



The Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 22 November 2016

12 noon

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Members present: Lord Patel (The Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

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Questions 216 - 223

Witnesses

I: Natalie Beswetherick, Chartered Society of Physiotherapy; Dr Nicola Strickland, President, Royal College of Radiologists; and Sandra Gidley, Chair, English Pharmacy Board.

Examination of witnesses

Natalie Beswetherick, Dr Nicola Strickland and Sandra Gidley

Q216 **The Chairman:** Good morning. Thank you very much for coming today to assist us with this inquiry. You are important witnesses because we hear a lot from nurses and doctors, even managers, but we need to hear more from other healthcare providers. I know it might seem a little strange, Dr Strickland, to have the Royal College of Radiologists included in that, but you might also have experienced other diagnostics and what the future might be for the long-term sustainability of diagnostics, and we would like to hear about that. I know we have had a change of witness because of illness, but we welcome Ms Natalie Beswetherick. Sandra Gidley, you have had experience of the Health Committee and politics before.

Sandra Gidley: I was hoping you would not notice.

The Chairman: This is a different kind of experience for you. If I may start with you, please say who you are, and if you have an opening statement to make, please do so, and then we will move on to questioning.

Sandra Gidley: Thank you. I am Sandra Gidley. I chair the English Pharmacy Board at the Royal Pharmaceutical Society. The Royal Pharmaceutical Society is the professional leadership body for pharmacists, something akin to a royal college. We represent the third largest healthcare profession in the UK. We do not just represent community pharmacists; it is hospital, academia, pharmacists in any setting. We have been doing quite a lot of work thinking about how we could make a more useful contribution to the health service in the future.

Dr Nicola Strickland: I am Nicola Strickland. I am the president of the Royal College of Radiologists. I am sure you are all totally aware of this but I want to be absolutely clear in the beginning that we are a college of doctors. We comprise clinical radiologists: doctors who interpret X-rays and scans, and perform interventional radiology on patients. We also comprise clinical oncologists, who are doctors who oversee the cancer pathway and administer chemotherapy drugs and radiotherapy for both curative and palliative care.

As for what our specialties represent, it is important to bear in mind that there is almost no medical diagnosis made nowadays without some form of imaging preceding that diagnosis, be that plain X-rays or a scan of some sort. There is almost no cancer that is treated without clinical oncologists as part of that pathway, and it is only clinical oncologists who can administer radiotherapy. Also remember that there is not a single surgical operation of any gravity performed which is not preceded by imaging, so our specialties underpin the whole of modern healthcare and the whole of the cancer pathway. In fact, the NHS will collapse if our current workforce crisis is not solved, because we underpin the whole of

modern healthcare. That is my major concern as president of this college at the present time.

The Chairman: Whilst it is true that you are a college of doctors, you work with other health professionals, and of course, the key reason for having you here is to hear how you work with other health professionals.

Dr Nicola Strickland: We do indeed. Absolutely. We form a team.

Natalie Beswetherick: My name is Natalie Beswetherick and I am director of practice and development at the Chartered Society of Physiotherapy. I am here instead of my colleague Professor Karen Middleton, who, as you heard, is unwell today. My first notification of this was late last night, after returning from a Christmas shopping spree with my 80 year-old mother. The CSP is the professional body for physiotherapists in the UK. We have 52,299 registered physiotherapists here. Not only do we represent them and work with them but we also cover the support workforce as well as our students. Physiotherapists work across the care continuum and they work in every speciality. Many of you may not have met one in person. I am one. It often depends on your personal experience or your family's experience whether you have received care from one. Thank you very much for inviting me today.

Q217 **The Chairman:** Thank you very much. Looking ahead to 2030 and beyond, what do you think would be the impact of changing demography, changing patterns of disease and models of care, and how do you think—this is the important question—not only the workforce that you are familiar with in your own area but the workforce that you work with should change? What contribution can a workforce like yours make to that change?

Dr Nicola Strickland: In clinical radiology and clinical oncology one of the biggest challenges is the pace of the advance of technology and what we are able to do nowadays as doctors within these specialties. Certainly, even in the time in which I have been a radiologist, there has been a massive increase in the complexity of the investigations we perform. If we take, for example, CT scanning, we can now do complicated non-invasive studies such as CT colonography, CT cardiac scans, MR cardiac scans and whole-body MR scans, so not only has the diagnostic capacity that we can offer increased but the imaging that we produce is far more complex, and it takes far more training and time to interpret those scans. The other branch of our college is clinical oncology. The complexity and planning in the types of radiotherapy that we can offer, targeted at particular types of cancers in particular patients, has also increased enormously, as well as the training and time required to administer that.

There are also, on the other side, spiralling healthcare requirements, in that patients are tending to live longer with their diseases and require more imaging and more treatment. They are surviving longer with their cancers because treatments have become more effective, and therefore they are requiring treatment for far longer. The incidence of cancer is increasing, partly due to our ageing population and partly due to our

unhealthy lifestyles, with obesity, smoking and other risk factors increasing the number of cancers we are diagnosing. We know that there is a big focus on screening to try to diagnose cancers in particular early so that we can treat them effectively.

The Chairman: Apart from the workforce in radiology and clinical oncology, you also work with other health professionals such as radiographers, physicists, et cetera. Is there a role in looking ahead to expand their role in delivering the service?

