daloni and Rob Martinez in the first part of the session. How representative are they of the stories that your organisation is getting back from your members?

Dr Augst: Very representative, of course. Another thing that struck me, listening to both patients here today, is how gracious and generous they still are about the services that are on offer and the conversations they are having. We needed almost to prompt Daloni to describe to us the things that are simply not working.

It is important that in hearing signals from patients we amplify them consciously, because people are moderating down so much of the distress that they are sharing. They are giving the NHS the benefit of the doubt now more than ever and completely understanding the pressures that the NHS is under. To pick up the cancer story we have just heard, our members Cancer Research UK and Macmillan both briefed me before this session. The numbers are staggering; 2.1 million people are now waiting for screening, tests and treatments just in cancer. Most of them are waiting for screening, which might sound less urgent, but if 290,000 people are missing out on testing, as seems to be the case, 20,000 cancers will have been missed by now.

It is not just waiting for tests and screening. We have 12,000 fewer patients receiving surgery, 6,000 fewer receiving chemotherapy and 2,800 fewer patients receiving radiotherapy. Those are staggering numbers, and that is just cancer. The British Heart Foundation mentioned that they had reached out and done a survey. Half their respondents said they found it harder to access services, and, of those, roughly half again had procedures cancelled. We have heard from our members, Action Against Medical Accidents, that they are picking up many more distress signals on their helpline. Avoidable harm is now very clearly happening.

We hear less about the less sexy areas of medicine. We have heard from endometriosis patients who have been waiting an awfully long time by the time they finally get a referral to be treated. If that is then cancelled, it can tip people over into deep despair. Neurology patients are not all able to wait forever. What we in this country call urgent care, which is to be seen in A&E, excludes an awful lot of care that is not emergency but is still quite urgent. What we have heard today is very representative.

Q162 **Chair:** Thank you. We will definitely come back to you, but I want to bring in your fellow witnesses. Sir Robert Francis, I am sure that your feedback from Healthwatch is similar to that. I would love to hear about it.

The thing that you are probably best known for in the NHS is your work on patient safety following Mid Staffs. Do you have any concerns that the patient safety agenda might go backwards as everything is eclipsed by coronavirus?

Sir Robert Francis: Thank you, Chair. First, I confirm that everything we hear at Healthwatch echoes the two patients from whom we have heard today and, indeed, what Charlotte said. People are and have been very understanding about the challenges and difficulties surrounding services during the pandemic, but many of them feel that they have been left in the lurch, if I can put it like that. They get messages that their so-called routine treatment has been cancelled or their screening has not happened, and then they are left, as the witness said, in a hole. They do not hear anything.

In addition to understanding, however, there is also fear, which inhibits some people from returning to services. Understandably, they do not want to run the risk of catching Covid, although it is fair to say that some are prepared to take some risk in order to get the treatment they need.

The overarching theme is that people who are either looking for treatment or who are in treatment but it is not happening are not being sufficiently involved in the decisions that are being made about what should happen next. A classic example is the concerns we have heard from people who were shielding. They received a letter saying they do not need shielding any longer, but they have had no contact from a GP or anyone else to explain why that might be the case. People who have cancer treatment that has been postponed are not being involved in discussions about the impact that might have. On the other hand, when waiting list decisions are looked at, what is being looked at may be the condition itself but not the needs of the person’s household. In a pandemic, things are very different from what they are in normal life.

What we have seen is a need for much clearer communication about what is available and how you get it. Secondly, there needs to be an actual conversation with patients about what their needs are in the context of the pandemic and what may follow it.

Thirdly, there needs to be a real look, as we come out of the pandemic, as to how people should be prioritised for the care that will slowly become available. Taking Mr Martinez’s example, is his place on a waiting list being properly assessed against other people in accordance with his actual condition and his needs, whether they be medical or social? That is the overarching position we should have, and it is common through cancer services, maternity services and so on.

