HOUSE OF COMMONS

Health and Social Care Committee

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

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Watch the meeting

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

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Witnesses

I: Chris Hopson, Chief Executive, NHS Providers; and Professor Andrew Goddard, President, Royal College of Physicians.

II: Sir Simon Stevens, Chief Executive Officer, NHS England and NHS Improvement; Professor Stephen Powis, National Medical Director, NHS England and NHS Improvement; and Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement.

Examination of witnesses

Witnesses: Chris Hopson and Professor Goddard.

Q179 **Chair:** Welcome to the House of Commons Health and Social Care Select Committee. We are focusing this morning on the NHS's ability to restart core services after the pandemic.

We have a fascinating panel this morning. We have an expert representing NHS organisations and a senior doctor. In the second half of the session, we will have Sir Simon Stevens, the chief executive of NHS England, with a couple of members of his team.

I welcome the two witnesses on our first panel. Chris Hopson is chief executive of NHS Providers, and a regular at the Health and Social Care Select Committee. Welcome, Chris, and thank you for joining us.

We also have Professor Andrew Goddard, who is president of the Royal College of Physicians. Both of them have been doing some very important research among their own members.

Chris, the last time you came, I asked if you would do a survey of your members so that we could try to gauge the temperature as to how optimistic people are that they will be able to restart normal NHS services as we move out of the lockdown. Can you tell us what some of your findings were?

Chris Hopson: There are really four findings. The first is that there is significantly increased demand from patients for treatment. That comes, in a sense, from three sets of demand. First of all, there is a backlog. We already knew before we went into Covid that the NHS was struggling to keep up with demand, but there is now more demand for patient treatment. That comes from the fact that the backlog has grown; the fact that we have had people who should have presented during Covid-19 but who did not; and then some extra demands that Covid-19 has created. For example, there is a need for rehab, and we are already starting to see extra mental health demand. That is the first message.

The second message is that trusts have very significant capacity constraints, particularly in acute hospitals. Because they have to carry on treating Covid patients, and they need to keep surge capacity and to ensure effective infection control, trusts are saying to us that, in acute hospitals, they are losing somewhere between 20% to 40% of the capacity they had before Covid.

The third message is that trusts are working as hard as they can to restart services. At the last Committee hearing, we heard a couple of patient stories that were clear about the impact that not being able to restart services has on patients. I assure the Committee that trusts are working as hard as they possibly can to restart those services as quickly as possible.

The fourth message is that, when you put all of that together, the problem—if I may draw a small picture for you—is that we already had demand mismatch, and what we now have is increased demand. We have 20% to 40% less capacity, so there is a much greater gap than we had before. Our members say that only 7% of them feel ready at this point to be able to meet the needs of all patients and users; 22% say that it will take three to six months to be in a position to meet all those needs and 14% say that it will take six to 12 months.

We have a growing gap. It seems to us that the task ahead of us is to do everything we can to close that gap. The reality is that we are not going to be able to fully close it, so the message of the survey is that we need a proper and mature debate about what the priorities are, and to recognise that we have to be realistic about how much the NHS can do. Just remember that everybody will be working at pace, as hard and with as much ingenuity as they can, and will be as committed as they were in the first peak. It is a difficult picture; that is probably the best way to describe it.

Q180 **Chair:** One of the impacts of that gap is much more pressure on staff. In your survey it was very striking that 92% of trusts said they were worried about staff burn-out. One of the pressures that staff feel is the worry that they might have Covid and be passing it on to their patients asymptomatically. Where are we with routine testing? What do your members feel about that?

Chris Hopson: I do not feel that we are in an entirely satisfactory position. As you know, Chair, on 29 April the NHS was sent a letter from Simon Stevens and Amanda Pritchard, the chief executive and the chief operating officer, that basically said that there was an intention to have regular staff testing as quickly as possible.

Another letter, sent out on 24 June, says they are going to continue to review the appropriate frequency for asymptomatic testing. Our trusts felt that two months ago there was a commitment that we would get to regular staff testing as quickly as possible, but two months later we still do not have a clear plan for doing that.

If I may dwell on that for a second, there seem to be three reasons for it. The first is that we are being told that, if you cannot test more frequently than twice a week, it is not worth doing. Again, I think there is a real debate that we need to have about that. Our sense is, yes, clearly, we want to test every day, but we cannot do that; but if you can test once a week or twice a week, that is something that is definitely worth doing.

There is also quite a technical debate, which again we cannot get to the bottom of, that says that, when you have low rates of prevalence, there is a problem with false positives. But when you talk to the experts, they say that there are ways round that. I do not want to throw words around, but double assay and pooling are two examples of where we think we can get over those false positives.

For us, the real reason why we are not doing regular testing of staff is that there does not seem to be sufficient capacity. We recognise that. If you have scarce capacity, you need to prioritise it. What we think we need is a clear plan from the Government that says, "Yes, we are going for regular testing." To be honest, if they are not going to do that, they should explain why. If we are going to go for regular testing, we would like a very clear picture of when that is going to come and how the capacity is going to be built up to achieve it.

You will remember from your time as Health Secretary that getting every single member of staff tested is a huge logistical challenge. We know, for example, how difficult it is to get flu vaccinations done every winter. Trusts need time to prepare. We need the plan clearly set out for how we are going to get there. Everybody knows that, if you want the gold standard of infection control and protecting everybody, staff and patients, we need to move towards regular testing of as many staff as possible.

Q181 **Chair:** Lots of people have been talking about regular testing. You and I talked about it at a previous Select Committee as well. To date, the response has always been, "Yes, we want to do it as soon as we can."

From the letters that have gone out that you referred to, it looks like the strategy is not regular mass testing of staff but targeted testing where we think there might be a mini-outbreak, based on sampling of the whole system. Could you give a comment? Derek Alderson of the Royal College of Surgeons said that the trouble with the approach we have is that it takes too long to know that you have places where you can do surgery, for example, where Covid is very low risk. That is what is holding back patients having their operations and is also making it much more difficult for staff.

Chris Hopson: The first thing to say is that every trust chief executive and trust leadership team will do absolutely everything they can to make the NHS as safe as possible. I certainly would not want the message going out to be anything other than that it is safe to come into hospital and have an operation.

You are right to identify that, if we want to reach the absolute gold standard, we should be heading towards regular testing of staff, and we need to get there as quickly as possible. It seems to us from our reading of it that, because there is limited capacity, the strategy says what is the best way of using that limited capacity. Obviously, the most important bit is to test symptomatic staff and patients, but you are right that the letters last week were saying that the next use is outbreak. If you have an outbreak, use the testing for that. The next use is to identify areas of potentially high prevalence and use it to try to identify those.

As I said, the obvious next step is to ensure that we regularly test all staff, which is why we need a plan that says when we are aiming to get there and how we are going to build the capacity to do that. The letter that was sent out last week just used the words, "As prevalence changes

and evidence emerges, we will continue to review the appropriate frequency for asymptomatic testing in the NHS." To be frank, that is almost exactly the same wording as was used two months before on 29 April. We have not come much further, you might argue, in the two months since. Our trusts just want clarity. They want to know what is going to happen.

Q182 **Chair:** When I was Health Secretary, we used to regularly spar on the issue of whether the NHS had enough money. In this crisis, the Government have said that the NHS will get what it needs. Is your sense that the Government are honouring that very important financial commitment, or do you have worries on the money front?

Chris Hopson: There is a decision that needs to be made, probably this week or maybe at the latest next week, about what happens next. Again, if you do not mind me going back to my picture, we have demand up there and we have dropped capacity down there; and the key thing we need the Government to do is to help us get capacity back up.

They have promised that the NHS will have everything that it needs, but the NHS needs them to do three or four things in the decision this week. The first is that they need to ensure that we carry on using independent sector capacity. It has proved very useful to us, but we probably were not able to use it quite as efficiently as we would have liked in the first peak because it came upon us very quickly. We need that independent sector capacity.

We need to keep the Nightingales in some form. There has been very clear recognition that we simply do not have enough general and acute beds. We need to have that extra bed capacity better funded.

I think I have seen that the Prime Minister is announcing this afternoon that he is going to give more capital to emergency departments to enable them to expand. That is good.

There are two final areas. Our community services are under real pressure because of the number of discharges but, in particular, the complex Covid-19 rehab wards that are needed. We need to make more investment there to recognise the extra demand that they have.

The final thing, which we have already begun to see, is that Covid-19 is going to generate significant amounts of extra mental health demand. We need to be ready for that. We cannot wait until next year to build the capacity to meet that demand. We also need that.

I hope that by the end of this week the Chancellor's promise that the NHS will get what it needs will be met, but we must have the right decisions on those issues this week or early next week.

Q183 **Chair:** Thank you. I want to welcome Professor Andrew Goddard. He represents doctors with non-surgical specialties. You have also been talking to your members. I would like you to tell us what you have found.

One thing that strikes me is that there is a lot of variation in the response you are getting. In areas like cardiology, gastroenterology and diabetes, your members think that in six months' time they are still only going to be operating at half to three-quarters capacity, which is obviously very worrying from a patient point of view. Would you walk us through what your members are saying?

Professor Goddard: The variability is a really important point. As a whole, doctors would paint a slightly more pessimistic picture than even Chris's members have painted: 70% do not think we will be back to where we need to be in 12 months' time and 39% think it will be longer than 18 months. That is quite a long timeframe.

The variability is related to the different specialties. The specialties you have mentioned of gastroenterology, which is what I am, and cardiology are very procedure based. We have many of the problems that surgery has, with long backlogs of procedures that need to be done, and how we get on top of that. In the specialties of geriatric or acute medicine, they are already working at what they would consider nearly full capacity. Because much of their work is either out-patient or in-patient, and not necessarily procedure and elective based, they can get up to full speed relatively quickly.

Chris made some other important points. We were in a very difficult position before Covid. We were seeing year-on-year increases in admissions and out-patient referrals, and were struggling to think how we were going to deal with that. Bed capacity was at a point where we could not really go on any longer. That is why all the waiting times were going up.

Covid has created a new set of diseases, which is a challenge for us. Respiratory medicine and rehabilitation medicine in particular are getting a large number of patients that they were not having to manage before Covid. That is going to have a further knock-on effect.

The bit that Chris did not focus on a lot, which everybody in the medical profession is worried about, is what happens in winter. What sort of winter are we expecting? We could have a quiet winter. We might have a mild flu season. We may have a second wave of Covid. We could be hit with the double whammy of a big flu season and a big second wave from Covid. How much that is going to impact on our ability to catch up with where we have fallen behind during Covid is perhaps people's biggest concern.

My last major point, which I think you have already alluded to, Chair, is that the workforce are really tired at the moment. They have been working hard. That is all parts of the workforce, not just doctors; it is nurses and other healthcare professionals, who are all part of the hospital team. There is a mountain that people know they have to climb; they are willing to climb it and willing to pull together to do it, but it seems quite a

large mountain at the moment. The worry that the peak is going to get higher in winter is a big one.

Q184 **Paul Bristow:** We have seen quite a lot of extra staff being recruited or rejoining the NHS during the Covid pandemic. Can they be retained in the long term, and what do you feel we need to do to keep them?

Secondly, Chris talked a little bit about the role the independent sector might play in helping us with the elective backlog. Could you go into that a little bit more? Is it going to be some short-term role, or do you think we need a more comprehensive long-term deal with the independent sector?