Dr Nicola Strickland: I understand from the latest survey from the radiographers that they have an even greater deficit in their workforce than we do. Across the UK they have a 13% shortage of radiographers, so we do not have enough radiographers to acquire the imaging to work the scanners to take the X-rays, therefore I am loath to suggest that we try to move them into medical roles to perform diagnosis. In clinical radiology we have a 9% across-the-board deficit in our workforce and, unfortunately, of that 9% deficit in consultant radiologists, 41% of those consultant posts have been unfilled for over a year.

I have some solutions I could suggest that might be helpful for addressing that deficit. We need to divide it into the short term and the long term. In the short term we need qualified bodies on the ground effectively to do the work. Since it takes a minimum of five to six years to train a radiologist and about seven years to train a clinical oncologist, training more radiologists and clinical oncologists is what we need to do as the long-term solution. On the short-term solution, we could have, and there is a desire for, radiologists from English-speaking countries—I am thinking in particular of Australia, New Zealand, South Africa, Canada, and the United States—to work over here for a couple of years. I am not pretending for a moment it is because they aspire to working in the underfunded, overstretched, under-doctored NHS, but they have other reasons for wanting to experience a different healthcare environment. They like to be near Europe and to be able to visit countries and so forth in their spare time.

The Chairman: Do they have an excess of these people?

Dr Nicola Strickland: They do not have a shortage, and in some of those countries they have an excess. The most important thing is that they take a higher specialist exam that is at least as difficult as the FRCR, the fellowship of the Royal College of Radiologists, and it is a national exam across the board. In fact, some of those exams I would even venture are more difficult than our exam, because they take pathology as well, so we know they are well trained. We know that they are very keen to do fellowships in this country. At the other end of the spectrum, when they reach their late 50s and their children have grown up and so forth, again, they are quite keen to return to Europe for a couple of years. There are certainly enough qualified radiologists out there to come over here.

The barriers are that, first, the GMC will not recognise their higher board's exams as being equivalent to our own, and they have to go through a lengthy and costly equivalence process, even though they have a national exam—which is not true for other countries in Europe, I might say. I have been to the head of the GMC and put this issue before him. The other main barrier is the Home Office visa requirements, which would be tier 5, I understand. They need to be relaxed so that these people can come over without barriers. That is certainly one answer.

The Chairman: Let me go back to the original question with the other two, because I need your thoughts, too.

Sandra Gidley: I think it is worth clarifying the extent of training a pharmacist has. It is now a four-year master's degree with a year's pre-registration training, and the vast bulk of that training is in medicines and the use of medicines. It seems clear that we cannot keep on doing what we are doing and expect something different to miraculously happen by 2030. We believe that wherever medicines impact on the patient journey, pharmacists should be involved in some way. For example, with stable long-term conditions, pharmacists would be very capable of managing that, preferably working with other people in the healthcare team, such as general practitioners. The community pharmacy would be ideally placed to take on that role because a lot of people find their community pharmacy very accessible.

With the number of people who have a number of long-term conditions increasing, we have to recognise that it is far from unusual now, and this will only worsen, that people have three or four long-term conditions. I work as a community pharmacist as well, and it is not unusual to see somebody on 20 to 30 medicines. Those medicines have generally been added in fairly ad hoc by the poor hapless patient seeing a variety of different consultants for their different conditions, and the GP has not really the time or the capacity to review the medicines, because in many cases if the medicines are rationalised or optimised the patient is on fewer medicines, they feel better because they are not subject to so many side effects and it would save the NHS a bit of money too.

I know there has been some talk in this Committee about generalists and specialists, and whether it is perhaps wrong to have too many specialists, but I think it is worth saying that pharmacists are advanced generalists, because they have a very broad, overarching knowledge of all the drugs. There are some who specialise in certain areas, but there is a great capacity there for a workforce who can work with the medical profession and help make medication and its use much better, because if people are on a simpler medicines regime, they are more likely to take their medicines and, one would hope, get the benefit of them.

The Chairman: Physiotherapists?

Natalie Beswetherick: On the impact for the model of care, for me, and for the profession, the model of care that we need for that timeframe is already here. The problem is it is not everywhere; it is in tiny pockets.

The model of care I think your witnesses were probably alluding to in the last round is that community-based, multidisciplinary, integrated team, which will focus on earlier prevention as well as rehabilitation, and making sure that care is outside hospital and before anybody needs to go into hospital.

On the role of physiotherapists, we work with the nursing profession and a range of other professions—health and social care, occupational therapists, speech therapists—depending on the condition, but we need to make sure we have enough of everyone across the workforce. We are also in short supply. Our colleagues tell us they cannot recruit new graduates. At the moment there are vacancies across England, and they are not getting any better. Not only are we seeing those in graduates, what we call band 5 in the NHS, but they are also being seen in the higher grades, which is of great concern. To develop the team within that model—and I will come back to the interesting question about the generalist versus specialist—people do not seem to value the generalist as much as the specialist historically. Whether that is cultural I am not sure, but we need to pay attention to this. People working in primary care teams often work with very complex medicine and multiple conditions, and they are not seen as having that specialist-generalist approach. I concur with my colleague that we need to—I use the term advisedly—“sex up” the generalist, because we need to make it more attractive to a whole range of practitioners who at the moment are spending most of their careers in hospitals. We need that fundamental shift out of hospitals, in our view, into primary care—the wider GP primary care team as well as the community teams working across health and social care.

Q218 Lord Bradley: Continuing on the workforce theme, you started to identify significant issues around workforce. Would you like to say a little more about that, and about issues around staff shortages, particularly how you would address those issues?