On the other part of your question, I have been concerned that patient safety has been taking a backseat. It is not, I emphasise, and as far as I personally would say, in relation to the pandemic itself and the protection of people from that, albeit that there have been many different views about how that should take place. In a way, the understandable rush to change things around has meant that lots of things may be happening that have not been looked at from a patient safety perspective. Part of that is, I think, lack of involvement of the people most affected, who are the patients, and maybe in some cases the staff. We are talking about a balance of risk. Different people have different appetites for risk.

If I can put it bluntly, I feel that there is a slight atmosphere that the public and patients are being patronised and not trusted with the ability to participate in judgments they should make about their own health and safety. When we treat patients on an individual basis, we have a discussion with them. We work out a plan and move forward. When it comes to communities and the public, I see rather less of that happening.

Understandably, decisions have to be made in a hurry sometimes, but that does not mean that something to replace the normal process of consultation should not take place.

Patient safety as such is not being discussed as much as it should be. I wonder what will come out at the end of all this, when we look back, as to what could have been done better. Obviously, it is a little early to say what the impact of that will be.

Q163 **Chair:** I want to ask a very specific question. One of the biggest changes post Mid Staffs was the new CQC system of inspections and the ratings system—the Ofsted system. Some people have called for the CQC not to return to its pre-pandemic model of inspections when we get through coronavirus. What would your view be about that?

Sir Robert Francis: There is no simple answer, but a simple answer is that I would be concerned. I believe that the inspections system, and the ratings system that goes with it, since it started after 2013 has been very effective in putting quality and safety at the forefront of discussions about the provision of services in the NHS. It has incentivised those who lead providers in the system to think about quality and safety at the same time as they think about targets and money.

Can we improve the system? Yes. I do not speak on their behalf, but I am a non-executive director of the Care Quality Commission. Can we make it more focused and more intelligence driven? Undoubtedly. That is what the CQC wishes to do. I would be very sad to see the day when inspectors did not cross the threshold of hospitals to see what was going on and speak to staff and patients freely, and to look at the culture, which is something you cannot necessarily measure through outcome statistics. You need to go there.

It is not the only part of the system, of course. There are other things that help to ensure safety, but we are a long way from being sufficiently confident about what I might call self-regulation in the health service to say that we could do away with inspection. I confess that when you first introduced ratings I was a little bit of a sceptic about them. I have been converted because, while we might look at how they are rated, they have been a valuable tool for the public in understanding how good or bad their services are.

Q164 **Chair:** Thank you. Barbara Keeley wants to come back on that, but first I am going to bring in Dr Layla McCay. You speak for a lot of NHS trusts. We have been hearing a lot about the difficulties of getting back to normal because of the need for social distancing and additional PPE. What sort of capacity are your members, particularly your hospital members, telling you that they are going to be able to work at? What percentage of their normal capacity are they going to be able to work at in the post-corona environment?

Dr McCay: What we are hearing from our members is that pre-Covid-19 people were working at round about 90% or above capacity. The current expectation of our members is that in many places it is going to be down at around 60%. There are lots of reasons for that. As you mentioned, there is social distancing and separating Covid and non-Covid services, with the extra time taken to manage the extra hygiene measures being a key part of that.

Q165 **Chair:** You wrote to the Prime Minister about the need to set the public's expectations of what the NHS is able to deliver going forward. We do not know the size of the waiting list at the moment because the stats are not currently being collected, but it is estimated to be potentially up to 8 million, and some people have said it may be up to 10 million by September.

Could you help set expectations yourself? How soon do you think it will be, looking forward, before the waiting times for NHS services get back to the kinds of levels they were in January?

Dr McCay: It is hard to say because there are so many variables. Going into the crisis, we already had a waiting list of about 4.2 million people. During the entire pandemic period not as many people as usual were able to be removed from the waiting list, but of course more and more people have developed needs, whether they are needs where they have already come to see a doctor and started on a care pathway, or where they have not yet come to the hospital or their GP but are storing that up, and they will. If people are waiting and presenting at a later date, there is also the risk that they will have a more severe form of their disease, which will need more complex treatment.

