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Clearing the backlog caused by the pandemic

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Health and Social Care Committee

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Introduction

On 31 January 2020, the first two cases of covid-19 were confirmed in the United Kingdom,[1] signalling an unprecedented challenge for our health and care systems. With staff redeployed and services redirected toward providing acute covid-related care, much routine care was postponed or cancelled.

Now as we approach a third year living with Covid, the catastrophic impact on patients waiting for NHS care is becoming clearer. Of the 5.8 million patients waiting to start treatment in September 2021, 300,000 have been waiting more than a year[2] and 12,000 more than two years.[3] In July 2021 the Secretary of State for Health and Social Care, Rt Hon. Sajid Javid MP, said this could be just the tip of the iceberg because of missing patients who had not yet come forward, meaning the true waiting list could be as high as 13 million.[4] Even if this calculation represents a worst-case scenario, the prospect is sobering.

In this context, prioritisation of the elective backlog is understandable. However, we are concerned that a focus on those areas most amenable to numerical targets risks deprioritising other equally important areas such as primary care, community services and mental health services which all play a crucial role in keeping people healthy and out of hospital. There is also a risk that a new targets culture has unintended consequences, including compromises in the quality and safety of patient care. This is not a hypothetical concern considering that precisely this unintended consequence arose the last time tackling large waiting lists was a political priority.

Our inquiry also looked extensively at the issue of hidden demand. That includes not just 'missing patients' but people with mental health issues exacerbated by lockdowns and people living with medical conditions who have faced interruptions to their usual care—and whose health may have worsened as a result. There is also a backlog in public health, where children have missed out on universal programmes largely delivered at school.[5] We heard powerful testimony from patients who had felt "abandoned" by the NHS, who had to "fight" for care, and for whom delays in treatment meant ongoing uncertainty, with lives left on hold.[6]

This report recognises the government has made it a key priority to tackle the Covid backlog and been willing to increase funding accordingly. But commitment and resources do not automatically equate to delivery, which is why we make a number of recommendations to ensure that the expectations of both politicians and patients are met in these unprecedented times.

1 Department of Health and Social Care, CMO confirms cases of coronavirus in England, 31 January 2020
2 NHS England, NHS referral to treatment (RTT) waiting times data September 2021, 11 November 2021 (Patients referred for non-emergency consultant-led treatment are on RTT pathways. An RTT pathway is the length of time that a patient waited from referral to start of treatment, or, if they have not yet started treatment, the length of time that a patient has waited so far)
3 Nuffield Trust, NHS performance summary: September-October 2021, 11 November 2021
4 BBC News, Covid: NHS backlog in England could reach 13 million, says Sajid Javid, 7 July 2021
5 Royal College of Paediatrics and Child Health (RCPCH) (CBP0056)
6 Q71, Q81, Q144

Executive summary

1. The headline post-covid backlog is 5.8 million people waiting for planned care as of September 2021.[7] This represents the highest level since records began and includes 300,000 who have waited more than a year and 12,000 who have waited more than two years for their treatment.[8] The National Audit Office recently estimated that elective care waiting lists would reach 12 million by March 2025 if 50 per cent of "missing" referrals for elective care return to the NHS but activity grows only in line with pre-pandemic plans.[9] But however shocking such numbers are, they alone do not represent the scale of the challenge facing the NHS which goes far beyond elective care.

2. In emergency departments, waiting times in October 2021 were the worst since records began, with one in four patients waiting longer than four hours to be admitted, transferred or discharged and trolley waits at a record high.[10] We note that October saw the highest number of 999 calls on record.[11] There is a serious risk that the ongoing crisis in emergency care could derail the elective recovery programme.