Professor Goddard: I will cover the workforce bit. In some ways, the timing of Covid was quite handy because we had 3,300 or so medical students who were about to become F1 doctors, and we got them to come into the workforce. Those additional 3,500 trainees were really useful on the wards, and everybody felt it. They felt that the teams were bigger, more stable and able to cope with things. We are not going to have that in winter; that group is not going to be there because they will have become Foundation 1 doctors.

You mentioned retention. Retention was the big thing before Covid that everybody was talking about. How do we keep our trainees in the system so that they do not go off to other countries or just drop out of medicine? How do we stop people retiring early? Those issues are much the same. A lot of the things that came in during Covid—a focus on wellbeing; having easy car parking; having hot food 24/7; having a place where people could relax—are really important, and everybody has felt the benefit of them. We have to keep them. That would be my first major shout.

Loads of people said they would come back to the NHS. We had a group of people returning to the register. They were not all around retirement age. Many were younger than that. There have been problems in getting those people employed by trusts. Trusts have worried about how they are going to be able to afford to employ these people when they have had free hands and feet from people who have had cancelled activity. I think there were quite a lot of disillusioned doctors who offered to come back to the NHS but have not been given an opportunity, with some of the challenges and hoops they had to get over.

We will have to work through that because, come winter, we are going to need those people. They do not necessarily need to be on the frontline. They can be supporting; they can do virtual clinics, or mentor trainees and other doctors. They can support in that way. Retention is one of the key things we need to work on.

Chris Hopson: A great example would be that we know we are going to need to redesign our emergency care pathway. We are probably going to be asking people to ring 111 before they come into an emergency department. A very good use of the doctors and nurses who volunteered

will be to expand our 111 services, which we will need to do if that is the pathway we are going to use this winter.

In terms of the independent sector, our sense is that it will probably go in stages. We have had the first stage, which is that we just wanted the bed capacity available in the first peak. The next stage is effectively contracting with the independent sector for the rest of the year. That capacity will be used in different ways in different places. It will not just be an elective surgery backlog. It could be, for example, as we saw a bit in the first phase, saying, "You concentrate in the independent sector on acting as a cancer surgery hub." It will be used in different ways in different places.

When we get towards the end of this financial year, we will need to think about what happens next. The one thing that is crystal clear is that we will have a huge elective surgery backlog, which, to be frank, will take many months, more likely years, to get through. One way in which we have traditionally done that is to use the independent sector. One of the things that we could possibly see coming out of this pandemic is a closer relationship and more effective use of independent sector capacity. Obviously, it will cost money.

There is one point to make. We need to be slightly careful, because to be frank it is often the same doctors who are working in a trust and who then go and work in the independent sector. We need to be careful that we are not robbing Peter to pay Paul. That is why ensuring that local trusts have significant input into how independent sector capacity is used feels quite important.

Q185 **Dean Russell:** This question is for Chris Hopson, and it is about the patient side of things. We have a huge backlog. One of the most debilitating parts of waiting for surgery, even minor surgery, is pain. How much opportunity is there, when moving forward and looking ahead, to prioritise those who are in the most pain to be able to have their elective surgery sooner rather than later? I imagine that must be affecting their lives in every possible way. I appreciate it is not an easy way to prioritise, but it must be looked at moving forward.

Chris Hopson: When I said that we need an honest and difficult debate about priorities, that is a very good example of where we are going to have to make some important decisions about how we prioritise. It has usually been done on the basis of clinical need, in which pain is an element, but also potentially in terms of quality of life and criticality, or mortality or life. There are a bunch of decisions that are going to need to be made.

Again, we are looking for some national guidance from royal colleges, but also from NHS England and Improvement about how that prioritisation is going to be done, but prioritise we are going to need to do.

Q186 **Sarah Owen:** This question is for Professor Andrew Goddard. I spoke to

a band 5 nurse on a cardiac ward who is a GMB member. I have to declare that I am also a GMB member myself. He said, "Prior to Covid we had vacancies on the ward, and as a result we are short-staffed and also reliant on bank nurses, who are usually not specialised in cardiac care. This is to add to the ongoing stress throughout the Covid pandemic."

The question is not just about testing and retention, but about whether we are recruiting enough specialist staff to be able to deal with the capacity for resuming services and clearing the backlog. Are there any additional barriers to hiring specialist staff, whether that is immigration policies, Brexit or the physical travel restraints that the pandemic has caused?

Professor Goddard: All of the above, basically. We knew that we were short of staff before Covid—short of nurses as you have described. We have been calling for the doubling of the number of medical students for two years, because we know that the demand is there and is likely to be there moving forward.

The challenge is that you cannot magic up nurses or doctors; they need to be trained. We have historically in the UK relied on other countries to help us out, either in the short term or in the long term. One of the challenges of Covid, of course, is that people are less likely to want to travel or to be able to travel, so our reliance on the immigrant workforce is going to be a bit of a problem.

We need to work with the Home Office. We were reliant on the Home Office for improving mobility, particularly with Brexit and the impact that has had on EU staff perhaps not wanting to work in the UK. We are getting a bit of a collision of problems.

There are bits of the workforce that we can think about. For supporting the medical profession, which clearly I know more about than the nursing profession, the advent of physician associates was a great thing for us. They are generalists who can work in multiple settings. There are things that we can do to improve that. We have been expanding the number of physician associates being trained, but many hospitals struggle to employ them because they are not regulated. A simple thing like getting physician associates regulated so that they can prescribe makes them a very useful part of the workforce. They can support both the specialist nurses as well as the doctors. We are going to have to think laterally, but we also have to think bigger.

Chair: Finally, our new Committee member, Neale Hanvey, to whom we extend a very warm welcome.

Q187 **Neale Hanvey:** Thank you for your kind words, Chair. I want to pick up on the issues around capacity across three specific domains. We have just spoken a bit about HR and the confluence of Brexit, immigration policy and the current situation.

I am also interested in lateral thinking around the use of labs and clinical

facilities, and how we can use novel approaches. What strategic planning is going on regarding HR and recruitment of the workforce, labs and pop-up capacity in other areas and the expansion of clinical facilities? You have spoken about the independent sector, but are there other opportunities to do that? What is the financial envelope around that? I address that question principally to Chris Hopson.

Chris Hopson: The way I would probably describe it is that chief executives felt they were serial problem solvers in the first pandemic wave. I think they now feel that they are in exactly the same position. They are looking at the problems in front of them and working out what they should do to try to resolve those issues.

To give you a couple of examples, if you look at where the pinch points currently are in the system, a lot of them are around diagnostics. Endoscopy is one of the ones that people often focus on, with the need for very deep cleaning of endoscopy equipment for very understandable reasons. There is also the fact that quite a lot of diagnostic equipment is to serve both Covid and non-Covid patients.

One of the questions that we are absolutely in the middle of looking at, in the spirit of your question, is whether we can create diagnostic hubs that potentially sit outside the core hospital, maybe in a separate area, or even in a separate physical location, so that you can maximise the throughput by having non-Covid patients go through that. You are then reserving diagnostic capacity inside hospitals solely for Covid patients. Everybody is looking at this as a potential opportunity, in a sense, to try new ways of working.

The other thing about the HR side is that the one thing our members feel very strongly about is that, in the first peak, they felt they discovered, or had the opportunity to do, some things that they had never been able to do before in terms of flexibility around workforce practices. Andrew Goddard was talking about people being able to move specialties at real pace, being able to do very rapid training and being able to act up and do different things. One of the bits that people are really keen about is that we do not allow that system to, if you do not mind the phrase, re-ossify and go back to being very rigid and very firm. They want to keep all of that flexibility so that we can carry on doing some of the things that were done. Again, that will help in HR with recruitment and retention.

Chair: Thank you. That brings us to the conclusion of the first half of the session. A very big thank you to Chris Hopson and Professor Andrew Goddard, both for your evidence this morning and for the surveys you both did ahead of this evidence session, which are going to be extremely important to the final report that we produce. Thank you very much for your time this morning.

Examination of witnesses

Witnesses: Sir Simon Stevens, Professor Powis and Amanda Pritchard.

Chair: I welcome our second set of witnesses for the second half of this morning's inquiry: Sir Simon Stevens, the chief executive of NHS England; Professor Steve Powis, the medical director of NHS England; and Amanda Pritchard, the chief operating officer of NHS England. You were all before us a few months ago, when we were allowed to meet in person. Times have changed, and we are very grateful to you for sparing the time this morning.

We want to start by thanking you and, through you, your teams—indeed all NHS staff—for the absolutely extraordinary achievement that saw not a single coronavirus patient denied an ICU bed or a ventilator in the first phase of the pandemic. Please pass on our thanks to the entire NHS for that heroic effort.

That does not mean there are not other big challenges, and that is what we are going to be talking about this morning. There is lots of ground to cover. We are going to start with what we have just been hearing about from Professor Andrew Goddard and Chris Hopson, which is the big backlog of people who are waiting for surgery, and how we are going to tackle that mountain of work. Dr Luke Evans has some questions for Sir Simon Stevens.

Q188 **Dr Evans:** Good morning and thank you, Simon, for being here. I have a couple of quickfire questions. Could you tell us how many appointments have been cancelled due to the pandemic? There is a breakdown I would like to go through on that, if possible.

Sir Simon Stevens: Good morning. The number of elective admissions in March and April was around 725,000 lower than we might have expected, given pre-Covid levels of growth. The drop was greatest in April, when there were around 530,000 fewer elective episodes. The number has begun to recover quite significantly since then. As we speak, we think we are now somewhere north of 55% of pre-Covid elective activity levels.

Q189 **Dr Evans:** Can you give us the percentage of drop at its worst, if that is possible?

Sir Simon Stevens: At its worst, we think it fell to about a quarter of the usual level. It has now rebounded to around 55% to 60% and is heading up such that we think we may be at around three quarters of usual activity going into July/August. That is on elective activity.

Q190 **Dr Evans:** Do you have a breakdown of some of the more specific stuff? If you do not, I will not stay on this question and we will move on. If you do, it would be quite useful for the public to know.

Sir Simon Stevens: I imagine that we will talk specifically about cancer. As we intended, we saw a much higher continuation of cancer care,

including cancer surgery, during the March/April period. Although there was a drop-off in referrals, we saw around 96% of the usual treatment starts for cancer over that period.

Q191 **Dr Evans:** Given the backlog, it is good to hear that it is returning. How long do you think it is going to take to clear?

Sir Simon Stevens: Paradoxically, I suspect that, contrary to some of the commentary, the waiting list will go down before it goes up, potentially significantly. The reason is that fewer people are coming forward and being referred on to a waiting list than was the case before. We have seen the overall waiting list drop by over half a million people between February and April, but we expect that as referrals return that will go up quite significantly over the second half of the year.

Q192 **Dr Evans:** Perhaps I could deal with both of those parts separately. Communication is key. There are lots of people who are worried, and a lot of GP workload at the moment is, "I haven't heard from the hospital; what is going on?" Would the NHS commit to writing to patients to give them a ballpark time for how long they are likely to wait for their follow-up appointments?

Sir Simon Stevens: Follow-up appointments or their operation?

Q193 **Dr Evans:** Whenever, depending on whether they are waiting for elective surgery. The biggest anxiety people have is not knowing if their knee replacement is going to be next month, next year or anything in between. That goes for all the appointments. A lot of GP work is admin stuff trying to follow that up.