Dr Nicola Strickland: For radiology and clinical oncology, we need to plan for the long term as well as trying to stopgap the short term. For the long term there is untapped capacity in the district general hospitals. We are not using district general hospitals for training radiologists and clinical oncologists as much as we could. Although there are staff shortages in many DGHs, there are also district general hospitals where there are consultant radiologists who could and would like to train juniors across the board, from year one to year five. There is a vast untapped potential out there. In fact, our college has been identifying specific hospitals which could accommodate more trainees if funding could be found.

The other thing we have done already is to set up academies to speed up training, to concentrate training, such that there are dedicated lectures, simulation and so forth within these academies. We have three already: one in Plymouth, one in north Norwich and one in Leeds. There is potential for several more, and there are business plans under way already for one in Wales and one in the East Midlands. There would be room for one in the West Midlands, one in Kent and one in Scotland. Those academies could train more radiologists than they do; throughput

could be far greater. They could also be used to train radiographers on a parallel pathway, so the same building, the same focus and the same supporting district general hospitals and teaching hospitals could be used to train the whole team, if you like. Those are two important ways of planning for the future.

For the stopgap, we could also use our international medical graduates better and facilitate them coming over. We would also advocate making their visa entry requirements much smoother so that they could stay longer if they wished. We would advocate maintaining the pre-Brexit situation whereby radiologists and clinical oncologists from the rest of Europe are accepted automatically as having equivalent training to our own radiologists. At least that means there is freedom of movement, and we need those radiologists at the present time to support our health service and to support our workforce.

The Chairman: Natalie, what is your response to that question?

Natalie Beswetherick: The main issue for the physiotherapy profession is that we are in short supply. Demand has exceeded supply for the last few years, made worse by the decision by Health Education England for 2016-17 to reduce the number of people being trained by 6.2%, so we are adding insult to injury. We have also relied, like many professions, on EEA as well as overseas-trained physiotherapists. Currently 12% of our profession is trained overseas, and that is 7% European and 7% outside Europe. To maintain our workforce we need that pre-Brexit position to be maintained, otherwise we will add further to an already significant impact on our profession.

Changing to more people working in a different way, we have to sort out this supply side. If we do not sort it out, we cannot increase the new models of care that we need—they are in existence but we need them everywhere—to deliver a sustainable NHS. As previous witnesses have said, we cannot carry on doing things the way we always have, which has been very much around a hospital-based service. We need to start investing much more in primary care and community-based services.

Sandra Gidley: I have some good news and bad news because, unlike the rest of the workforce, pharmacists are not in short supply. The reason for that is very simple. It is because the funding for a pharmacy degree is different from that of a medicine degree. Over the past 10 years or so the number of schools of pharmacy has doubled, and there are a lot more graduates who are keen to embrace new roles in new models of care.

The bad news is that, probably as a result of some in the profession regarding this as an oversupply rather than an opportunity to use more pharmacists, the number of pre-registration places looks as though it will be capped, and it is becoming clearer that not all pharmacy graduates will be able to take up a pre-registration place.

The Chairman: Who does this capping?

Sandra Gidley: I think Health Education England. We do not have the full details. Nobody is completely transparent about the numbers at the moment, but if you have Health Education England in front of this Committee it might be worth probing this in some detail. We are concerned that there will potentially be a cap. This will mean that there are highly trained pharmacy graduates with a master's degree who will not be able to qualify as pharmacists.

The Chairman: What do you think is the reason for capping?

Sandra Gidley: Probably finance. Partly finance, because there is a cost to the NHS in funding the places, and partly a reaction to some of the concern that too many pharmacists are being produced. If we are looking ahead to 2030, I would say we are not producing too many pharmacists; we are producing a lot of very useful graduates we could be making use of, but that is not the short-term view.

The other thing that is increasingly clear is that, as models of care change, it is helpful to have an adaptable workforce. When somebody takes up a pre-registration place, it is worth looking at the model used in Wales, where the pharmacist will have experience of hospital, community and working in a GP practice, because all three roles are very different.

I also want to make a quick comment on Brexit, because 13% of our new registrants are from the EU, and EU citizens represent 5% of the workforce. We do not know what the impact of Brexit will be but it is worth taking into consideration.

Lord Warner: This is a question mainly directed at Nicola and Natalie. Can you tell us a bit more about what proportion of your registered members work in the NHS and work outside the NHS, and is there a shift going on which we should be worried about in the longer term?

Dr Nicola Strickland: In clinical radiology and clinical oncology the vast majority of those doctors work in the NHS. They may do some private work in their spare time or in a single session.

The Chairman: They are not exclusively private?

Dr Nicola Strickland: Not exclusively. I do not have the absolute figures but definitely less than 10% would work in the private sector. The only thing that is changing, which you need to be aware of, is that there is a huge backlog of unreported radiological examinations, plain X-rays and scans now in the UK—and to give you some idea of that, I am afraid that 230,000 examinations on patients are waiting over a month to be reported. Of course, associated with that is not only the inefficiency in the pathway but the fact that there are patients on the end of all those examinations who are anxious about the results of their scans but are not being told what they are for over four weeks, because of the workforce, and the fact that we do not have enough radiologists, even though they are working pretty much flat out. What has happened to fill that gap is that private teleradiology companies have sprung up, and those are

mostly staffed by NHS radiologists but one would say that is outside the NHS.