There is anxiety about the non-Covid care that is coming up. We do not know how much capacity we are going to need for Covid-19 patients, or whether there is going to be a second wave, but, in addition to the acute Covid care, we must remember that lots of the people who required Covid care will have ongoing, long-term needs—for example, in rehabilitation and mental health. That is capacity that will be needed not just in the acute sector but in primary care, in community services and in social care. All of those things are building up.

We must also remember the context in which we are working. We already had lots of workforce shortages. Now we are looking at staff who have been working incredibly hard during this entire period. Many of them are exhausted. Many of them have experienced traumas. That will impact on the amount of ability they have, just as we move into what could be another challenging winter. There could be a lot of flu. There could be increasing demand for all the other things that are coming forth, not to mention other things in the pipeline. There was so much preparation for Brexit last year, and that could be coming up again this year.

There are many things that are happening at the same time, which some of our members have described as brewing a perfect storm. As to what will actually happen, it depends on all sorts of variables, not least the extent to which we are able to prevent a second peak of coronavirus.

Chair: Thank you. My colleague Barbara Keeley wants to talk about patient safety.

Q166 **Barbara Keeley:** This is a question for Sir Robert Francis. Given what we have heard from the Association of Directors of Adult Social Services about rapid discharge spreading Covid-19 into care homes, should we now re-evaluate the principle of rapid discharge? We have touched on what we have to do in terms of the second wave. What do Government and the NHS have to do differently in order to ensure patients' safety if we are preparing for another surge—a second wave?

Sir Robert Francis: I confess that, when I first saw the initial guidance that patients were to be discharged within two hours of being declared medically fit, I wondered how that could possibly happen safely. We heard stories that rather confirmed that, sadly. Needless to say, we at Healthwatch have heard a fair amount about it. In any revisiting of it, we need to take that into account.

First, as in fact was the position before the pandemic, patients and their families have been concerned about the level of information and communication given to them. Of course, in a pandemic that is even worse, because if they are not being told whether or not the patient either has or has not had Covid, what are the family meant to do, let alone what is a care home meant to do?

We disregard at our peril the emotional impact on patients of being discharged from hospital very quickly into, frankly, unknown situations. We need more support given both to care homes and indeed to families about how to care for their family members. That is happening, but we continue to hear, and it is sad to keep repeating this, about the difficulties people have on being discharged from hospital with regard to medication, whether they have been given the right prescriptions or whether the discharge summaries convey the correct information, and matters of that nature.

That is an area we are particularly concerned about. As I say, Healthwatch is intending to undertake some research and monitoring of it. Obviously, we would be happy to share those findings with the Committee as and when we get them.

Q167 **Barbara Keeley:** Do we need to set up dedicated step-down facilities to prevent discharge continually reintroducing Covid into care settings? That has worked in some parts of the country.

Sir Robert Francis: I am not an expert in that, but for a family that has a member in a care home, the idea that people might be discharged into that care home without anyone knowing whether they have Covid or not seems very concerning. Where there is no test result available or no other information upon which a proper decision can be made, it would seem logical that people should be placed in some sort of interim facility. What I would not like to see is a sort of holding pen developed where proper care is not given and people are forgotten about. It is very important that there are properly run facilities, with the ability and capacity to look after people well and safely.

Q168 **Sarah Owen:** There are two areas that I want to concentrate on as regards communication with patients, as that is something that has come up in both panel sessions. My questions are for Charlotte and Robert.

The first thing is about the limbo that patients feel, as we have heard today. How can we make communication better for patients who are currently undergoing care during the pandemic?

Secondly, how do we better communicate the services that are still available? It is cervical screening awareness week. I am booked in for mine in the next couple of weeks, but it is well overdue. I am not going to lie; I am a little bit nervous about going in to get it done. How can we and the Department for Health communicate better about the services that are available and that they are safe to use?

Dr Augst: Let me just pick up the first point around communication with people who are themselves waiting or should be receiving services. If I had to step right out and say what was the common thread through all the stories we have heard so far, it is this.