Sir Simon Stevens: To locate it in the phasing of where we are in responding to the coronavirus pandemic, because that answers the question of when we will be able to do what you have just rightly suggested, obviously in the March/April/May period hospitals were, over that entire 90-day-plus period, having to respond to looking after more than 100,000 coronavirus emergency in-patients who needed care. As the Chair said at the start, they did that successfully, ensuring that everybody who needed coronavirus emergency care was able to get it.

As we speak today, we still have more than 3,000 coronavirus patients in hospitals. Nevertheless, since the end of April we have been restarting some of the urgent care services. That has particularly been the priority for May and June. Going into July, we hope that we will, on the back of some decisions that we want to be able to take around access to independent sector hospital capacity and other capacity that we will need, set a clear trajectory for the rest of the year. At that point, when hospitals know what resources and beds they have available, they will be able to provide the kind of guidance that you mention.

Q194 **Dr Evans:** Often in medicine, all roads lead to radiology and histopathology to get the tests and results you need. Is there any plan significantly to bolster capacity with mobile units, or to bring more people

in to try to deal with the backlog that is potentially going to happen when we have a sudden peak? As you rightly pointed out, there was a dip and then a re-referral rate. That will be a big sticking point for dealing with the backlog.

Sir Simon Stevens: Yes, you are quite right. It is worth remembering that four fifths of the patients who are on a waiting list are typically waiting for a test or an out-patient appointment rather than waiting to be admitted to hospital for an operation. Given the pressures on hospitals and diagnostic teams over the March/April/May period, there has been a big reduction in the flow of patients through those diagnostic services. Therefore, as your last panel suggested, we have to do something different. We have to expand diagnostic capacity. We also have to do it in new ways. That will be particularly true for endoscopy, for the reasons that were mentioned. It will be very relevant for cancer care, particularly bowel cancer services.

We are looking for a radically different model of doing endoscopy investigations and looking at the use of non-invasive methods for screening where that is appropriate—CT colonography. We will be looking at wider use of FIT testing as part of the screening process and looking to run dedicated diagnostic endoscopy suites, with three sessions a day. It is taking a Nightingale-type approach, if you like, to new dedicated diagnostic facilities. The first of those is going to be the Exeter Nightingale, which we are going to partly repurpose for non-Covid CT scanning. That will begin next Monday and run 8 to 8, seven days a week.

Yes, there is an opportunity and a necessity, quite frankly, to do something quite different in diagnostics.

Chair: We are going to bring in somebody who is joining the Committee for the first time this morning, Neale Hanvey. As well as being an MP, he is a cancer nurse. He has practised in both England and Scotland.

Q195 **Neale Hanvey:** I want to talk a bit about operational standards and how they have been impacted by the pandemic. I had a look at some data in one of our papers. In terms of a return to normal functioning, there seems to be lack of clarity around medical oncology, clinical oncology, clinical haematology and lab haematology. All of those are really important in establishing where we are and how we move forward.

I would be interested to know particularly about operational standards. Which ones have been most severely impacted? In some reports, breast cancer is down to below 20% in some areas. What workforce investment is going to be required to enable those services to recover and to enable vital services like radiotherapy to get back to a functioning capacity?

Professor Powis: Simon has already spoken about the need to bring services back on board. That is happening at the moment, but there are also significant challenges that we face as we do that.

On the cancer question, we did not stand down cancer services at all during the peak of the pandemic, but there is no doubt that they were disrupted for a variety of reasons, some of which were around local services and others were around individual clinical decisions as to what was the best course of treatment for individual patients at the time. Those are all being stood back up as we speak, and as Simon indicated.

Diagnostics, including lab diagnostics, is a key component of that for the reasons that Simon has given. It is not just lab diagnostics but radiology endoscopy. Simon has already spoken about one of the things at the challenging end of that spectrum, which is endoscopy. That is really important in bowel cancer, through screening programmes and through patients who present symptomatically. Upper GI endoscopy—putting a telescope down through the mouth into the oesophagus, gullet and stomach—is what we call an aerosol-generating procedure. It is a procedure that has a higher risk of generating droplets and aerosols that might contain Covid. A particular high-level form of personal protective equipment is required for that, whereas lower GI endoscopy—investigating the bowel—is not an aerosol-generating procedure and requires a different level of PPE.

There is quite a complex mix in endoscopy services. As Simon said, we are working very hard with our regions, with local teams and with experts and professional groups. Andrew Goddard, who was with you half an hour ago, is a gastroenterologist. We sought advice from Andrew as well, on how we can operationalise bowel and endoscopy services in the light of infection prevention and control and PPE to get back towards the flows and the throughput that we had prior to Covid.

That will require imaginative and innovative thinking. We cannot go back to exactly where we were prior to Covid. We have to do things in a new way. Some of them are things we already wanted to do. Some of it is accelerating work that we already had in place, but in addition we need to think differently about how we get procedures back up to normal levels in a different working environment.

Q196 **Neale Hanvey:** I am particularly interested in the various different pinch points as people go through their journey. Primary care has had a significant impact from Covid, with GPs working incredibly hard. My question is about the cancer journey and how we ensure that patients continue to progress, whether or not with cancer waiting times managers, and how patients are being tracked. What effort is being put into tracking patients and making sure that they progress along that journey within the operational standards?

Professor Powis: I will take the first bit and then pass over to Amanda for some of the more detailed operations. The very first part of it is to ensure that we encourage patients to seek advice. During the peak of the pandemic, there was a reluctance, perhaps understandably, on the part of the public to come forward if they had symptoms.

The very first bit of this, even before we get to a GP referral, is to remind everybody that the NHS is still there, and if you have symptoms that are suggestive of a cancer—a breast lump or a change in your bowel activity—you should do what you have always done and seek advice. We launched a "Help Us, Help You" campaign in April to encourage people to do that. Our charity partners, Macmillan, and so on, have been doing the same. We need to remember that we still need to carry that message; it is important that all of us get the message out that you need to access services.

It is of course the case that GPs and primary care need to do what they have always done and get referrals into the hospital system. I gave the example of endoscopy. We need to rethink the processes in various cancer pathways to make sure that they are optimised and working as well as possible for a Covid environment, because we are going to be in a Covid environment for some time to come.

Q197 **Chair:** Amanda, do you have anything to add?

Amanda Pritchard: I support what both Steve and Simon have said. We are conscious that it is terribly important that when we focus priorities around the restart we do so around the patients whose need is greatest. That means every single step of the pathway, as was rightly said. As Steve just said, encouraging people to have the confidence to start the pathway is a critical part of that. Then we must focus particularly on some of the constraints and diagnostics.

Simon has given some examples of where we are trying to think very much more radically and differently about how we increase capacity around some of the critical diagnostics like endoscopy. There are, of course, many others.

The independent sector has been critical to our ability in particular to maintain cancer services throughout the pandemic. About half the beds we have been using in the independent sector have been for cancer patients. The ability to maintain access to beds, as well as to theatres, is all part of that pathway. We are taking targeted action in each of those areas. The cancer team, led by Cally Palmer, have been working on this throughout. I believe she has talked to the Committee previously about some of the work they have been doing, and the work of the Cancer Alliances is supporting that across the country.

Q198 **Neale Hanvey:** The key thing in terms of intelligence is what information is coming from the cancer waiting times management teams about where the key pinch points and the narrow apertures are. Could you say a few words about whether that dialogue is happening, so that those key challenges can be identified?

Chair: Briefly, Amanda. Thanks.

Amanda Pritchard: As colleagues have said, at the moment our ability across the NHS to maintain the treatment part of cancer care has been

strong throughout the pandemic, but it is particularly around diagnostics that we are seeing some of the main constraints.

Q199 **Chair:** Sir Simon has just said that even in July and August the NHS will not have 25% of its normal capacity when it comes to elective care. That obviously has a pretty direct impact on patients. We are going to play a couple of clips of evidence that the Committee has received from patients in earlier sessions, and then there are some questions from Rosie Cooper and Dean Russell.

The first clip is from a knee surgery patient, whose surgery was cancelled. He is called Rob Martinez.

A video was played to the Committee.

Mr Martinez's surgery was cancelled in April. He was told there was zero chance of having it again this year.

We also heard from a cancer patient whose chemo was stopped but has now restarted. She is called Daloni Carlisle.

A video was played to the Committee.

Q200 **Rosie Cooper:** I was rather surprised at the reaction from most people on seeing the evidence given by the patients, both Mr Martinez and Ms Carlisle. People have expressed surprise and shock at hearing their evidence, so I would like to ask the panel. Did it surprise you? What is your reaction to it? If you are not surprised or shocked—as I was not—how is this continuing?

Sir Simon Stevens: I had the opportunity to see the testimony that Ms Carlisle and Mr Martinez gave at your Committee a few weeks ago. Like Rosie Cooper, I think it was very distressing to hear that.

All of us have family members and friends whose care has been affected by the coronavirus pandemic. The question particularly that Ms Carlisle raised was one of communication from the hospital to her. It is not for anybody to second-guess the discussion between her and her clinicians about the balance of risk in starting a course of chemotherapy during the middle of coronavirus, but in a sense that was not the sole concern. It was also a question of communication.

The case of Mr Martinez speaks very directly to the question that Luke Evans raised earlier, which is that patients will want to know when their care can be rescheduled. We are very happy, with their permission, to follow up both Ms Carlisle's and Mr Martinez's cases with the hospitals involved, if they will let us know which they are.

Q201 **Rosie Cooper:** Thank you, but, Simon, this is not exceptional. It has been made worse, I totally appreciate, during these Covid times. Everybody is doing their best, but we are forgetting the patient.

A friend of mine was diagnosed with an oesophageal cancer. They had had two rounds of chemo and were due to see the consultant. The

consultant meeting took place over the telephone. There was no warning to him or his family. On that telephone call, he was broadly told, "Chemo's not working. It is time to get your affairs in order." He did not have family members with him. He was very distressed. It affected him greatly. How many more patients around the country is that happening to today, where they are getting poorly communicated bad news, and we are not putting in place any care for those people?

Sir Simon Stevens: I hope that is not a general experience. Indeed, without in any way detracting from the importance of what you have just said, only within the last several days the annual cancer patient experience survey has been published. That shows that patients' experience of their cancer care on the NHS is the highest it has been in five years, including on questions such as communication.

We have gone through a very difficult period. This has been the most difficult year the health service has ever experienced. Quite clearly, hospital teams have a big job of work to do to connect and communicate properly with patients whose care had to be paused so as to reduce their risk of infection from coronavirus.

Q202 **Rosie Cooper:** Absolutely. Communication was poor in the first place. It is undeniably worse. In fact, I was quite shocked that the communications about the shielding programme were so dreadful. Even local GPs were not clear. They thought it was specific cancers, and thousands were left off the list. I have to thank Liverpool CCG and NHS North West, who did their level best.

Simon, this programme was run from the centre by a lady called Emily, I am told. I asked for her email so that I could send her a message.

Sir Simon Stevens: Sorry, which programme?

Rosie Cooper: The shielding programme.

I was told I could not be given her email. I said, "Okay, that's fine. Can she contact me?" That was at least two months ago. I have not heard from her. If the centre cannot communicate with MPs, how are we going to expect them to communicate properly with patients and the people who rely on the service? An awful lot of the things that go wrong are based in poor communication. If we get that right, patients' wellbeing and doctors' wellbeing in trying to deliver a service would be so much better.

Chair: Rosie, we seem to be losing you. Simon, did you get the gist of that? We just need to fix a technical problem at this end. Apologies.