The Chairman: Physiotherapists?

Natalie Beswetherick: The breakdown for the physiotherapy profession is that about 75% work in the NHS and 25% in the private sector. There has been a shift over time, but more recently we have seen two important things that cloud it. One is that quite a lot of NHS contracts go to private sector individuals through the any qualified provider commissioning route. The other thing we have noted is that far more people are what we call portfolio workers. They do a bit of both; they do NHS and private work side by side, so you might have two contracts. That is the general division.

Lord Lipsey: What is happening in pharmacy is quite astonishing to the Committee. Here we are short of resources, and we are preventing people who have been trained from becoming pharmacists. However, would you agree there is a problem, in that so many pharmacists are in fact working as small shopkeepers and not in the wider role you have had? Is there a route forward by giving pharmacists much greater prescribing rights, which would enable them to do a lot of work which at present goes to GPs?

Sandra Gidley: Yes. It is unfortunate that the shopkeeper image predominates, because for most of those shopkeepers there is a shop front but 90% of the income from most businesses, most community pharmacies, is from the NHS these days. That is for medicine supply and giving medicines advice, some of that in relation to long-term conditions and some of it in relation to the New Medicine Service. There is probably a little bit of an image problem but that is for the profession to take on.

You are absolutely right that increasing prescribing pharmacists would help with some of the workforce pressures. When Maureen Baker was in front of you she mentioned pharmacists working in GP surgeries. This is a new role that was not exclusively the province of the RCGP; the Royal Pharmaceutical Society had quite a big part in developing this role alongside the RCGP. These pharmacists—I am not sure if the Committee is aware—are not dispensing inside the doctor's surgery; they are performing the medicines use reviews and taking on the work which GPs have to do at the moment without a pharmacist which is medicines-related. For the average GP about an hour of their day is spent on medicines-related issues, and that is what the pharmacists in GP surgeries aim to help with. What we have found is, where they have been in place a while, they have gained the trust of their medical colleagues, and they have increasingly taken on responsibility for things like asthma clinics and sometimes diabetes clinics.

The Chairman: So there is wider role that a pharmacist can play that we need to think about in the long term.

Sandra Gidley: A big value: if they can prescribe, they can take some of

the burden off the GP, but we need to have more pharmacists prescribing.

Lord Kakkar: Can I ask each of the three organisations how frequently you meet with HEE to discuss new models of care and how that should inform longer-term workforce planning?

The Chairman: There should be a quick answer to that.

Sandra Gidley: We are trying to meet them monthly at the moment, because we really need to be plugged into them, but they like to keep things to themselves.

Dr Nicola Strickland: We have no fixed meetings with them. I took up office in mid-September and I have had one meeting with Wendy Reid and discussed my proposals for solving the workforce crisis with her.

Natalie Beswetherick: We meet regularly, basically as a HEE group for the allied health professions. That is on a regular basis, and we make our point time and time again.

Q219 **Bishop of Carlisle:** Sticking with the workforce for a moment, I would like to focus, if I may, on the skills mix of individuals within the workforce. There seems to be a general agreement that extending the scope of the skills mix would be a good thing in the longer term, or could be a good thing, and you have all hinted at it in a variety of ways. Natalie, you talked about valuing generalists more than specialists. Nicola, you talked about collaboration and the co-operation that is required. Sandra, you talked about adaptability just recently. I wondered what you all felt was necessary for training in your particular professions for that greater skills mix and adaptability to be a regular feature.

Dr Nicola Strickland: One of the issues with the radiographers that we have noticed is that there is no way they can easily progress their career pathway, and I think that is one of the reasons why they have this enormous deficit of 13% in the profession. The answer is clearly not to try to make them do roles that will deplete them further from taking the images and producing the scans. The only way to increase their banding, which is the only way they can earn more and progress up their pathway, is to recognise that there are things they can do within their own skillset that would be hugely beneficial to team working, which should be better remunerated and should enable them to increase their banding—for example, post-processing of images. I spoke earlier about the increasing technology and the complexity of the scans. There is no point in giving me, as a radiologist, a whole-body MR scan which will contain at a minimum 3,000 images that are not stitched together so that I can review each different magnetic resonance sequence from the head down to the toes in one complete package. What will tend to happen is that, without the proper post-processing of the images, they will all arrive on my PACS, on my digital reading machine, in small bits, so that I will have the neck imaged in five different ways, and then the chest imaged in five different ways, and so on; they are not stitched together.

In the few centres where there is sufficient funding, radiographers will take on that role. They understand the anatomy, they will stitch the images together, and they will be served up to me in a report in a way in which I can efficiently report them and compare them with the same body parts on a different imaging study. That is quite complex work, and radiographers need to be trained to do that, and they need to be remunerated and recognised. There are many such examples in cardiac scanning, colonography and so forth. Other examples would include paediatric radiology. We know that there are a lot of medicolegal cases relating to non-accidental injury and child harm. It is difficult to image a child who may be frightened and crying, and to image that child well. It is a skill, it requires training, and it should be recognised and remunerated. There are all sorts of ways in which radiographers could stay within their profession of radiography.

What is happening at the present time is that the taxpayer is effectively funding radiographers to be trained within the NHS, and as soon as they are trained they will go off into the private sector or will join industry and become demonstrators for machinery, or will join locum agencies and are then employed back, as it were, to the NHS at large cost. Without the incentives for radiographers to move through their banding and be better reimbursed, there is not any career pathway. It is foolish, in our opinion, to deplete the workforce of radiographers more, to train them to report complex scans, when they do not have a medical background and therefore they would be working at a disadvantage. Those are all ways we could progress that profession.