3. During the first wave, the number of appointments in general practice fell by a third from 24 million in March 2020 to 16 million in April 2020[12] and around half a million fewer people than planned started Improving Access to Psychological Therapies (IAPT) treatment during 2020/21.[13] In social care, efforts to accelerate discharge from hospital to free-up beds for patients from the backlog have placed even greater pressure on care staff and unpaid carers. The response to covid-19 continues to make demands on resource, not least in the expansion and acceleration of the booster vaccination programme in response to the potential threat from the Omicron variant.[14]

4. The Government and NHS have both recognised the scale of the problem. During this inquiry, the Government made several welcome announcements of financial support. This included an extra £5.4 billion over the six months from September 2021 to support the NHS response to covid-19 and help tackle waiting lists this year[15] and a further investment of £36 billion in health and social care over the next three years funded by a new Health and Social Care Levy to be introduced from April 2022.[16] These were supported by subsequent announcements on capital spend and infrastructure including 100 new diagnostic test centres.[17]

7 NHS England, NHS referral to treatment (RTT) waiting times data September 2021, 11 November 2021
8 Nuffield Trust, NHS Performance summary: September-October 2021, 11 November 2021
9 National Audit Office, NHS backlogs and waiting times in England, 1 December 2021
10 Nuffield Trust, NHS Performance summary: September-October 2021, 11 November 2021
11 NHS England, NHS responds to highest number of 999 calls on record, 11 November 2021
12 Nuffield Trust, Primary care, 23 September 2021
13 The Royal College of Psychiatrists (CBP0070)
14 Department of Health and Social Care, All adults to be offered COVID-19 boosters by end of January, 30 November 2021
15 Department of Health and Social Care, Additional £5.4 billion for NHS COVID-19 response over next 6 months, 6 September 2021
16 Department of Health and Social Care, Record £36 billion investment to reform NHS and Social Care, 7 September 2021
17 HM Treasury, Budget and Spending Review – October 2021: What you need to know, 27 October 2021

5. This funding is planned to allow an "extra 9 million checks, scans and operations for patients across the country"[18] and the Secretary of State said that NHS England would deliver an elective recovery plan setting out further detail on "how it plans to meet its workforce requirements" by the end of November 2021.[19] We note that this has not yet been published.

6. During our inquiry, we heard many times that workforce shortages were the "key limiting factor" on success in tackling the backlog.[20] Without better short and long-term workforce planning, we do not believe the 9 million additional checks, tests and treatments will be deliverable. Amanda Pritchard, Chief Executive of NHS England, told the Committee that the NHS had "29,000 more full-time equivalents now than we had a year ago"[21] but added that was "not enough."[22] We note there are currently 93,000 vacancies for NHS positions and shortages in nearly every specialty.[23] We remain unconvinced there are sufficient plans for recruitment and retention of staff ahead of April when the funding from the new Levy begins. Our concerns also extend to the social care workforce, which has at present 105,000 vacancies and a turnover rate of 28.5%, rising to 38.2% for nurses working in social care.[24]

7. We welcome the Secretary of State's announcement that Health Education England (HEE) will publish a refreshed Framework 15—a long-term workforce strategy—but note that this will not arrive until Spring 2022, by which point the money from the Spending Review funding will already be arriving in the system.[25] We are particularly concerned that the newly-announced takeover of HEE by NHS England may delay this commitment further.[26] But even if it is not delayed, the plan will come too late for any short-term measures that could help source more staff before the start of the financial year.

8. We have previously recommended that the Health and Care Bill include provisions to require HEE to publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years. We note the Government decided to vote down an amendment to make this law in the Health and Care Act. This creates a gap between ministerial rhetoric about supporting frontline staff and refusal in practice to do the biggest single long-term change that would relieve the pressure they face. We continue to believe that giving hope to NHS staff that the appropriate number of new staff will be trained in the future is the biggest single measure the Government can take to gain the confidence of frontline staff that it has a grip of this problem.