Sir Simon Stevens: I heard Rosie very clearly and I agree with her. To clarify, on the shielding service, the question as to who should be included in the extremely vulnerable clinical category was determined by the chief medical officer. Those names were identified by NHS Digital, but there was an opportunity for people to ask their GP if they felt they should be on that list. That was the route that was taken, and as a result

2.2 million people at the greatest risk of severe illness from Covid-19 were identified.

The Government subsequently issued updated advice on shielding and set out a series of measures between 6 July and the beginning of August. I am very happy to get those to you, Rosie, if your office does not have it at this point.

Q203 **Rosie Cooper:** Thank you. I understand that you want to build on the response to the question you answered from Luke about how many cancers are likely to have been missed or not diagnosed if service levels had been as they were pre-pandemic. Then I would like to ask a quick question about dentistry, if I may.

Sir Simon Stevens: Amanda Pritchard will respond on dentistry. On the first of those questions, I think it is too early to say, quite frankly. As you know, most referrals, fortunately, when checked out do not result in a cancer diagnosis. Where people have put off coming forward since April, as Steve Powis said, we have been encouraging them now do so. It is important to get signs and symptoms checked out. A number of cancers can be quite slow growing. We want referrals back and cancer checks coming through the system.

Until we have the ability to see what that looks like in the round, I do not think it is a question that can be answered. What we can say is that the number of cancer treatments held up pretty consistently through the peak of the coronavirus, but clearly there were aspects of diagnostic care and chemotherapy in particular where consultants would have felt that it was more risky for patients to embark on an immunosuppressing course of treatment when there was so much coronavirus in the community.

Q204 **Rosie Cooper:** In essence, we heard evidence from the BDA that dentists were facing an existential crisis. Most MPs have heard from dentists who are really angry and distressed, and who feel that their ability to open up and get going financially after the pandemic eases is going to be difficult.

I know we are now slowly getting back to opening dentists, but aerosol-generating procedures are going to be difficult. How are dentists going to cope financially with the gaps between patients and the cost of PPE, and is the NHS helping them to cover those costs? How can they be supported to deliver safely the volumes of care that we previously had?

Amanda Pritchard: Dentistry is a hugely important service. We are very much aware that the whole of the dental sector has, as has the rest of the NHS, stepped up through the Covid crisis despite considerable pressures on their services.

Our particular responsibility is to NHS dental practitioners. What we have done is maintain a roll-over contract model from last year, so that there is stability and a reliable source of income that is separated from the amount of activity that is being done at the moment. Exactly as you say,

in common with the rest of the NHS, there are real constraints around the productivity that dental services are able to operate. At the moment, balancing safety and patient needs, we absolutely support dentists making some local judgments about what the right balance is to make sure they are able to operate safely.

From an NHS perspective, we are working closely with the BDA around things like PPE costs. We are conscious, as has been mentioned, that both the demand for PPE and the price of PPE has risen, so we are very keen to continue working with the BDA to make sure that we support NHS dentists through that.

Q205 **Dean Russell:** Sir Simon, my questions are around the mental health of patients, a little bit about staff and also communications to staff.

First, could you give an outline of the extra pressure that was put on the NHS around mental health during the pandemic, and what was done to meet the demand?

Sir Simon Stevens: You are right. I think the Committee has heard from my colleague Claire Murdoch, our national mental health director. Claire set out some of the new services that were expedited, including crisis care and crisis helplines for patients, as well as a support offer for staff through the pandemic period.

The honest answer is that there is a big unknown as to how much of an additional burden of mental ill-health there will be coming out of the last four months. There is some evidence that there will be higher rates of mental distress. The extent to which that is also clinically identifiable mental disorder is being investigated. Professor Sir Simon Wessely, the Regius Professor of Psychiatry at King's College London, and the Institute of Psychiatry are doing fact-based empirical investigations on this point right now.

In a nutshell, we believe there will be increased mental health demand, but the precise size and shape of it is yet to be determined and seen.

Q206 **Dean Russell:** Looking ahead, I appreciate that there is a great unknown, but based on the need to plan resources and support, can you assure me that the parity of mental health care, and the planning, will be equal to care around physical health?

Sir Simon Stevens: The first thing is that, as you know, I have committed over a number of years that mental health investment will grow faster than overall growth in the NHS budget. Looking at the financial year that we have just concluded, 2019-20, I can confirm that once again the mental health investment standard was met nationally. Mental health services grew faster than the NHS overall last year, and in fact the mental health investment standard was exceeded by £200 million or thereabouts.

Looking at the year we are now in, obviously we are in completely changed circumstances. We want to ensure that that commitment remains for the regular work of the NHS and that the extra costs that providers have to incur for coronavirus have been reimbursed on an at-cost basis.

Too many of the buildings and facilities in which NHS mental health care is being delivered are out of date and need a significant upgrade. That is why one of the things I have personally been pushing, and am very pleased that the Prime Minister's announcement today gives effect to, is capital investment to phase out altogether so-called mental health dormitory wards across NHS mental health providers. The money we are getting today—part of the £1.5 billion—will enable mental health providers to do that.

Q207 **Dean Russell:** Fabulous. Will that help to support a decrease in the waiting times for children looking for mental health support? That has been a big challenge for a few years for many, and a lot of parents have been concerned about those waiting times.

Sir Simon Stevens: Yes, you are quite right. One of the things that we have committed to, and that mental health services are delivering on, is an increase in the proportion of children and young people who are getting specialist mental health services. For the year we have just come out of, Claire Murdoch, her team and the mental health services, managed to expand faster than was planned for last year, but we clearly have a long way to go.

Part of that is an unknown around how much the mental health needs of young people can be met through, for example, schools-based programmes as against referrals to the specialist CAMHS services—child and adolescent mental health services. That is why a quarter of schools are now running additional schools-based models to test out that proposition before a decision is made nationally on what the scaling of the programme should look like.

Q208 **Dean Russell:** Related to NHS staff and mental health, when Claire Murdoch gave evidence a few weeks ago, I raised not just supporting NHS staff but also their families, especially during the very intense peak of Covid. She assured me then that the families of NHS staff would be reached out to so that they have support. I have followed up with her since, and she has assured me that that has happened.

I am interested to know your take on the next few months to support mental health for staff. I know you visited Watford General Hospital recently. They have had the sanctuary at Watford Football Club next door. A lot of organisations have done something similar. Is that something that can be continued far into the future to support staff and provide additional wellbeing care?

Sir Simon Stevens: The answer is yes. Necessity is the mother of invention. As you heard from Professor Goddard earlier, a lot of the

support that has been put in place during this terribly difficult and trying period for staff now has to be the new normal in how we provide support going forward. Amanda may want to come in on that point, as she has been actively working in that area.

Amanda Pritchard: I echo what Simon has just said. There has been the most unbelievably difficult period for NHS staff across the last few months. As colleagues have said, the response—thank you for acknowledging it again—has been completely remarkable. Out of that, if we can find some things that have worked well to support our staff through the pandemic that we can now make much more the normal routine offer, that is very much the commitment that I and all my colleagues have made. We are absolutely committed to that.

Q209 **Dean Russell:** I have one final question, Sir Simon, about communications. Rosie previously asked about communications to patients. One of the things that seemed to be a big issue, especially during the intense period when PPE was a concern for staff at the start of the pandemic, was that it felt like there was not necessarily the greatest communication. Some of the anxiety I heard from staff was fear around what could happen rather than what did happen. For example, there was a fear around PPE not being delivered because it was over a short period of time, but that actually never happened. Anxiety levels seemed very high, and it felt like communication could have solved some of that.

I am interested in your view of what happened around communications to staff during the pandemic. Hopefully, there will not be a second wave, but if there are intense periods moving forward, how could that be resolved and improved on?

Sir Simon Stevens: That is a fair point. As you say, although there was no national stock-out of any PPE item, the distribution challenge was pretty intense on the Department of Health, and the armed services who helped with that as well, as PPE distribution went from serving 238 health service bodies to north of 50,000. You raise an important point.

More generally, I think there is a sense that communication on a range of topics has been quite comprehensive. Steve Powis and his colleague Keith Willett, as well as Ruth May, the chief nursing officer, and many of my national clinical team are holding weekly and fortnightly webinars and information sessions. Amanda is doing a daily update for the health service. There is a sense that people have had the freedom to innovate and get on with it, but nevertheless there has been pretty significant communication and support.

Q210 **Dean Russell:** Perhaps I could follow up on that very briefly with Professor Powis. Did you feel that it reached the frontline? I have been volunteering in a local hospital, and I felt that sometimes there was a disconnect between what I was hearing as the MP speaking to senior staff and what people on the frontline were hearing. That is not a criticism of the brilliant work that the team were doing, but I am interested in your

view on that.

Professor Powis: I recognise that that can sometimes feel or be the case. It is important that we use as many different communication channels as possible to ensure that people know what the position is.

On the point about PPE, for instance, the royal colleges, the BMA and the RCN are important routes for us to get the message through to the wider constituency of staff. For instance, throughout this I have been meeting regularly, obviously remotely using technology, with the presidents of the colleges, the BMA and the RCN. Until recently, I was doing that twice a week. We would spend an hour on a call together. There would always be a PPE update in that so that those presidents and key individuals knew exactly what the position was. We have moved it to once a week now as we have moved into a slightly different phase. We still give that update. That allows them to pass it on through their channels as well.

Similarly, once every two weeks—it was once every week but is now once every two weeks—the chief nurse and I do a similar webinar with medical directors in individual trusts, and with representatives from other bits of the health sector and chief nurses, so that we can tell them what the position is, so far as we can see it.

It is not just one route of communication. It is using multiple routes of communication. You can never do enough to get the message all the way through. Certainly, we have been using lots of different routes to try to impart what we believe the position to be.

Q211 **Chair:** Thank you very much. As we are talking about the new normal in the NHS, particularly about issues affecting staff, I am going to talk more about PPE and also about BAME staff. I want to focus a little bit on testing.

Sir Simon, could I ask you about your letter to the NHS of 17 March? It was a very important letter, telling hospitals to free 15,000 beds. That was absolutely essential if we were to avoid a northern Italy-style meltdown. What puzzled people is why that letter did not say that patients going into care homes should be tested.

We know that was not the PHE advice at the time, but we also knew then about asymptomatic transmission. SAGE had been talking about that since the beginning of February. At the same time in Germany, they were saying that patients discharged from hospitals to care homes either had to be tested or they had to be quarantined for two weeks. We should have done that here, shouldn't we?

Sir Simon Stevens: As you say, Chair, there was an absolute necessity to ensure that hospitals were able to deal with the very sharp increase in the number of coronavirus patients headed their way. Indeed, the day before that guidance was issued, the advice that we were receiving from SAGE and from SPI-M was that perhaps 2 million people might require hospitalisation. Given that we have 100,000 hospital beds, that obviously

was a very concerning scenario; so absolutely hospitals took action to free up beds. The vast majority of the patients who left hospital went back to their own home or to community health services. Only 2.8% of patients who left hospital over that period went to a care home, and that is a significantly lower number than over the same period last year.

On the question of testing policy per se, and the fact that we were following the Public Health England advice issued to us on 11 March, I think Steve Powis will want to come in on that.

Professor Powis: As you have pointed out, the advice at the time from Public Health England was that where testing capacity existed it should be used to test people in ITU with pneumonia and people who had been admitted to hospital who were unwell, and to support outbreak investigations and test key workers. At the time of that letter, the Public Health England advice on testing was indeed followed.