Sandra Gidley: It has been alluded to that the biggest training change or change to skill mix would be to increase the number of pharmacists who can prescribe, and to do that one of the easy changes to the law would be to allow pharmacists to supervise that. At the moment we can only be supervised by a doctor or a dentist because of the way the law was written at the time, so it is sometimes difficult for pharmacists to find a mentor for this role. That would enable pharmacists not only to play a greater role in GP surgeries and help with the GP crisis in staffing, but to play a bigger part in care homes. Care homes are very often overlooked. They contain some of our most vulnerable citizens, who are on the most medicines, and who, quite frankly, often receive the poorest care, because the GP contract does not enable GPs to devote enough time to properly reviewing the medicines. We have demonstrated that by basing pharmacists in care homes as part of a multidisciplinary team. The multidisciplinary aspect is very important—we could save £135 million a year. That is with reduced prescribing, reduced hospital admission and reduced waste. This is not insignificant and should be given more attention.

The other greatly overlooked group of patients are those who are being supposedly cared for in their own home but are being neglected in their own home, because there is no time to visit them to see if they receive the care they need. Pharmacists can also be based in accident and emergency, and again, a recent study has shown that by giving extra

clinical training there, pharmacists can take on about 60% of what is coming through the door.

There is a need to think about investing in the workforce, and unfortunately all we have heard about at the moment is cuts in the community pharmacy grant. To me, this is the wrong way of looking at the problem. We should be looking at the capacity to deliver services rather than trying to achieve short-term savings.

Bishop of Carlisle: Can I be clear on that? That means pharmacists would be diagnosing and prescribing.

Sandra Gidley: No, not diagnosing. I need to be clear on that, because pharmacists are not trained to diagnose. Some become quite good at it by dint of 35 years of looking at people over the pharmacy counter, but that diagnosis should always be made by a medical practitioner. This is why the multidisciplinary team aspect is so important.

Bishop of Carlisle: Thank you very much. Physiotherapists?

Natalie Beswetherick: In most cases the scope of the profession does not need to be extended but rather fully utilised, with an expansion, I believe, in advanced practice skills and the optimisation of the support worker workforce. On those two elements, we need that wider skill mix, and we need an increased workforce. The percentage changes might need to be more in that support worker workforce and optimisation of the voluntary and third sectors.

That is against a background of people being enabled and supported to self-manage. The more we can do that with all ages, the more effective that will be for the long term. At the minute we are fighting a war on two fronts. Many elderly people are having to go into hospital at crisis point. We have a system that is arranged around that. We need to start much earlier on, in my view, in primary care, where we can help people to understand how they can self-manage, to understand when they might need to call in support and additional work.

Some great work is being done by advanced practice physiotherapists, as some of you may be aware, in the field of musculoskeletal—the bones and joints system. We are doing quite a lot of work putting advanced practice physiotherapists into GP practices, where they can see, assess and diagnose a range of musculoskeletal conditions. This work is being imparted on a number of GP practices across England. The joint guidance on this was published this month by the CSP, the Royal College of GPs and the BMA. We believe we need to pursue that, look at that model and look at that effect, because that can be a way of releasing some GP time to look at those more complex elderly patients with several comorbidities.

In the physiotherapy profession we have quite an extensive workforce that we often share across the professions. They have myriad names; whether they are called healthcare assistants, rehab assistants, therapy assistants, there is a whole range of them both in health and social care.

They will often have work delegated by a range of those health and social care professionals, but we ensure that they are providing the appropriate ongoing rehabilitation and exercise programmes for people who need to maintain health and fitness, I would hope increasingly in their own homes or closer to home rather than in a hospital setting. Even if people have gone into hospital, we need to see the workforce increasingly doing that when people leave hospital, because many, especially elderly patients, fall off a cliff; there is nothing for them then, so we need to optimise that support and voluntary sector workforce to help us.

The Chairman: A quick question from Lord Willis, then I will move on to Lord Kakkar.

Lord Willis of Knaresborough: This question is for two of our witnesses. First of all, is there any empowering of other people within the healthcare service to deliver physiotherapy services at a lower level going on? It seems to be incredibly frustrating that you are waiting for a physiotherapist to come for a community visit, but also in hospital, for very short periods of time, when there are care assistants there who could do some of those basic tasks. Does that ever happen? To Sandra, when I go abroad, I always go to the pharmacist, who is able to care for me very well, in my fluent French or Spanish or whatever, to deal with my problems. Surely that is a step we ought to be taking.

Natalie Beswetherick: Yes, it does happen. Increasingly, whether it is in elective care, planned care or emergency admission, the support worker workforce will often be the person who you will be seeing and who will be carrying on your care, educating carers and family members to support that person with their rehabilitation after hospitalisation or in the community. That happens, and in some cases, particularly in the community, there is not enough of it being done, and I think that is a gap. As with any qualified professional and like all allied health professionals, physiotherapists are autonomous professionals; it is a three-year minimum BSc Honours degree, but many are now qualifying at master's level, to deliver the care, and as they become expert and are working at advanced practice levels, they may be doing that assessing and diagnosing and doing that management plan. They are increasingly also helping with the support worker workforce, enabling them to teach others, because a lot of this needs to be done day in, day out. We do not have a physiotherapy workforce, and never will have, that could be with every patient every day. That is part of what we do. We teach others and enable them to self-manage and perform that essential rehabilitation.