18 Department of Health and Social Care, Innovation and new technology to help reduce NHS waiting lists, 8 September 2021
19 Q198
20 Royal College of Physicians (CBP0001)
21 Q163
22 Q164
23 NHS Digital, NHS Vacancy Statistics England April 2015 – June 2021 Experimental Statistics, 26 August 2021
24 Skills for Care, The state of the adult social care sector and workforce in England 2021, accessed 7 December 2021
25 Qq203–205,
26 Health Service Journal, Exclusive: Health Education England to be merged into NHSE, 17 November 2021

9. Additionally, without such an independent forecast of future workforce needs, it remains impossible for anyone - including this committee - to know whether enough doctors, nurses or care staff are being trained. This is a significant accountability gap which prevents Parliament doing appropriate scrutiny. It also means existing staff do not know when they can expect the pressure on them to lift, which is likely to lead to more resignations. In that context we believe it is totally unacceptable that the budget for HEE, which funds training places for new doctors and nurses, remains unresolved. We understand that prior to the NHS England merger announcement, HEE were being asked for large cuts and that at best current doctor and nurse training levels will be maintained. It is extremely disheartening that given the pressures faced by the NHS there appears to have been no discussion about increasing the numbers entering training.

10. Our inquiry also focused on the wider capacity available in the system to tackle the backlog. We heard that there was an important role for the independent sector in providing capacity. Given that its hospitals tend to be in more affluent areas[27] it is important to ensure that any use of such capacity does not exacerbate existing health inequalities given that the biggest increases in waiting lists are in the areas of greater deprivation.[28]

11. We heard that technology and innovation had much to contribute but also that basic IT infrastructure was lacking, making it difficult to spread innovation.[29] There is also a need for more "headroom" in the system—both in terms of the number of beds available, and in giving staff the time and space they need to step back and consider how best to deliver the right care in the right setting.[30]

12. ***Our key new recommendation is that, by April 2022, the Department of Health and Social Care works with NHS England to produce a broader national health and care recovery plan that goes beyond the elective backlog to emergency care, mental health, primary care, community care and social care. It should be sensitive to the needs of local populations, incorporate the plans already announced in the ten-year plan, and explain how they will be delivered by the new Integrated Care Boards[31] (ICBs). That plan must also set out a clear vision for what 'success' in tackling the backlog will look like to patients. In setting those metrics for success, the plan must take account of the risk that a reliance on numerical targets alone will deprioritise key services and risk patient safety. Instead, it must embrace a range of indicators to demonstrate that hidden backlogs are also being tackled and compassionate cultures encouraged.***

13. We have heard much about how a robust social care system that can support hospital discharges and free up capacity is essential to clear the backlog. Social care, however, did not receive an adequate settlement in the spending review, with the £5.4 billion over three years falling well short of the £7 billion annual increase we have previously recommended. Even after the spending review period, there is no guarantee of additional

27 Q40
28 NHS Confederation (CBP0058)
29 Q50
30 For example Q155, Policy Connect (CBP0093)
31 ICSs will be made up of an ICS Partnership and an ICS Board (ICB). The ICB will be the statutory body that plans and provides NHS services. Many of their responsibilities will be transferred from CCGs.

funding from the Health and Social Care Levy, so we remain very concerned that social care will remain the poor relation. Without the right support for social care, a recovery plan for the NHS is doomed to failure. The Government deserves credit for grasping the nettle of social care reform by publishing its White Paper on 1 December 2021. Although the White Paper sets out an "ambitious 10-year vision", it does not acknowledge the scale of resource needed if the sector is to recover from the crisis it faces right now. There are welcome commitments on areas including workforce and unpaid carers, but these do not go far enough. We recommend that Government publishes a ten-year plan for social care, setting out in more detail how it will operationalise the ambitions it has now set out. Government must also publish a People Plan for social care, aligned to the ambitions set out in the NHS People Plan.[32]

14. We also looked at the additional pressures created by long covid, which has seen over 400,000 people in the UK self-reporting symptoms a year after getting the virus.[33] There are issues with the capacity of secondary care long covid support clinics; workforce availability; services for children with long covid; understanding of long covid in primary care; and consistency of access to gold-standard services across the country. We recommend clear incentives for ICBs to deliver innovative, integrated care, and that they are held accountable for doing so. While financial incentives can play a role in this, so can regulation and long covid provision should be one of the key areas assessed for the new Ofsted-rating system.