Clearly, care homes—

Q212 **Chair:** Professor Powis, could I just jump in? We know that you followed the PHE advice, but we also know now that that you are 13 times more likely to die in a care home in Britain than in a care home in Germany. To cut to the chase, knowing what we know now, would you have written exactly the same words in that letter, or would you have said that before being discharged to a care home people either had to be tested or they must be quarantined, which is what happened in Germany?

Professor Powis: As you know, as we moved into April the advice was changed in order to test. The fact of the matter is that we—

Q213 **Chair:** I just want to understand. You would have written a different letter, knowing what we know now.

Professor Powis: It is always difficult going back in hindsight to a particular point in time, but clearly in April we moved to testing people coming out of care homes. As our knowledge of the virus has changed over the months, so the various guidance and advice has changed.

It is also the case, as Public Health England said at the Public Accounts Committee last week, that testing capacity was very constrained at that time in early March. There were many fewer daily tests available than there are now.

Q214 **Chair:** Yes, but you wanted to free 15,000 beds, and we were doing about 5,000 tests a day. It would have been three days' worth of testing.

Two weeks after that, it is clear, looking at the SAGE minutes, that SAGE was very worried about it because it asked you to do an investigation into nosocomial infections—infections in healthcare settings. On 2 April, NHS England sent out more guidance to care homes, and it was explicit. It said that some discharge patients might have Covid-19 whether symptomatic or asymptomatic. But still no tests were required.

Let me read you what one London CCG said to a care home: "There is no need to wait for a positive/negative swab result for discharge patients as the result takes at least 48 hours to come back, and they could still acquire the virus whilst waiting for their test result, which will give false assurance." Basically, that CCG was saying that testing was a waste of time. You would not agree with that now, would you?

Professor Powis: I would say that testing is important. Of course, as I said, in April we introduced testing on discharge. As you also know—you made the point about asymptomatic patients—a negative test is not always a guarantee that somebody is free of Covid. It has absolutely been the case that in care home settings there is real importance for infection prevention and control. I know that care homes have been focused on that, and care home staff have done a great job.

Indeed, the NHS and the chief nursing officer have provided a lot of assistance in terms of our expertise in infection prevention and control in helping care homes where they need it. You also—

Q215 **Chair:** But it would have helped those care homes enormously in that infection prevention and control if they knew definitively whether someone had tested positive or not.

Looking at the SAGE minutes, we knew by the end of April that nosocomial infections had risen to 20% of all infections—20% of all new infections were happening in healthcare settings—but it was not until 18 May that the official NHS England/PHE document on infection prevention and control was updated to include the 2-metre social distancing rule. That was too late. It was in the middle of May, when we had seen the rise in nosocomial infections happening from the end of March. Why did it take so long to update that document?

Professor Powis: I think that document was largely bringing together a group of existing guidance and measures. It was providing further clarification to our healthcare organisations. Throughout this, there has been a focus on infection prevention and control.

You know from your time as Health Secretary that the NHS has been focused on this for some time. MRSA and C. difficile are all infection control challenges that the NHS has risen to and has reduced. Hospitals in particular have directives on infection prevention and control, and throughout this they have been working to minimise the risk of healthcare-associated infection.

On the figure of 20%, it is important to clarify something. I think that figure has come from a limited study looking at infections after five days in hospital. In that period, it is not clear, because of the incubation period of around five days, whether it is a community-acquired or a hospital-based infection.

We have now put in further guidance and are collecting further data on infection rates beyond eight days and beyond 15 days. The figures are

coming down; they are much less than the figure you quoted. That figure was not certain at the start.

Q216 **Chair:** I understand that, Professor Powis, but the document I have here is the official Covid-19 infection prevention and control guidance put out by the NHS and Public Health England. It did not have the 2-metre advice until late May. That was too late.

What it looks like from the outside—please tell me if this is wrong—is that because you were focused on one very important risk, namely hospitals being overwhelmed Lombardy-style, we took our eye off the ball when it came to infection prevention and control in healthcare settings. That is why, among other things, 5% of patients in care homes have died from coronavirus, which is much higher than in some other countries.

Professor Powis: No, I would not accept that we have taken our eye off infection prevention and control. I think people have been focused on it throughout. There are very many important components to infection prevention and control, such as segregating patients when they arrive, if they are suspected of having Covid, and certainly when they test positive. Organisations have been doing that throughout.

Q217 **Chair:** That was the advice for care homes in Germany, but it was not the advice for care homes here.

Let us move on to solutions, if I may, for care homes. If you are running a care home today and you have a potential outbreak, and you want an NHS community nurse to come and help you administer tests to all your residents and cope with a very difficult situation, will you get that help from the NHS?

Professor Powis: We have put a variety of additional support into care homes, including bringing forward the plan we had with primary care to ensure that there is frequent and regular general practitioner input in every single care home.

Q218 **Chair:** The reason I say that is that care homes say that they will not get that help. They say they ask for help from NHS community care and the NHS will not send round a community nurse to help them. Amanda, you could help as chief operating officer by sending out an instruction to the whole NHS saying that this disease is something the NHS is committed to help tackling, wherever it occurs, and it is absolutely essential that NHS community organisations give all the help to care homes that they need. Would you be willing to do that?

Amanda Pritchard: We have given a very clear instruction to the NHS to do two things. The first was to make sure that we were offering training on infection prevention and control to every single care home. That has been done, and there has been a programme of super-trainers and local trainers so that it is not just a one-off thing; it is about sustainable transfer of skills and sustainable support for the sector. The second thing, as Steve said, is that we have given a very clear commitment to bring forward the enhanced care and care homes

package, so that every single care home now has a named clinical lead through primary care, providing exactly the kind of local co-ordination and support that people need.

In terms of the actual support in outbreaks, obviously that involves multiple different people working together, including PHE. Where we are specifically talking about taking swab tests, that is something that under current arrangements people are able to self-administer. It is not a complex task that requires a level of clinical expertise, as a blood draw would. Clinically, if you are talking about taking bloods, that is very different, but if you are talking about the swab tests, the support that we have offered, and that we have instructed through CCGs should be offered as part of the infection control package of training, of course includes providing support on how to do that swabbing locally.

What we are trying to do is get the right balance in a sustainable support offer for the sector, which I can say with certainty that my colleagues across the NHS are very willing to provide.

Q219 **Chair:** That is excellent, and I do not doubt it for a moment, but it is not the perception in care homes. A lot of care homes feel that, basically, if they have what they think might be an outbreak or a symptomatic patient, when they contact their local NHS it is not seen as a problem of the NHS because it is in a care home and not in a hospital. If you would undertake to reiterate through the network the point you have just made, that would be really helpful.

Sir Simon and Professor Powis, I want to go back to staff testing. You will be familiar with the Addenbrooke's study, where they tested all staff and found that 3% of staff were asymptomatic carriers. Then they started regular testing and isolating of staff and managed to get it down to one in 840 after just a month. That is pretty convincing, so why haven't we introduced weekly or routine testing for all NHS staff?

Professor Powis: I think Chris Hopson referred to that in his evidence to you. We last wrote out to organisations around that and wider aspects of healthcare-associated infections last week, on 24 June. In fact, the testing of staff and patients has evolved over the months of the epidemic, as testing capacity has increased and we have learned more about the virus. I will give you the brief context and then the specifics of last week.

As you know, at the very start we focused on testing patients who were symptomatic. That was the right thing to do with the sickest patients. We moved a while ago to testing all patients who were admitted. That was another important component of infection prevention and control testing. That was with all emergency admissions and has been happening for many weeks. We have talked about testing patients in other discharge settings.

In terms of staff testing, very early on we made testing available to symptomatic staff. That was really important because of healthcare-

associated infection risks, and for staff safety and to ensure that we were operating correctly in terms of operational capacity. Then we moved to make that available to households of members of staff who had become infected, and staff were having to self-isolate—

Q220 **Chair:** Professor Powis, time is short. The letter you sent on 24 June is very clear that basically you will have regular testing of staff only when the SIREN study—an antibody study being run by PHE—indicates that there has been a growth in prevalence.

Professor Powis: Not quite. On staff testing, in the letter of 24 June, it remains that all staff with symptoms or members of their household are a priority.

Chair: But regular testing.

Professor Powis: It also says that where there is a higher prevalence—a higher rate of transmission in a particular setting—organisations should increase the frequency of their testing of non-symptomatic staff. Thirdly, and separately, it says that on the advice of the chief medical officer—the advice of the chief medical officer was sought on this, and I know he has a very clear view on it—we should proceed with routine testing in the context of the SIREN study.

I do not want to put words into his mouth, but I am sure what he would say if he was here is that we do not have the evidence base on which to know exactly how frequently staff should be tested. One of the things that we can do in the NHS is get that evidence base. We have done that in the recovery trial for dexamethasone in treatment. We can do it when it comes to testing, and, perhaps just as importantly, we can learn about immunity and how immunity develops by asking NHS staff to recruit to a research study.

That is why his view, and I agree, is that we should take this opportunity of doing regular testing within a structured study that will allow us to get to the gold standard that I think Chris talked about earlier and understand what the best basis for testing should be going forward. Of course, we will keep that under review.

Q221 **Chair:** I understand that. Sir Simon, you know that you could go to the Prime Minister and say, "I would like to test everyone in the NHS at least every fortnight, maybe once a week if there is a bit of growth and maybe twice a week if there is an outbreak." That is an extra 200,000 tests a day. If we did that, we would take a great weight off everyone's shoulders because we would know that we had a structured system in place to find asymptomatic carriers quickly.

That is what NHS Providers—Chris Hopson's people—are saying. It is what the royal colleges want. It is what would allow us to know that elective care centres had a very low risk of Covid. Instead of which, we have a system where 20 to 40 people in every hospital are being tested on a regular basis, in an organisation of 3,000 to 5,000 people. We may

be lucky and spot a growth in Covid or we may not. It is a randomised very small sample, hospital by hospital.

Why don't you just go to the Prime Minister and say, "I need a testing capacity. I know it will take until September, but in April we got it up to 100,000 in just a month, so by September, ahead of winter, I, as chief executive of the NHS, want to know that everyone in the NHS is being tested either once a week or once a fortnight. By the way, I would also like it for the social care system as well"? Why don't you do that?

Sir Simon Stevens: Let me say two things. First of all, throughout this, decisions on testing—who should be tested and how frequently—have been led medically. It is the chief medical officer and Public Health England who determine that. If Chris Whitty is giving the advice that he is, we are going along with that.

That is not the end of the story. There is a second part, which is what you are getting at, Chair. We want to see a significant further increase in testing capacity on the sort of timelines that you have described. I have discussed this with Dido Harding, who, as you know, is leading the testing and tracing service. I think their clear intention is to substantially expand testing capacity in the direction that you describe.

Q222 **Chair:** Let us tie that down because it would be very exciting for NHS staff if that was the case. Basically, by the end of September we will do routine testing fortnightly, or more frequently as necessary, for all NHS staff, so that we know as we are going into winter, with the risk of a second wave that could be so much more damaging, that NHS staff will be doing everything they can to minimise the risk of asymptomatic transmission. That is what you are saying.

Sir Simon Stevens: That is not what I said, Chair, but it is not inconsistent with the thrust of it.

Q223 **Chair:** It is what you said was possible and was going to happen.