There was obviously a problem way before Covid. We are currently interviewing people about their experiences of cancellation and delay. We have yet to meet anyone, before or after Covid, who says that they have ever had a referral acknowledged. Your GP refers you and then you do not hear anything. The anxiety of not knowing whether you are actually on a waiting list, whether you will be seen or whether your referral has been lost adds a whole layer of distress to what is already a distressing situation.

The thing that strikes me, both from the patients we heard from today and from all the patients we have met so far, is how little they expect. They do not expect everything to be back to normal in four weeks' time and for us to be back to the activity levels we have seen. They are really understanding, but they want to know what's what.

Moving to the slightly bigger picture, after talking to patients and the public, I think the approach we are currently taking is very unsophisticated. Basically, whether we get through the next winter and the next period largely depends on how we all behave. What happens inside hospitals is only a very small part of how we weather this storm. Whether we wash our hands, whether we keep our distance, whether we keep shielding and whether we call 111 before we go to A&E will determine whether we weather the storm. It is upon all of us. If this period has taught us anything, it is that the NHS would have gone under if people had not changed their behaviour. The patient and the public are the most important actor in this.

You would not approach communication with the most important actor anywhere else with a mix of saying, "The NHS is open but don't waste our time. Fingers crossed." That seems to me to be the approach we have taken. We are saying, "Do come. Don't come. Fingers crossed that the right people come." That is not how we can resolve this. If we are to rely on people changing how they use emergency care and primary care, we need very tailored communication.

One thing that comes through from all the patients we have spoken to, and all the patient groups we are working with, is that ideally that communication needs to be led by the clinical team. Rather than printing on the back of the bus, "The NHS is open but don't waste our time," we need to get the cardiologist, the endocrinologist, the diabetes nurse and so on to write to the patient and say, "This is how it is going to work around here now. If this happens, this is what you do. If that happens, you've got my number. For everything else you go to the GP." Everyone in that local place must know that that is the deal now.

To pick up your example of cervical screening, I got the letter; I was overdue and I had to go. I was then told, "We haven't got any lab capacity." I got a communication from the NHS saying, "It's really important; you've missed it and you've got to go." Then I was told by my GP, "Even if I did you a smear test, I couldn't send a sample anywhere because all the labs are doing testing." We need to get our ducks in a row, and then we need to communicate what the local deal is.

Q169 **Sarah Owen:** I do not know if any other panel members want to come in on that. It was related to my second question about people not coming in for screening. Are there any reports of delays for tests and results and whether that is impacting on treatment?

Dr Augst: For cervical screening, we were told that there is no testing for cervical samples at the moment.

Q170 **Chair:** Sir Robert wants to come in on that point.

Sir Robert Francis: We are being told that patients in the sort of category you have just mentioned are left not knowing where they stand, because appointments of one sort or the other are cancelled. The anxiety for people, particularly those who may be awaiting a suspected diagnosis but that is not confirmed, can only be imagined. I am afraid that the inevitable fact of these delays—I am sure that some of them are unavoidable—is that there will be an uptick in the number of people who come to a late diagnosis and therefore need more serious treatment, with everything that goes with that.

On your communication point, it seems to me that people need to know why appointments are being cancelled and what is being done about that for them in their circumstances. It is not just an administrative matter of a duplicated letter saying the same thing to everyone. People have the right to be treated as individuals. I appreciate the challenges of that in the current circumstance, but I do not believe that it is impossible to organise a system that treats people as individuals in a better way.

On the other point, about the availability of services, it should not just be assumed that people are in the same condition or in the same place as they were when they were first asked to go for an appointment two months ago. There needs to be thought given to, first, what their needs are now, and then, assuming that they need to come in for something, they need to be given an explanation of what that entails. I have no personal experience, but anecdotally I hear that people are very surprised when they turn up at a non-Covid, clean ward or out-patient place to find it completely deserted with clearly no risk at all, or very little risk, in relation to getting Covid there. Where it is appropriate, there should be reassurance given to people and an explanation about what is going to happen when they come to hospital for surgery, or wherever else they have to go.