15. Clearing the backlog presents a massive challenge to health and social care services that have already given so much during the covid-19 pandemic. Alongside the practical suggestions we make on workforce and integration we also believe there is a big opportunity to change ways of delivering care that are no longer fit for purpose, and to build on the new integrated, safe and effective models that have emerged. For the good of patients, staff and the public this opportunity must not be wasted.

32 Health and Social Care Committee, Second Report of Session 2021–22: Workforce burnout and resilience in the NHS and social care, HC 22, paras 164, 166, 167

33 Office for National Statistics, Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 2 December 2021, accessed 2 December 2021

1 Scale and impact of the backlog

The scale of the backlog

16. Attempts to quantify the backlog are not straightforward, particularly as each period of the pandemic has seen different activity levels. In the initial stages hospital activity declined, with GP referrals 75 per cent lower in April 2020 than pre-pandemic levels and unplanned admissions to hospital falling by a third.[34] However, more recently, emergency activity has reached or sometimes exceeded pre-pandemic levels with the number of A&E attendances in June 2021 reaching the highest level for any June on record.[35] In October 2021, A & E waits were the worst since records began, with one in four patients waiting longer than four hours to be admitted, transferred or discharged, and trolley waits at a record high.[36]

17. Furthermore, while waiting times for planned care are a key metric with which to measure the rate at which NHS activity is returning to pre-pandemic levels, Policy Exchange among others have noted that elective care is "not the only area to be experiencing the ripple effects of the pandemic", with mental health, cancer, neurological disorders and "other often overlooked areas such as addiction and eating disorder services" requiring "proportionate focus and energy."[37] Accordingly, our inquiry attracted submissions from a range of professions and areas of specialty.[38] We also heard about a backlog in training, whereby new surgical trainees had been unable to gain the experience they need due to scarcity of opportunities caused by the pandemic.[39]

Pre-existing backlog

18. We heard that waiting lists and access to treatment were already an issue before the pandemic hit.[40] NHS Providers told us that "demand was already outstripping capacity", with trusts "recording their lowest results against national performance standards in elective surgery and emergency care in over a decade" and "community, mental health and ambulance services […] facing increasing demand, limited investment and workforce constraints."[41] The Royal College of General Practitioners (RCGP) warned of GP services that were "already extremely over-stretched."[42]

34 Nuffield Trust, Chart of the week: Are hospitals returning to pre-Covid activity levels?, 22 July 2021
35 Nuffield Trust, NHS performance summary: May-June 2021, 8 July 2021
36 Nuffield Trust, NHS performance summary: September-October 2021, 11 November 2021 (121,251 patients spent more than four hours waiting on a trolley from a decision to admit to admission in October 2021. 7,059 people had a trolley wait of over 12 hours.)
37 Policy Exchange, A Wait on your Mind? A realistic proposal for tackling the elective backlog, accessed 16 November 2021
38 See, for example: Asthma UK and the British Lung Foundation (CBP0033), Diabetes UK (CBP0042), Cancer52 (CBP0045), Macmillan Cancer Support (CBP0047), Endometriosis UK (CBP0049), Cancer Research UK (CBP0051), MS Society (CBP0092), British Heart Foundation (CBP0081), British Dental Association (CBP0034)
39 Q32
40 See, for example: British Orthopaedic Association (CBP0008), Independent Healthcare Providers Network (IHPN) (CBP0024), Digital Healthcare Council (CBP0043), NHS Confederation (CBP0057)
41 NHS Providers (CBP0027)
42 Royal College of General Practitioners (CBP0090)

Known unknowns

19. When attempting to quantify the scale of the backlog, waiting lists and A&E attendances can tell us about the health needs of those who are known to services. However, a second category exists–those who have health needs that are not yet known to services. For the Institute for Fiscal Studies (IFS), those patients who did not receive care during the pandemic represent a "known unknown." The scale of these known unknowns, together with NHS capacity to deliver non-covid treatment, are important considerations when making future waiting list projections.[43]

20. Ben Zaranko, Research Economist at the IFS, outlined these modelling uncertainties:

> We think the biggest is the question of how many of the missing patients remain […] There is no sense that people are flooding forward for treatment. That might be good if all you care about is the length of the waiting list, but you might be concerned about the people who are perhaps not getting the care they might benefit from. […]
>
> Are the missing patients who return going to be in need of more intensive care? Are more of them going to be admitted than we might previously have expected because they have waited longer?[44]