Sir Simon Stevens: What I said was, and what I stand by, is that, if Dido Harding were here before you again, I think she would set out the further testing expansions that are in train. The aim, clearly, by the end of September or October is to have significant extra lab capacity so that, were the chief medical officer then to recommend a change in the asymptomatic staff testing policy, that would be something that could be delivered.

Q224 **Chair:** A final question. One of the constraints, apparently, is that you insist that all NHS staff testing has to be done by NHS labs, when there is actually extra capacity in the other labs—

Sir Simon Stevens: No, that is completely untrue. To be clear about it, if NHS staff are asymptomatically going to be tested, obviously it needs to be done in a way that is convenient for them. It will not make sense to send them off to drive-through testing centres, for example. The different testing modalities need to be aligned to the clinical case, the purpose and

the turnaround time that is required, which I know is also a subject dear to your heart, Chair.

Chair: Thank you. That is very useful clarification. We are going to move on to PPE issues.

Q225 **Dr Davies:** PPE has been an issue of concern to many over recent months. Sir Simon, where do you feel that we are now on the availability of PPE to NHS staff reliably, consistently and in terms of the type of PPE being consistent too? Where there has been fit testing for a particular type of mask, are NHS hospitals able to access sufficient quantity of those masks rather than different types each time?

Sir Simon Stevens: It may be that Amanda or Steve want to come in as well. The straight answer to your question, as the Secretary of State said yesterday, and at an interview that Lord Paul Deighton gave, is that the situation has improved dramatically over recent times. Looking forward, not just over the next three months but into the winter period, I think the Department of Health team have increasing confidence that supply will be available on a predictable forward basis rather than some of the more just-in-time approaches that were in place while there was a huge worldwide crunch on PPE supply and a massive spike in worldwide demand.

Professor Powis: It is absolutely the case that the supply lines are more secure now and the distribution network, which of course has gone to a very large number of organisations compared with where it was at the start, led with our support by DHSC, is in a much more secure and robust place.

Fit testing is a very specific question. To be clear, fit testing is the process that is used to ensure that the FFP3 masks, which are the masks used in aerosol-generating procedures and in parts of organisations where AGPs are common, fit between the mask and the face. It is absolutely the case that faces are different and not every single type of mask fits as perfectly as we would like on to every individual face.

We are doing work with Government and colleagues in NHSE to ensure, now that supply is much more stable, that organisations get a range of different masks in different sizes and of different makes where they need them, so that there is more flexibility in ensuring that individuals have a choice of the masks that fit best. Of course, it reduces some of the failure rates when you do the fit test. It also ensures that organisations that have a preference for a particular type of mask, because their staff are used to it, are able to be supplied with that. You have raised a very important point, and it is work that we are doing as we speak.

Q226 **Dr Davies:** Thank you. The situation as we talk now seems a lot better than it was, but, as I see it, we face a couple of challenges. First, there is the desire to increase routine treatment in hospitals, which is going to require additional PPE. There is also the potential threat of a second

peak, and the challenges that the coming winter may throw at us. Are you happy that the supply of PPE will be able to keep up with both of those demands?

Professor Powis: Amanda might want to come in, but, as Simon said and as I have iterated, the forward look in terms of security of supply is in a better place than it was a few months ago. Much of the supply comes from the far east. Of course, as their production lines, particularly in China, have got under way, following their epidemic, supply has become more secure. There are more direct relationships with those factories now. Supply is also being ramped up in the UK through Lord Deighton, so there is a greater mix of suppliers.

Of course, as I said, the DH leads, with our support. I think we would all say that we have more confidence in the supplies looking forward. It is going to be important that we build up PPE capacity. As we go into winter, we all hope and plan that we do not get a second wave, but we cannot exclude that, and we must get ahead in terms of the amount of PPE that is required.

Q227 **Dr Davies:** Amanda Pritchard, there is obviously a cost involved with all this PPE. Who meets the cost of it? How does it impact potentially on the provision of other services if there is a large bill to meet?

Sir Simon Stevens: Amanda, do you want me to take that? PPE costs are being met directly by the Department of Health and Social Care, which is procuring it for the NHS.

Q228 **Dr Davies:** Finally, what do you expect the functioning of hospitals to be, bearing in mind that we have hot and cold zones, that distancing is required and the potential limitations on PPE availability? At what percentage of normal operation do you expect them to function?

Amanda Pritchard: What we can say is that across the whole of the NHS—not just hospitals, but primary care, community mental health and across the board—people are working incredibly hard to get back to, as close as possible, normal levels of activity. For all the reasons we have discussed, there is real awareness of the need to get to a new normal that means that everybody can access the care they require.

What that means in the short term is that we are very keen to continue the partnership arrangements with the independent sector because that provides some much-needed additional capacity on top of normal NHS facilities. It means that we have a real task ahead of us to make sure that we support our workforce. That is critical because you can have all the facilities in the world, but if you do not have the workforce you cannot use them.

We are also thinking carefully about the things you have just talked about. How do we use technology most effectively to find different ways of accessing services? How do we make sure that the people who need face-to-face care can access it safely? At the moment, all the effort is

going into really trying to push that restoration journey but recognising that it is not straightforward.

Chair: A very important issue is the impact of Covid on BAME staff. Sarah Owen has some questions.

Q229 **Sarah Owen:** Professor Powis, every one of the 44,000 deaths in the UK is a tragedy. Over 60% of healthcare workers who have died during this pandemic have been black, Asian or minority ethnic. What are you doing to protect that group of staff? May I just flag, Professor Powis, your reference to the term "far east"? It is an outdated term. It is one that is only western in its view.

Professor Powis: Thank you for pointing that out; apologies.

On the issue of our staff who are at greater risk of Covid, our BAME colleagues are a particular risk group and there are other risk groups as well, as you know from the evidence that we have learned on this. It is absolutely critical that we support them and that there is support in all our healthcare organisations in all our settings to identify their particular needs and make adjustments to work settings, work environments and their own work where needed.

We have been working on this during the course of the epidemic, particularly as evidence has emerged over those individuals who are most at risk of complications and harm from Covid-19. As you are probably aware, a number of weeks ago, we worked with independent experts and NHS employers to formulate a risk assessment and a risk framework. Risk assessment tools were distributed to organisations, and we have been asking organisations, where they have not completed those risk assessments, to complete them in the next few weeks.

That is a really important conversation and process with individual members of staff, because, of course, individual risk can only be judged in the context of an individual's personal work circumstances. Where adjustments need to be made, which could be redeployment to another work setting, working from home or a variety of measures, we have asked organisations to go through that process and ensure that all staff who have increased risk have that conversation and the opportunity to adjust their working environment to minimise risk.

Q230 **Sarah Owen:** Thank you. Sir Simon, as we have just heard, managers are carrying out risk assessments. My concern is that there are not enough BAME NHS workers in management positions. A survey of BAME NHS workers by ITV News found that 50% felt that discrimination in the NHS played a part in the disproportionate deaths among BAME staff. Of the hundreds of trusts, the number of chief executives who are BAME is still in the single digits. Six years on from the "snowy peaks" report, why has more progress not been made?

Sir Simon Stevens: The first thing to say is that I agree with your underlying point, which is that the NHS is both part of the problem and

part of the solution. As a result of something called the workforce race equality standard, we have now begun tracking at every trust the experience of black, Asian and minority ethnic staff compared with white and other staff groups.

We have seen demonstrable progress in some of the core HR measures of fairness at work, in the likelihood of being shortlisted for promotion, access to training and ending up in a formal disciplinary. We have also seen a 30% increase in the number of black, Asian and minority ethnic very senior managers across the system. In parts of the country such as London, where we had the indefensible position that a large number of trust boards did not have a BAME non-executive, that has now changed in every organisation across the capital.

Nobody thinks that is good enough. I certainly do not. That is why every part of the NHS has been asked to set measurable, quantitative goals for improving diversity at all levels through the organisation. That is something we are doing at NHS England and NHS Improvement as well.

Because you cannot separate the workforce experience from the patient and community experience, we are also funding, with the NHS Confederation, an independent race and health observatory, which will generate not only actionable information but catalyse some of the wider changes that are needed in the way in which we offer services to different community groups—for example, the type of work that Professor Jacqueline Dunkley-Bent, our chief midwifery officer, has been leading with black mums and access to maternity services. A huge change programme is needed across the NHS. We do not dissent from that whatsoever.

Q231 **Sarah Owen:** Specifically on the point that NHS staff, particularly BAME NHS staff, feel that discrimination has a big role to play in the disproportionate number of deaths, one nurse said, "All BAME nurses are allocated to red wards and my white colleagues are constantly in green wards." That was at the beginning of the crisis. Do you think the NHS has a structural problem with addressing racism?

Sir Simon Stevens: As I said right at the start, I think there are systemic features to discrimination and racism, and the NHS is both part of the problem and part of the solution. Where staff have concerns in that way, we think it is very important that they are able to speak up freely using the Freedom to Speak Up guardians network to do so. That will help shine a light on whether there are particular practices in particular organisations that need to change. The reality is that we have a big difference between different parts of the country and different parts of the NHS in what our staffing mix looks like.

I was talking with black and Asian staff at North Middlesex hospital a few weeks ago, where 62% of the hospital's employees are from a BAME background. On the other hand, there are parts of the country where that

is many fewer. The reality is that the NHS has always relied on a diverse workforce and we have to become a better employer.

Q232 **Sarah Owen:** I have two more questions on that, Sir Simon. A group of people who have not been praised nearly enough are hospital cleaners. They are quite literally trying to rid our hospitals of the virus every day, but many have reported feeling scared or concerned about their safety during the pandemic, and about the insecurity of low pay, having to work for private companies such as ISS rather than directly for the NHS. Couldn't they be better protected physically and financially if they were brought back in-house?

Sir Simon Stevens: That is a bigger question. As part of the wider changes we are looking for in the NHS, we want to move away from a regime where we have to have competitive tendering of services under the various competition and procurement regulations we are subject to. That is one of the recommendations that we, the NHS, have brought to you as Parliament to consider in an NHS Bill, which we hope Parliament will consider at some point in this Session or beyond.

There is also some concern in parts of the NHS that, with community health providers who provide school nursing, sexual health services or other health visitor services to local authorities, we are beginning to see some councils suggesting that they should be retendered right now. A number of community health providers think this is not the moment to put those community health services through a competitive tendering process.

Q233 **Sarah Owen:** Lastly, we have heard from other panels who have attended the Health and Social Care Select Committee that staffing is an issue; vacancies were an issue before the pandemic, and if we are to clear the backlog, that is going to continue to be a problem. With Brexit on the horizon and the immigration policies from the Home Office, what barriers are there in recruiting the international healthcare professionals that the NHS needs?

Sir Simon Stevens: Brexit has already happened, but in terms of the flexibilities that we will have as an employer, the argument has been heard and listened to that we need to continue to be able to attract staff internationally, while at the same time growing the number of people who are trained here in Britain.

I am quite optimistic, actually, that we are going to see a significant increase in nursing and other areas. We are up 11,000 nurses over the course of the last year. As I look at the number of applicants for undergraduate nurse education to start this September—up significantly on last year, and in the case of mental health nursing up by nearly a third—it is entirely plausible to think that we will have the biggest intake for undergraduate nursing this autumn that we have ever seen. I am actually increasingly optimistic.