I would like to make one more point about communications, although we might come to it later. A lot is being done, and quite well done, by way of digital appointments and communication of that nature, and we have heard a little bit about that. We must not forget those for whom that is not appropriate for all sorts of reasons, as has been mentioned. We have heard of difficulties around basic stuff like the translation of guidance and information into a number of different languages, where people would normally expect that.

We have also heard about communities who are not getting guidance or information because it is just assumed that, if you put these things out in the media or online, people will get them. In certain communities, you need to go through the organisations that know about those communities and can reach out to them. Even now, therefore, it looks to us as though there are areas where the public health guidance has not necessarily been received or understood in the way that it may be by the rest of us.

Digital communications are great because a lot of people—maybe the majority—can benefit from them, but they cannot be the only solution. We have to remember the other people whose needs cannot be met that way.

Chair: Thank you. Dean wanted to ask a question about the digital side.

Q171 **Dean Russell:** Sir Robert, one of the things that we have seen, and we heard from the evidence of Daloni earlier, is the use of telephone consultations, and I have heard of video-conferences being used. There are two aspects of that where I am interested to get your view.

First, do you see it as something that could be permanently put in place moving forward, and what are the benefits of that? Secondly, on the flip side, have you seen, or are you aware of, risks around patient safety where things could get missed by not having face-to-face consultations?

Sir Robert Francis: The answer is yes to both. Clearly, an enormous amount could be done by way of digital appointments, and we should bottle that and keep it. There has been a notorious reluctance—not necessarily willing reluctance but institutional reluctance by the NHS—to do what everyone else is doing and to communicate in a way that most of the rest of society has been doing for a long time. You can reach people in a digital way as you could not possibly do otherwise. By the way, we are only at the threshold of exploiting the benefits of that.

For instance, you can reduce the number of appointments for conveying results if you have a face-to-face conversation, as we are having at the moment. But, as I mentioned, there are people who are socially isolated or elderly people who may be living on their own. There are people who still do not have internet access. There are people in communities where access is difficult, even if they have a computer in their house, because there are privacy issues and the like. We have to cater for them.

If we can reduce the number of face-to-face appointments required for everybody else, then there should be a much bigger capacity to deal with the parts of the community that have special needs. There has been a fall in the number of GP appointments generally, and that is understandable in this circumstance, but at Healthwatch we wonder what the effect of that has been, and we need to keep an eye on it. We need to see whether things are being missed and what the gaps are that need to be filled.

Dr Augst: Might I briefly come in on digitisation or telemedicine? Digital is a bit grandiose when you think that someone just picks up a phone and speaks to someone. As Sir Robert said, it is something we have done for a long time in many other aspects of our lives.

As Daloni said, you need to be confident to have a successful remote consultation with someone. We have very strong evidence emerging—for example, from our friends at Rethink Mental Illness—that almost 80% of people living with severe mental health say they feel their support has been severely cut and that they do not feel very supported at all in the offer that is available to them remotely. In this country, 1.9 million households do not have access to the internet, and 25 million people are on an expensive pay-as-you-go tariff. You need confidence, but you also need money to make it work. As we know, that is not evenly distributed.

We need to move from a perspective that, "This works for a lot of people. Let's hope it doesn't exclude people," to, "Because there is a real risk that we will exclude people, we will tailor our technology responses and our face-to-face responses to pick up people with the biggest need and who find it the hardest to access services anyway." We must focus on meeting the needs of people who have the most complexities going on and might find it the hardest to get solutions.

Sir Robert Francis: I agree with Charlotte about the importance of remembering people's mental health needs, where there are going to be an increased number because of the impact of socialisation and Covid. Of course, telephone or even digital communication like this is not always the right way to look after people, even for a conversation about their mental health needs. There are indications in other fields that some things are very difficult to talk about anyway, and you need human contact to enable it to happen.

Q172 **Chair:** It is interesting, because there are also mental health patients who prefer remote consultations.

Sir Robert Francis: It is a matter of choice.