21. Even in the IFS's most optimistic scenario, the number of people waiting for treatment would rise to over 9 million in 2022 and would only return to pre-pandemic levels in 2025. That would require the NHS to increase capacity by 5 per cent in 2021 and 2022 compared with 2019 and then by 10 per cent in 2023 onward (the equivalent of treating around 1.6 million additional patients per year, relative to 2019 volumes, at a potential annual cost of at least £2 billion, before any allowance for additional infrastructure). For the IFS, the number of patients with covid-19 who need treatment, together with the ability of the NHS to adapt (or relax) infection control measures will be "crucial determinants" of NHS capacity, while "the number of 'missing' patients returning for treatment will be more important initially than it will be for the medium-term trajectory."[45] With covid-related measures such as social distancing and staff self-isolation constraining NHS capacity,[46] we heard that it is extremely difficult to accurately quantify the true scale of the backlog that health and care services face.[47]

The impact of the backlog on services

22. We called for views on the likely scale of the backlog across a range of healthcare services, including elective surgery, and mental health, cancer and GP services. We have not gone into detail on cancer services, as they will be covered in-depth in our parallel inquiry.[48] However, it is clear that there has been significant and ongoing disruption to cancer services: at the height of the pandemic many cancer treatments were postponed or cancelled, due not only to infection concerns but also capacity shortages. Moreover, the number of people being referred for urgent cancer tests has still not recovered to normal

43 Institute for Fiscal Studies, Could NHS waiting lists really reach 13 million?, 8 August 2021
44 Q156
45 Institute for Fiscal Studies, Could NHS waiting lists really reach 13 million?, 8 August 2021
46 Nuffield Trust, Chart of the week: Are hospitals returning to pre-Covid activity levels?, 22 July 2021
47 See, for example: NHS Providers (CBP0027), NHS Confederation (CBP0057)
48 Health and Social Care Committee, Cancer services, accessed 18 November 2021

levels.[49] In the first session of our inquiry, Shirley Cochrane told us about the impact that losing access to her usual follow-up care had on her. Having been diagnosed with breast cancer in 2016, she was left feeling like "I have been abandoned by the health service throughout the pandemic—like someone has literally pulled a security blanket away from underneath me."[50]

Elective procedures

23. Professor Derek Alderson, the then President of the Royal College of Surgeons for England, previously told us that patients were "waiting unacceptably long times for their surgery"[51] during the pandemic. The drop in elective admissions was greatest in April 2020, when there were approximately 530,000 fewer elective episodes of care than might have been expected.[52] Elective activity, "at its worst", fell to approximately 25 per cent of the usual level of activity, according to Sir Simon Stevens, the former Chief Executive of NHS England.[53]

24. In August 2021, the IFS reported that waiting list growth so far had in fact been "remarkably small given the incredible disruption to the NHS from COVID-19," with 3 million fewer elective admissions and 17 million fewer outpatient appointments during the first ten months of the pandemic than in the same period the previous year. According to the IFS, this was because at the same time as hospital activity fell—and fewer people "exited" from the waiting list—so did the number of people joining the waiting list following a referral from a GP or hospital consultant. The waiting list actually fell between March and May 2020, with the IFS calculating that between March 2020 and May 2021 there were 7.4 million fewer people joining than implied by pre-pandemic patterns. This was likely due to:

- changes in the behaviour of patients (who were less likely to seek care as a result of concerns over potential infection and a desire not to overburden the NHS);
- genuine reductions in the need for care (e.g. due to fewer industrial and sporting injuries requiring elective or outpatient care) and;
- changes to how the NHS and doctors operated.[54]

Some of these considerations may explain why the NHS Confederation's forecast of a potential 10 million people waiting for routine surgery by Christmas 2020 did not come to pass.[55]

25. Understandably, debates about waiting times and the backlog often focus on the statistics. We wanted to remember that behind each of those figures was a person. James