Q234 **Sarah Owen:** Forgive me, Sir Simon, but I am going to have to disagree with your optimism around retaining some of the overseas and non-EU staff that we have, having spoken to a number of them. Black, Asian and minority ethnic nurses, radiographers and HCAs have told me how difficult it is working in the NHS as a BAME member of the community, with the immigration health surcharge, the visa implications and also dealing with what they feel is discrimination within the health service.

Sir Simon Stevens: I think the Government have agreed to waive the immigration health surcharge.

Q235 **Sarah Owen:** Do you know when it is going to come into effect, because it has not come into effect yet as far as I am aware?

Sir Simon Stevens: I know the Department of Health was asked that question within the last 10 days and said something such as, "Imminently."

Sarah Owen: Thank you very much.

Chair: In our last half-hour, we are going to look forward to some of the things the NHS might want to change permanently as a result of the lessons learned from the pandemic.

We had some powerful testimony from Dr Katherine Henderson, the president of the Royal College of Emergency Medicine. Laura Trott is going to start with some questions about A&E.

Q236 **Laura Trott:** Sir Simon, what is the cumulative drop in emergency admissions year on year since the beginning of the pandemic?

Sir Simon Stevens: The number of emergency admissions between March and May, for that three-month period, was about a third lower than you might have expected—in other words, about 530,000 lower. However, we are seeing now a significant rebound in the number of A&E attendances and emergency admissions. A&E attendances are back to about two thirds of their normal level, and emergency admissions are now back to about 85% of their normal level.

Q237 **Laura Trott:** Crowded A&Es are obviously incompatible with Covid-19, so what are your plans to deal with that rise in admissions?

Sir Simon Stevens: The first thing to note is that my colleague at NHS England, Dr Cliff Mann, has done a careful review of the type of patient treatments that did not show up, as it were, during April in the emergency departments. By a ratio of about 14:1, they were for the most part more minor conditions that could be treated either on a booked basis or at an urgent treatment centre, or in general practice.

The evidence you heard from Dr Katherine Henderson, president of the Royal College of Emergency Medicine, makes a lot of sense to us. Steve Powis and Amanda have been thinking carefully about what it will mean. We are obviously going to need investment in emergency departments

themselves, but we are also going to need to think about new options for patients alongside the traditional models of care.

Steve, do you want to pick up the baton at that point?

Professor Powis: Yes. Clearly, we want to ensure that our A&E departments do not become crowded, and that has always been important to us. Of course it is even more important now that we have Covid in the background, and we need to keep patients and staff safe for all the reasons we have been discussing. Extra prevention control and distancing are important parts of that. As Simon said, we agree with Dr Henderson in that there is a real need to do that.

There is a variety of ways in which we can address that. One of them, and Amanda might pick up the baton on this in a minute, is to ensure that we use our 111 service, and services prior to the A&E department, to signpost people and to help people, and ensure that they get their treatment in the most appropriate place. That is a direction of travel that we set out in the long-term plan and in other strategic plans prior to Covid, and it has come even more sharply into focus during and post Covid.

Q238 **Laura Trott:** To confirm, Professor Powis, because this is important, you are going to move to a Call First approach, as we have discussed previously at this Committee. Do we know when that will happen?

Professor Powis: We are piloting various forms of Call First in London, Portsmouth and other areas, because we want to make sure that we get the exact model right and that we get the data back that will tell us what the right model is.

In general, you are absolutely right: we want to move, as we wanted to move before Covid, increasingly to a 111 first model that ensures we do everything we can to give appropriate advice to signpost people to the most appropriate place for treatment. As Simon said, Dr Mann's analysis shows that during the Covid epidemic it was the more minor illnesses that perhaps we could treat in a different setting, with those individuals not attending A&E to the same extent. Amanda will put a bit more flesh on the bones of the 111 first-type approach.

I have been undertaking a review of some of the key standards around A&E for the last 18 months or so, at the request of the previous Prime Minister. We have been working closely with a number of test sites where we have tested a different set of measures other than the four-hour standard, which is the key standard in A&E at the moment, and we have worked closely with our royal college colleagues, including Dr Henderson. I am really grateful for the work she has done on that.

What we have learned from Covid is that the measures we were working on, which were very much focused on a set of measures that would reduce crowding in A&E, are indeed the ones that we would want to take

forward. That is another aspect of how we can evolve post Covid into a new environment that optimises how our emergency departments work.

Q239 **Laura Trott:** To confirm, it will be a permanent change.

Professor Powis: We were doing the testing prior to Covid. We need to report on what that testing showed. We were looking at how we could do that with our colleagues in DH. The message I would like to put out is that we have been working closely on that with our professional colleagues, including Dr Henderson, and we have a common view as to the way forward.

Q240 **Laura Trott:** Amanda, is there anything you want to add?

Amanda Pritchard: As Steve said, this is a continuation of work that was happening pre-Covid, but we have, as with a number of other things, learned a lot over the last few months about what can be done and what can be done speedily.

In a with-Covid world, as has been said, it must be right to try to find better ways of directing patients to where they need to go to get the care they need, and, if they need to visit A&E departments, as much as possible should be in a planned, booked way so that we avoid overcrowding. However, it is worth saying that we are not at the moment envisaging that the 111 first model would be the only way you could get to A&E. It would absolutely remain open to people who need to go directly to A&E for urgent emergency care. The purpose of the pilot is to make sure that, whatever we do, we balance the needs of local populations and patients with a safe way of providing services and ensuring we have access right.

Q241 **Laura Trott:** One of the things Dr Henderson said was that it needs to be accompanied by an increase in walk-in services and other GP services. Will that be the case in the pilots that are taking place?

Amanda Pritchard: The way the pilots are working at the moment is trying to use 111. I should say that the evidence is that 111 also significantly increased the volume of calls they were handling during the pandemic. Again, we have a kind of baseline that is quite different from the previous baseline in showing what we can do through 111, and we thank all the colleagues who volunteered to be part of that service.

One of the things that we are trying to do in the pilot is to use 111 as a way of directing people to the appropriate next-step service. Getting the range of bookable services as wide as possible is part of the pilot. Portsmouth is particularly focusing on that as a critical part of testing the model.

Q242 **Laura Trott:** There are many other questions, but I am conscious of time.

With regard to planning for a second wave, Professor Powis, you said earlier that we will be in a Covid environment for some time to come.

What are your planning assumptions around what will happen with Covid-19 through the winter and into next year?

Professor Powis: First, we have always worked very closely with colleagues in SAGE and with SPI-M, the modelling subgroup of SAGE, in our modelling and planning activity, and we continue to do so. We ensure that our models and our planning for the future are aligned with what the epidemiologists and the experts in SAGE are looking at going forward, and we will continue to do that. That is evolving all the time. Every week, there is a new set of forecasts. The R rate, as you know, is now updated by SAGE every week, and we will continue to keep a close eye on that.

I am going to answer the question in a number of different parts. First, going forward, we are beginning to see outbreaks and localised increases in transmission rates. The task there is for local NHS planners to ensure that they know that there may be a possibility locally of that occurring, and therefore they can make local plans, and we are supporting our regions and local teams on that. It is not a national plan; it is ensuring that local health systems are well connected to local government and local public health.

At a national level, we need to keep an eye on whether there might be a second wave. Clearly, Government policy—

Q243 **Laura Trott:** I am sorry, Professor. To clarify, you are planning on the basis of that.

Professor Powis: There are a number of components. We need to review the use of the Nightingale hospitals and what capacity we may want to keep there as an insurance policy against a second wave. Amanda and Simon have already mentioned the use of the independent sector to give additional flexible capacity, so that is currently under review as well.

We also need to think particularly about our usage of intensive care beds in the NHS and how they may be utilised in a second wave. One of our priorities if there was a second wave—again we all hope and plan that there will not be—would be to manage that in a way that did not mean that we had to stand down routine services in quite the way that we had to do in April, for all the reasons that we talked about at the very start of this session. If there was a second wave, there would be some similarities of approach, but building on the lessons we have learned there would be some key differences as well.

Laura Trott: That is very helpful. I am very conscious of time. There is so much more to ask, but I shall stop there.

Q244 **Chair:** Thank you, Laura. I want to ask Sir Simon a quick follow-up question on A&E. One of the things that has defined A&E in the last two decades has been the 95% target. I want to ask about the role of aggregated national targets, for which the NHS has become a world leader. Many people inside the NHS think it leads to a lot of

micromanaging of what chief executives are asked to do; indeed, I was accused of that often when I was Health Secretary.

Do you think the change in A&E that we have been talking about could also lead to a broader move away from aggregated national targets and replace them with local standards in the way that Professor Powis talked about? We would still have a four-hour standard and an 18-week standard, and local NHS organisations would still be obliged to meet those standards, but we would not aggregate them at a national level.

Sir Simon Stevens: I understand completely what you are saying, Chair. We will continue to need national goals for overarching improvement, and the NHS long-term plan contains a number of very significant commitments that we absolutely want to advance. For example, if we are going to drive cancer outcomes in this country, we need to improve early diagnosis, so it is quite right that we say we want to go from a situation where just over half of people get their cancers diagnosed to a situation where three quarters are diagnosed over the course of the next five or 10 years. Clinically-led and patient-focused goals that drive improvement absolutely make sense.

In the specifics that you mention, obviously part of what Steve Powis has been doing with the medical professions, patient groups, nurses and others is looking at whether particular measures end up driving other behaviours. If we get to a situation where, because we are living in a Covid world and people do not want to be sat next to each other in crowded A&E departments, they will want the convenience of being able to book a time slot when they need it, you have to begin to capture quick care in the patient experience in a different way. But those are all the sorts of considerations that Steve Powis and the clinical panel he is working with are engaged in.

Chair: Barbara Keeley has some questions on social care.

Q245 **Barbara Keeley:** The Chair has already asked questions around the lack of testing of patients being discharged to care homes, but I want to focus on what should have been done with the care sector when planning was being done.

Sir Simon, talking to the Committee in March, you acknowledged the fact that the social care sector had been under enormous pressure for a long time and that we needed to support and strengthen social care, but what we heard with the Chair's questions earlier was that the focus in March was really on freeing up the 15,000 hospital beds for the NHS that were needed, and to discharge people. You also talked about the social care sector playing its full part in that discharge.

Earlier, in response to the Chair's questions, panel members talked about infection control and advice on segregating, but from my experience—lots of MPs were in touch with their care homes right at the start of the pandemic—in March and April, when patients were being discharged without testing to care homes, there were homes with 50% of their staff

ill or self-isolating, and there were homes that had very large levels of vacancies anyway. We know that they had real problems with PPE; they just couldn't get it. The point about segregating is that many care homes may be suitable for communal living but are not designed to ease segregation.

Given all that, in a care sector under enormous pressure, with the workforce problems that they actually started with, did we protect hospitals at the cost of spreading Covid into the care system—even that 2.8% of patients discharged to care homes without testing? Was that the wrong thing to do?

Sir Simon Stevens: There is a general point, which is that the coronavirus pandemic has shone a very sharp spotlight on some long-standing weaknesses and lack of investment and resilience in the social care sector, which I know you have rightly been campaigning about. It is inconceivable that, coming out of this coronavirus pandemic, there will not be a much more fundamental question about how to support and strengthen social care.

It is not just questions about how the burden of funding it is fairly split between people or, indeed, about the overall amount of funding. It is also about the way in which care itself is provided. It encompasses, as you say, questions around the social care workforce, where there are more vacancies in social care than there are in the NHS. It encompasses concerns about the proportion of workers in social care who are on zero-hours contracts without career progression, and the fact that there is a 30% turnover of staff in social care. All of those are profound questions that, clearly, over the course of the next several months—certainly no more than the next year, I think—have to be addressed. That is the context.