Q173 **Chair:** It all goes to show that you have to be led by what the patients think is right for them.

Sir Robert Francis: That is right.

Dr Augst: The voluntary sector has been delivering mental health support remotely for decades. That is how we deliver most of our support. Most of the support that comes from the charity sector is delivered online and on the phone. It can be done, but we must not be blind to the fact that it will not work for everyone. There is so much that needs to be wrapped around it by way of messaging.

We are part of a small project. We can share the evidence with you. People were saying that things like the answer machine message become really important. Does the answer machine message say, "We are closed. Do not bother us," or does it say, "Great that you are calling. We will get back to you. We take your concerns seriously. Please hang on in there. We are right on it"? That is not about great technology. It is about knowing that people are reluctant to seek help. They do not want to waste the service's time, and your messaging needs to overcome that reluctance.

Q174 **Paul Bristow:** I can definitely see the importance of things such as telemedicine as a means to try to reduce things like out-patient appointments, which, in many cases I feel, are unnecessary. Isn't there an opportunity to think about how we might improve NHS productivity across the board as a result of the backlog challenge we have? This is a question perhaps for Dr McCay. Is there a root and branch thing we can do, looking at productivity in a whole range of areas such as care pathways where we might do things differently? How might we change the culture in the NHS, so that it is not, "Well, we always do things the way we have done"? Can we not look at new treatments and new technologies? NICE has a role in all of this. Do you think there is an opportunity to look at new pathways about how we can improve productivity?

Dr McCay: Absolutely. There are a few things. One is that having to change services so rapidly to meet the needs of the Covid-19 pandemic has shown people what can be done. We have heard from members across the whole country—in hospitals, primary care and in CCGs—that they are doing things they would never have imagined, and at pace. They are doing in a few weeks things that might have otherwise taken years to accomplish. They are incredibly excited by what has been accomplished and the proof of what has been accomplished.

We were speaking about digital a moment ago. One of the barriers to implementing helpful digital things is that some people were a bit anxious and concerned about whether it would work. Having now been able to try out whether it would work, and finding that in many cases it has worked, has really moved things forward.

There is a lot of excitement, but at the same time there is balance. We need to look at what has worked really well, what is worth keeping and what is worth bringing within the system: "Okay, this is something that we did because of need and because there was a pandemic, but it is not right for everyone so we need to tweak it or discontinue it." We need to set that within a wider conversation. We do not just want to return to the old ways of working that we once knew. There is an opportunity to think about how we plan, commission and deliver care in new and more effective and productive ways.

There are lots of different opportunities. At the NHS Confederation, we are currently working through an NHS reset project. We are looking at many different areas to think about what we have learned from Covid. How are we now going to change the conversation? How can we improve the way the NHS works? That is right across the board, from workforce to mental health, to governance and regulation, all the way across to how we work and have different relationships with folks that we have not necessarily worked with quite as closely before.

A really interesting productivity gain that many of our members talk about a great deal is in integration and joint working. Pre-Covid-19, many NHS services felt that they had to work in certain silos; for example, they felt that communication between the NHS and local government was quite difficult. Many of those challenges have been very much reduced by need during Covid-19. Now there is a groundswell of enthusiasm for making things better for patients by working more closely and effectively together within and across sectors. There is a great deal to be done.

Q175 **Paul Bristow:** How do we ensure that we capture those lessons learned? How do we ensure that this is not a missed opportunity and we just go back to the same as normal? How do we prevent that from happening?

Chair: Could you give a fairly brief answer, Layla, because we have to wrap up very soon? Thank you so much.

Dr McCay: It is a bit of a joint effort. NHS England and Improvement have a role to play. We are working with the Health Foundation and the AHSNs to bring together some of those things. What we need to do is explicitly look at what has changed in the way we do things and evaluate the extent to which it has been positive or not. We need to understand how, if and why to bring that forward. That is done not just with healthcare but by bringing in patients and the perspectives of everyone involved in the situation. It is a big and exciting opportunity.