Sandra Gidley: I would hope you do this in the UK as well, because pharmacy could be the gatekeeper to the NHS, and if there were a properly funded national minor ailments scheme, where people access the pharmacy first, this could take a lot of pressure off GPs and a lot of pressure off A&E. I have noticed—it is probably a function of the fact that everybody gets everything free on the NHS—that when I work in inner-city Southampton, people will go to the GP and take up the GP's time for painkillers, things that are fairly standard but would need a prescription.

When I work in leafy Winchester, mothers buy their Calpol and people with backache buy their painkillers, so it is a very different demographic and a different way of using pharmacies. It seems to make sense to think of a way where people who have lower-level needs, who see a GP—we ought to be using more of the GP's skills—could be accessing the pharmacist for the help and support they need.

Q220 Lord Kakkar: We have heard an awful lot about the need to reorganise the way healthcare and social care systems are delivered, and in particular that there needs to be much more integration between the two to achieve long-term sustainability in the NHS. Why do you think that has not been achieved so far? How could it be achieved moving forward, and who should be responsible for trying to make that happen?

Sandra Gidley: People have been talking about this for more years than I care to remember. One of the basic problems is that social care is not free at the point of delivery, it is rooted in poor law, and healthcare is on a system that is mostly but not exclusively free at the point of delivery. Coupled with that, you have two different systems and two silos where budgets are guarded very zealously. Going back 15 years or so, we had huge problems with delayed transfers of care because the money was not in the right place. It has got better but it seems to be getting worse again.

The right care fund seems to be a step in the right direction, because unless you have pooled budgets which force people to work together imaginatively it is not going to happen very successfully, and, rather than thinking of the patient, people will think of their budget. This is not something that is major Royal Pharmaceutical Society thinking but it is clear that some attempt needs to be made to integrate this more fully. One of the suggestions made in the earlier session was that there could be a department of health and social care. Unless you start at the top, it does not send the right message anywhere else.

Dr Nicola Strickland: From the perspective of the Royal College of Radiologists, I think I have already outlined how one could incentivise radiographers to remain within their profession, even though they do not come under the remit of our college, and recognise that there are complexities within the work that they perform which should lead to a higher banding, and that would encourage them to stay within the NHS team and not go into industry and so forth.

The overwhelming shortage in the workforce for us, as radiologists and clinical oncologists, means we are so overwhelmed and swamped with the amount of reporting and interventional work that we need to do that we can almost think of nothing else, if you like, because there is such a huge burden in that respect.

We have integrated care across regions to some extent with regional multidisciplinary team meetings. I think that could be extended. We need decent information technology networks whereby we could work within regions more than just within our little hospital trusts or groups. The

Health and Social Care Act did not in any way facilitate that, because it really promoted competition between different hospitals rather than working as a unit within referral patterns within regions. Our college has put on our website, if anyone is interested, a comprehensive document, which is a specification for how to implement regional networks whereby imaging studies can be shared across region. The reason why that is so important is that we could then share out specialists—for example, those in particularly short supply, like paediatric radiologists, head and neck radiologists and so forth. You could get an expert opinion across region if you could transfer those imaging studies between hospitals in a seamless manner.

This particular document, which happens to be called *Who Shares Wins*, if you would like to look at it on our website, not only specifies the need and the reasons for implementing that but it gives a technical spec, because we have consulted with industry as to how that could be implemented so that trusts would simply have to take that document and use it as their specification. I think that would also help to integrate healthcare in our particular disciplines as much as possible.

I think it is important to realise, and it is not always evident to the public, that issuing a diagnostic report on a scan—or indeed on a chest X-ray, which is one of the most difficult areas in fact to report, as you will be well aware—is not just a yes-no answer; it is not like taking a blood sample, putting it through a Coulter counter machine and finding out whether the haemoglobin is normal or abnormal. It is very much dependent on a medical background and the entire medical knowledge. Therefore, there is no way out of increasing the workforce in clinical radiology and clinical oncology because of the need to have that knowledge to be able to issue what is in fact a consultant opinion, based on one's knowledge of the possible disease states that could be giving rise to the appearance of the scan, and to issue a diagnostic and actionable report, rather than a descriptive report. Any of you around the table here could describe to me what you see on a chest X-ray—I could give you the jargon so you could describe it so that it sounds correct in medical terms—but you could not tell me what that patch of whiteness in the left upper lobe represented, whether it was a cancer, whether it was a longstanding area of fibrosis, whether it was an asbestos plaque or whether it was pneumonia, because you need a medical background. We have to recognise that, while we can integrate across the different hierarchies, from doctors to radiographers to healthcare workers, there are certain medical tasks that we just need enough workforce to be able to do.

The Chairman: Natalie, the original question from Lord Kakkar.

Natalie Beswetherick: Thank you. I agree that nationally we need a joined-up health and social care department. At a more local level the sustainability and transformation plans seem to be the best bet we have. They are the only show in town. They are, as I understand it, trying to bring together local authorities—local government—with health and social

care, and we need to see whether that will work. They are all different sizes, so whether that will work I am not sure, but we need to make sure they are given enough time to be able to make a transition.