On the specific points you raise, those were points—I will not put words into their mouths—that were specifically responded to and addressed by the Department of Health and Social Care last week at the Public Accounts Committee when it set out what its plan was through the pandemic to support the care sector. It is a question that Chris Wormald, Rosamond Roughton and Catherine Frances were discussing with the PAC last week, and I won't second-guess what they said.

Q246 **Barbara Keeley:** Following up on that, should we be moving Covid-19 patients into care homes at all anymore? Should it be done, even with testing, and should we look at using some other form of step-down care for them, to prevent transmission from people discharged to the rest of residents in care homes? What should we do on an ongoing basis? That has been done in some areas, I think, with some success.

Sir Simon Stevens: As I think your Committee heard in an earlier evidence session, and as you, Chair, referred to, it is worth remembering that we introduced mandatory testing for patients being discharged to care homes before they did in Germany and in Scotland. That was not the

principal difference. It was the question you are raising, Ms Keeley, in terms of isolation or quarantine facilities. Steve Powis may want to come in on that.

Professor Powis: I do not know the answer to the question of what would be best. It is a perfectly reasonable question as to whether there should be some other form of step-down facility. Local government has had the option to consider that as part of discharge arrangements, and in some places it may well have happened. As Simon said, some of these issues are clearly for the Department of Health and Social Care, but I agree with you that, going forward, it is one of the things that we should be thinking about.

Q247 **Barbara Keeley:** At the start of the crisis, many areas took the decision to withdraw NHS services from care homes, so that meant no GP visits. We heard last week from a panel of care staff who talked about providing end-of-life care.

As we move forward, what are you doing to ensure that support is rolled back out to care homes? I think that was touched on earlier. Care staff have shown that they can do many of the jobs that were effectively forced on them during the pandemic. Do you think that responsibilities and perhaps some funding should now be transferred to some extent from the NHS to care providers to help them do what they have been asked to do?

Sir Simon Stevens: I certainly think that care providers should be properly funded for doing as you describe. What the NHS has done is bring forward the enhanced support for care homes that was going to be introduced nationally from this coming October, and that is now in place across the country, with weekly check-ins, named clinical leads and the opportunity to do medication and other reviews in support of care home staff.

On the earlier point you made about fewer face-to-face visits between care homes during the middle of the Covid epidemic, that was in part a response to the infection control guidance. A study by Public Health England in April suggested that one of the main routes for transmission in care homes was from the community to care homes. Providing remote support was part of the infection control response, but, as you say, we are coming through that.

As Steve said, all care homes have been offered support with their infection control; 70% have taken up the offer from the local NHS, and just under a third have chosen not to. Is there any question but that care homes need and will get more support? I do not think there is a question; that has to be done.

Q248 **Barbara Keeley:** In planning a better future for social care, many people feel that too much of the debate is around the relationship of social care with the NHS—we focused on that again this morning—where social care

seems to be a distant second priority to the NHS. They feel as if they were an afterthought in the planning for the pandemic.

In preparing for any second wave, what can we do to address that imbalance and ensure that social care gets the respect and support it needs? How can we ensure that we do not repeat the mistakes we saw in March and April, and that they get sufficient PPE, training in infection control and adequate medical support for their residents and support for when they may be providing end-of-life care, which is a vital issue that they have taken on?

Sir Simon Stevens: Yes, I agree with you. Again, I draw attention to the plan that the Department of Health and Social Care has set out for the next phase. There is complete acceptance that there needs to be a beefed-up support offer for care homes.

Going back to the premise of your question, I am afraid I do not think we accept that the NHS was wrong to mobilise for a large increase in coronavirus patients who needed hospital care, most of whom of course themselves were very elderly and vulnerable.

If we cast our minds back, there was a fabulous and tragic programme on television last night, on BBC Two, called "Italy's Frontline: A Doctor's Diary". It describes 17 March, the very day when Steve Powis and I were last before you; in Cremona hospital in Lombardy, every ward was filled with Covid patients and the doctor featured had to choose between treating a 35-year-old or an 85-year-old. We did not experience that, as a result of the mobilisation across the NHS, and I do not think it should have been a question of either/or. What hospitals did, they absolutely needed to do and would need to do again.

Q249 **Barbara Keeley:** What could we do to avoid it being an afterthought, because they felt they were an afterthought in planning? I think that is the case.

Professor Powis: There is international learning here as well and people have hinted collectively at looking at other countries. Sadly, care home deaths have been a feature of the pandemic in many, many countries. There was a publication last week from the International Long-term Care Policy Network that showed that care home residents made up 41% of deaths in England and Wales. The figure is 49% in France, 47% in Sweden and 44% in Scotland. It has been a feature in many countries. As I think members have hinted, there are various things that we might be able to learn from looking at how various countries have handled this, but it has been a feature of the pandemic that care homes, whatever the circumstances, have unfortunately been hit with many of the sad deaths.

Chair: Thank you. Paul Bristow has our final set of questions.

Q250 **Paul Bristow:** I have a quick question first on the voluntary sector. Has the NHS used patient groups and the charitable sector effectively enough as a source of information and signposting, Sir Simon?

Sir Simon Stevens: This is an important opportunity to record our collective thanks to all the voluntary organisations and, indeed, volunteers who have helped the NHS response since the pandemic began. Although this coming Sunday there will be one last clap for carers, it is not solely an opportunity to show our gratitude to frontline NHS staff; it is also an opportunity for those of us in the NHS to thank everybody else who has helped sustain the work that our colleagues have been doing. That is true for care staff, it is true for us and for train drivers and staff keeping food on the shelves in supermarkets, and it is certainly true for volunteers.

We have had a huge volunteering effort across the NHS, not just through St John's Ambulance, the Red Cross and many local organisations, but through the NHS volunteering programme as well—so much so, in fact, that we have had more volunteers than there were people asking for things to be done. That is partly because friends, neighbours and family have chipped in to help. But it is something that, again, we want to sustain and build on rather than see as a short-term, time-limited part of how the NHS has responded.

Professor Powis: Could I make a specific point on our partners and colleagues in the charitable sector? The first thing I did this morning was to have one of my regular conversations with the chief executives of the Richmond Group, which is a coalition of major health charities. I would like to put on record my thanks for the support they have given during the pandemic. They have played important roles, such as encouraging patients to access the NHS and not be frightened of coming to hospitals during the pandemic.

They were making it very clear to me, and I agree with them, that they will have an ongoing role in providing support and confidence to the patients and citizens they look after in all sorts of areas, from mental health through to my own personal area at NHS England of cardiovascular, stroke and respiratory medicine, which is going to be really important in lung damage going forward and, of course, cardiovascular disease. Our charitable partners have done a magnificent job and are really up for working with us over the next six months.

Q251 **Paul Bristow:** I would argue that it is not just an important role. Would you say the NHS has always been culturally fit for purpose to deal with patient groups and the charitable sector in the past? If you do not feel it has been fit for purpose in the past, how do you intend to address that moving forward?

Professor Powis: They are a core component of our work going forward. The long-term plan, for instance, was developed very much with our partners in the charitable sector. In the areas I am responsible for—cardiovascular and respiratory—those programme boards are co-chaired with the chief executives at the Stroke Association and British Heart Foundation. Going forward, we absolutely see them as partners, and they have a huge amount to contribute.

Q252 **Paul Bristow:** That is reassuring. I have a few more questions. First, to Sir Simon Stevens, how do you rate your leadership during the pandemic?

Sir Simon Stevens: Our role in the national NHS is purely and simply to support frontline staff to do an outstanding job under incredibly difficult circumstances. That is what all of us have been seeking to do. I think they have done that, and they are worthy and deserving of our support and thanks.

Q253 **Paul Bristow:** Do you think you have done a good job?

Sir Simon Stevens: That is for others to decide.

Q254 **Paul Bristow:** Okay. I suppose what I am getting at is this. Who is actually accountable for decisions and perhaps operational failures in the NHS? Is it you or is it the NHS England team collectively, so therefore it is no one? Or would you say it is the Secretary of State? Who would be accountable, if indeed it is felt that there have been operational failures?

Sir Simon Stevens: I think you would need to name the specific to be able to get a sense of exactly what you are talking about.

Q255 **Paul Bristow:** Let us talk about the chief dental officer and some of the failures in dentistry. Would you say she was responsible, or would it be you or the Secretary of State?

Sir Simon Stevens: What are the specific failures you are talking about?

Q256 **Paul Bristow:** Our Committee has heard on a regular basis about quite considerable failures in dentistry. I can bring up some specifics in terms of what people have said, but it is clear to me, and from many involved in the dental service, that they have not had the support that they required. A lot of people are now talking about resuming dentistry practice. It is not going to be there for a significant period of time. Who would you say was responsible for that—you or the chief dental officer?

Sir Simon Stevens: In this forum, I am not going to talk about individual colleagues in that way. You would not expect me to do so. The substantive question, I think, is what needs to happen in order to get dentistry back on its feet. Amanda has already discussed that to some extent.

If you don't mind me saying so, it is a bit of "the devil if you do and the devil if you don't." At a point when dentists were continuing to work, there was a suggestion that we should be more assertive in stopping that and setting up alternative services. When some of the alternative services were set up, the chief dental officer was criticised for those. Then, when individual practices were given the ability to restart safely if they felt they were able to, she was criticised for that as well. There are always two sides to every story, aren't there?

Q257 **Chair:** These are fascinating questions, and I am sorry that we have to

move on because we have come to half-past 12.

Before I conclude, because other life as well as Covid has been carrying on, one of the issues this Committee looked at in enormous detail in the last Parliament was the battle of cystic fibrosis sufferers to get the drug Orkambi, which is hugely beneficial but was very expensive. I think, Sir Simon, you want to update the Committee on some of the work you have been doing on that issue.

Sir Simon Stevens: Thank you very much, Chair. Because the Committee's predecessor spent so much time focused on that question, and because it matters so much to thousands of cystic fibrosis patients across the country, I want the Committee to hear first that this morning, I am pleased to say, NHS England has been able to sign a commercial agreement with Vertex Pharmaceuticals to make available their new triple therapy the very day it gets its European marketing authorisation. Furthermore, we have also agreed flexibility so that clinicians will be able to use that not only for its European licence indications and any future extensions but for other drugs in the portfolio for rare mutations that might be covered by licensing by the US FDA as well.

The last piece of good news is that, in negotiating, NHS England has also inserted into the agreement tag-along rights for Scotland, Wales and Northern Ireland, so that, should those devolved Administrations want to benefit from the agreement, they can do so. This really is a very significant day for cystic fibrosis patients. Three in five with that genetic condition potentially will benefit from the triple combination that tackles the underlying causes of the disease by helping lungs work effectively.

Chair: Thank you. That is fantastic news to end the session on and will be enormously welcomed by thousands of families up and down the country. Thank you for sharing that with us and thank you for pursuing that very important issue.

We thank you, Professor Powis, and Amanda Pritchard, for your evidence this morning. It has been a very long and very comprehensive session. You will appreciate how difficult these issues are and the enormous public interest. You have given us very full and frank answers, so we are very grateful for that. Thank you to my colleagues and to the technical team at the House of Commons, and to Previn Desai, who has been managing the project from the team.