Chair: We have time for two brief questions, although they may not be brief topics. Barbara Keeley and Rosie Cooper will ask the final two questions. I am afraid we only have time for fairly short questions and answers.

Q176 **Barbara Keeley:** I am starting to hear in my constituency about the distress of people who are shielding. How can we protect and safeguard the physical and mental health of people being asked to shield from here on? Is there anything about the long-term effects we can expect to see from people who have been shielding?

Dr Augst: We have picked up a lot of this through our work on Our Covid Voices, where people can tell their stories, and a lot of shielded people have. It is massive, and it is exacerbated by lack of clarity in communication. It has been massively exacerbated by the way decisions have come out and have been communicated with the shielded population.

If you will permit me to briefly zoom out to the conversation we have just had about rebuilding services and building on what we have learned, the shielded population could be the ideal group to understand what good wraparound care needs to look like. We do not want those people to have endless contacts with health professionals that expose them to risks. If we do not deliver good support that helps them to cope, we are wasting our energy. To pick up Mr Russell's point about how we can increase productivity, the definition of unproductive care is care that does not deliver for patients what they actually need.

The shielded need help with coping as well as with clinical care. The VCSE can support that, but the NHS needs to get its act together and help to communicate. Would shielding have worked better if we had acted with the shielded and with organisations that understand shielding? Yes, it would. That is where we need to understand the challenge of communication as a two-way challenge. The NHS needs to be much better at communicating and talking, but it needs to be even better at listening to what people really need and the practical needs that cannot be met by the NHS but could be met by others, like the VCSE. It is also obviously clinical needs. There needs to be a co-production on what the next stage looks like.

Chair: Thank you. I think quite a lot of people would say that politicians are also better at broadcasting than receiving when they talk to people. The final question is from Rosie Cooper, please.

Dr Augst: I think Daloni also wanted to say something.

Chair: I will come to Daloni, but Rosie first.

Q177 **Rosie Cooper:** Many patients are concerned that the many changes that involve communicating with GP practices and the NHS generally via an externally provided platform potentially adds to worry and insecurity, with damage to the doctor/patient relationship, should there be data breaches. Does the panel worry about that?

Sir Robert Francis: People worry about that, and they are right to be worried. It is necessary to assure people, because if there is not confidence in these systems, however good they are technically, they are not going to be used. The answer is yes.

Equally, our findings are that people understand that they are likely to get better care if their information is shared among other health and care professionals who are involved in treating them. It stops all the same questions being asked over and over again. They are willing to go along with it, but they need to be assured about data protection.

I do not know that it matters whether the organisation that has the platform is external or not, so long as it is—can I dare say it?—properly regulated, properly overseen and is seen to maintain the standards of security that the NHS is obliged to maintain.

Q178 **Chair:** Thank you. Daloni, do you have a final brief comment? You have been very patient listening to all of us.

Daloni Carlisle: I am still awake, just about. I wanted to talk briefly about shielding. I am supposed to be shielding. The advice is completely impossible to follow. It is utterly meaningless and has caused an enormous amount of distress. Personally, I read the top line that says that it is up to you whether you follow it. I make my own judgments about my own safety. I feel reasonably confident in doing so, but I know people for whom it has caused extraordinary distress. It is utterly useless. I cannot tell you how galling it has been for people. Something has to be done about that.

Chair: Thank you very much indeed. We have had a very good session. What we have come away with is a very strong sense that the NHS getting back to normal—whatever normal is—is going to be an incredibly long and difficult journey, and a very complex process.

We have had some excellent evidence from patients. Thank you very much, Daloni, for appearing. We appreciate that. Also, thanks to Rob Martinez in the first session. Thank you very much to our witnesses in the second panel: Sir Robert Francis, Dr Layla McCay and Dr Charlotte Augst. We appreciate you giving up your time. If there are further things that you want to say but you have not had a chance, please write to us because we are producing a report on the next steps for the NHS as we try to resume a more normal service. Thank you, everyone, for watching this morning. That concludes this morning's session.