We are really great at changing systems and processes but what we never do—and I am thinking about sustainability—is think about culture and what it means to the average person in the street, the population, about what the NHS is and what care they can expect. For a lot of people out there at the moment, we need sustainability and we need to think about doing things differently, but we need to engage with the public so they understand that, because a hospital is going to be closed and needs to be closed, for the right reasons, it does not mean a loss for them. What we need to be able to persuade them is that they will have the care delivered in the most appropriate place. I do not think we ever spend enough time thinking about the local people, and getting them on side to understand that we will be having a sustainable care delivery system for the future that their future generations can enjoy as well.

Lord Kakkar: With regard to the STPs, have your members working in the 44 footprints for them, in your opinion, been adequately consulted and participated in the development of these programmes?

Dr Nicola Strickland: They have not been consulted at all but our college has made an effort. When I found out from the Academy of Medical Oncologists that STPs were going to come into existence and there were 44 of them, we found out who they were, their names, and I personally emailed every single one of them with some suggestions, in particular this document about setting up regional IT networks, so that they would be in possession of that information to help them to further their work.

The Chairman: All of you shook your heads.

Q221 **Lord Warner:** Could you each say a few words about the extent to which the incompatibility of IT systems is one of the major barriers to joint working, and indeed enabling professionals to supervise lower-level people to carry out work?

Natalie Beswetherick: Our experience, whether you work in the acute hospital sector or in primary care or social care, is that there is no compatibility between the majority of systems. I live in Gloucestershire and I know the community system, all the GP practices and the local hospitals, as in the community hospitals, are all on SystmOne. They have a fantastic opportunity to share information as they need to, but that is rare. Nothing seems to talk to anything else, and it is a major barrier, in my view, to people being able to work at the top end of their abilities, because they constantly return to paper when you should not need to. Hospital systems are completely different from everything else and social care is even more different again.

Dr Nicola Strickland: In imaging we have standards that mandate the interoperability between a number of systems. If you take the imaging

system, the PACS—the picture archiving and communication system—where we now store all our images, and all the modalities, the CT scanners, the MR scanners, ultrasound scanners and so on, adhere to a standard called DICOM, which specifies certain fields. The RIS, the radiological information system—that is where you enter your patients as they appear and where the reports go—adheres to a standard called Health Level Seven, HL7. So there are standards, but the problem is that the vendors of the EPRs, the electronic patient records, of which there are only a couple in the UK, Cerner and Epic, and the GP systems, of which SystmOne is one of the larger providers, generally do not adhere to those standards, and therefore doctors are left in the community and in hospitals in different regions logging on multiple times to different systems. That is very time-consuming, and unsafe and dangerous, because you cannot directly compare information and you cannot gather information—images, for example—which are in one part of the country and see them on your system when the patient is being referred to your hospital. There should be mandated fields that vendors have to adhere to. One simple example is the National Health Service number; the NHS number is not specified to go into a particular field in all these systems, which would seem the most basic thing, and would also mean that these systems could search for information in other systems across the country. There are certain things that could be mandated by law that would help this interoperability.

Sandra Gidley: I am wondering whatever happened to Richard Granger and the NHS IT project. All this was supposed to have been sorted by now.

Lord Warner: I resigned.

Sandra Gidley: Right. From a pharmacy perspective, the problem we have is that we have only just been given access to a summary care record, which only has limited information on it, and the potential to deliver better patient care would be so much more enhanced if pharmacists could have read/write access to a fuller care record, which could also be accessed by other health professionals. There is resistance to this in some quarters but, if the permissions were in the hands of the patients, they should have the ultimate say in who has access to their records.

Q222 **Lord Lipsey:** A sub-theme of our inquiry has been regulation and the amount of it. I quote from NHS providers' evidence: "The regulatory environment has become much more complex over the past 12 months". Also, "The regulatory burden has significantly increased over the past 12 months particularly for foundation trusts". Would you agree with those assessments and what would you do about it?

Dr Nicola Strickland: I think in the medical profession much of this regulation stemmed as a kickback from the Shipman incident. The laudable idea was to reassure the public that doctors were keeping themselves up to date and were not up to any malpractice. Unfortunately, the net result of revalidation, which is a five-yearly

assessment by the General Medical Council, and the yearly appraisals we all undergo, has not been to safeguard the care we give to our patients; it has just been incredibly burdensome and time-consuming and, worse than that, is causing many doctors, certainly in clinical radiology and oncology, to retire early. As soon as they are in a position to retire, they will retire, and we are now finding that there is a 15% to 18%—

The Chairman: If that is the common consensus in medicine that that is what revalidation has caused, how does the profession deal with the GMC in that respect?

Dr Nicola Strickland: There is very little we can do, because it is mandated that we have revalidation. One thing that could be done is that, when you speak to the GMC, as I have done recently, we need tailored revalidation, so that supposing I am a radiologist towards the end of my career, this is how we would deal with it.

The Chairman: How do you deal with a regulator whose processes you do not agree with?

Dr Nicola Strickland: The way that it can be done is to take what the GMC mandates, which is that you revalidate in your area of practice—you keep yourself up to date, current and knowledgeable. The problem is that at the hospital level and the trusts level, on the yearly appraisals that doctors go through, this is being enacted in a blanket way, so that doctors who are, for example, in my area of interest, reporting plain X-rays and CT scans, never see a patient, and there are quite a lot of radiologists like that. They do not need to do compulsory courses in patient handling and resuscitation and so forth, because that is a complete waste of their time and it is counterproductive. It is so burdensome that they would rather retire than have to keep going through this. The appraisers, those doctors whose task it is to assess those doctors, need to talk to the revalidation officer and say, “Look, this is unnecessary. I want tailored appraisals for what this doctor is doing. He or she does not have to undergo patient-handling modules.”

The Chairman: To go back to Lord Lipsey’s question, Sandra?

Sandra Gidley: One thing I noticed, having 10 years out of practice, was that when I went back, the world had changed completely and you had to complete a lot more paperwork to keep various organisations happy. All of that has added to the everyday pressures on the pharmacy workforce. We have yet to go down the revalidation route, and, from what I have heard from the medical profession, there is some trepidation as to whether we will get it right. The tendency of the regulator is always to overegg the pudding, without thinking necessarily of the patient or whoever needs to be protected, or what is an appropriate balance. The vast majority of health professionals will do what they need to do to keep current, but it is the recording and all of the paperwork and processes around it that become difficult.

The Chairman: Apart from the professional regulation—and, Natalie, you

might answer that, too—Lord Lipsey’s question covers other regulations, such as CQC and Health Improvement.

Natalie Beswetherick: On an individual level, so I will cover that first, physiotherapists, like all the other allied health professions and social workers, are covered by the HCPC, and that level of regulation I think is fit for purpose. That can be evidenced by the low number of cases they hear. The balance of ensuring that patient safety is adhered to is the principle I would want to emphasise, and if the level of regulation is fine, what you should see is minimal cases that need consideration by that regulator.

At system level, I would agree that our members are saying that, especially in foundation trusts, it is almost that you have to do everything to make sure you have a positive CQC rating rather than dealing with what you need to every day. The CQC and all the work that goes with that is overly burdensome. Most people would say you are either going to be under improvement or in special measures, and all that seeks to do is make staff more depressed than they were, having to do the work for the regulation of those services and systems, rather than spend their time with patients, which they want to do.

Dr Nicola Strickland: There is no proof that these inspections lead to better practice or protect patients. That is one of the issues. There is no evidence to show that either revalidation on a personal level or the CQC or NHS Improvement inspections has improved things. That is a concern. There are inconsistencies in the inspection. If you take, for example, CQC visits, they assess radiology with outpatients. In our particular trust we were taken to task because outpatients did very badly, whereas in fact radiology did very well. Nevertheless, we were tarred with that brush, which is pretty depressing for every radiologist in the trust, obviously.

Q223 **Baroness Blackstone:** What is your key suggestion for change that the Committee ought to recommend in support of a more sustainable NHS?

Sandra Gidley: I think it would have to be think pharmacy first. We have not spoken about prevention today, but the network of healthy living pharmacies deliver a lot of public health interventions which will delay the onset of illness. As I have said, community pharmacies should be the gateway to the NHS, with the pharmacists part of any clinical team and pharmacists at each level in the NHS. The Health Select Committee in the other place frequently advocated medical leadership, which is now a concept that has been much more fully embraced, and we have the NHS Leadership Academy. However, with the Health and Social Care Act, I think it was a mistake not to ensure that pharmacists had a place on the boards of the CCGs. There has been low involvement in STP planning. I would contend that, unless you think pharmacy first, a vital piece of the jigsaw is missing.

Dr Nicola Strickland: Overall for the UK it is essential that we increase the percentage of GDP spent on the NHS if we want to see results, remembering that France and Germany spend about 11%, the USA

spends about 16.5%, and we in the UK, depending how you measure it, spend about 8.3%. In our disciplines, it is workforce, so we need to address the short term and the long term.

The Chairman: We need to make sure our record is correct, because we have heard different figures on GDP spending. With the new OECD ways of calculating, we are not far off Germany.

Dr Nicola Strickland: It would be 9.9% if you take social care out.

The Chairman: We need to make sure what those figures relate to. Your figures are different.

Dr Nicola Strickland: They were figures that I looked up. All I know is that the UK spends less than France and Germany and less than the USA, and we should spend the equivalent of the mean of Europe or of other westernised societies, so that we can aspire to the same level of healthcare. At the present time, whatever the figures may be, we are spending less than those other countries. I would argue that we should spend the same, or have the same level of healthcare. With respect to radiology and clinical oncology, we need to address the short-term shortage in workforce by trying to get radiologists in particular from overseas, as I have outlined—from Australia, for example—maintain the numbers coming from Europe, international medical graduates, and in the longer term use the potential for training in district general hospitals for training more radiologists and more clinical oncologists, and increase the number of academies we have and the throughput through those academies.

The Chairman: Natalie?

Natalie Beswetherick: I do not disagree with my colleagues. We have to get the money right. We cannot make the major changes we want unless we do some pump-priming to enable services to be developed in primary care and in the community before we remove them from secondary care. You cannot do it. You cannot just whip them out on a Friday and put them into the community on Saturday morning. That money is essential, because we have to get the supply right. Physiotherapy workforce is in short supply. The one ask I would make is that we need national accountability for the 10,000 workforce expansion for allied health professionals and nurses that was made in the last comprehensive spending review, and at the moment there is no accountability to deliver that. Without that workforce across allied health professions and nurses, we will not be able to get that sustainability in future. Thank you.

The Chairman: Thank you all very much for coming today. It has been very helpful. If you have further evidence that you would like us to receive that is pertinent to some of the questions we asked today, please feel free to submit it. You will get the transcript to look at. You cannot change it but, if there are any inaccuracies, please let us know. Thank you for coming today.