49 See, for example: Myeloma UK (CBP0006), Macmillan Cancer Support (CBP0047), #CatchUpWithCancer campaign, Action Radiotherapy (CBP0073), Cancer Research UK (CBP0051), The Royal College of Pathologists (CBP0011), Breast Cancer Now (CBP0080)

50 Q3

51 Health and Social Care Committee, Second Report of Session 2019–21, Delivering core NHS and care services during the pandemic and beyond, HC 320, para 30

52 Health and Social Care Committee, Second Report of Session 2019–21, Delivering core NHS and care services during the pandemic and beyond, HC 320, para 30

53 Health and Social Care Committee, Second Report of Session 2019–21, Delivering core NHS and care services during the pandemic and beyond, HC 320, para 30

54 Institute for Fiscal Studies, Could NHS waiting lists really reach 13 million?, 8 August 2021

55 BBC News, Coronavirus: NHS waiting list 'could hit 10 million this year', 10 June 2020

Wilkinson told us about the impact that the repeated cancellation of his heart surgery had on him and his family. This affected James and his wife, but also their young daughter who, having had his repeatedly-cancelled procedure explained to her, would then return from school the next morning "to find me at home and say, "Oh, that was quick, Daddy." Every time, I had to tell her, "I'll be in again.""[56]

Mental health

26. In mental health, the number of people presenting for treatment dropped briefly during the early stages of the pandemic, followed by "historically high" levels of presentation—with the pandemic itself having a negative impact on mental health which is likely to endure.[57] On 30 June 2020, addressing the provision of mental health services and managing the backlog, Sir Simon Stevens told us that:

> 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.[58]

27. The Royal College of Psychiatrists told us that the pandemic has:

> already had a significant impact (directly and indirectly) on the prevalence and severity of mental illness within the population and on demand for mental health services. This has increased pressure on an already stretched and historically underfunded area of the NHS.[59]

28. Its submission also describes the apparent impact of the pandemic on activity across a range of mental health services, for example:

- a 94 per cent increase in the number of children being referred to child and adolescent mental health services (CAMHS) in May 2021, compared with May 2019,
- only around one million people started Improving Access to Psychological Therapies (IAPT) treatment in 2020/21 compared to the target of 1.5 million set by NHS England, and
- around 215,000 adults missing out on referral to secondary mental health treatment in 2020/21, based on previous year-on year trends.[60]

29. The College divides post-pandemic demand into three categories:

- delayed or deferred first-time access: people with untreated mental illness who were it not for the pandemic would have accessed services earlier,
- deterioration of patients with existing mental illness due to the pandemic, and

56 Qq12–13
57 Q106
58 Oral evidence taken on 30 June 2020, HC (2019–21) 320, Q205 [Sir Simon Stevens]
59 The Royal College of Psychiatrists (CBP0070)
60 The Royal College of Psychiatrists (CBP0070)

- previously healthy people who have developed mental illness due to the pandemic.[61]

The Mental Health Investment Standard

30. The Mental Health Investment Standard (MHIS) commits the NHS in England to increasing local funding for mental health (excluding learning disabilities and dementia) at least in line with the overall increase in the money available to CCGs.[62] From 2019/20 onwards, as part of the NHS Long Term Plan, the MHIS includes a further commitment that local funding for mental health will grow by an additional percentage increment to reflect additional mental health funding being made available to CCGs.

31. On 19 October 2021, Amanda Pritchard told us that the "technical description of the mental health investment standard applies to the CCG allocations" and not to the additional funding committed as part of the backlog recovery package.[63] However, she added that the Secretary of State was "on record saying that mental health will need to be supported as part of that package" and NHS England remained "completely committed to the mental health investment standard." We were reassured to hear these commitments and will continue to take an active role in scrutinising future mental health spend.

General practice

32. The Royal College of General Practitioners (RCGP) told us that:

> we simply do not have enough GPs to meet the needs of a growing and ageing population, with increasingly complex needs, on top of managing the fallout from the pandemic. This includes increasing numbers of people experiencing 'long COVID' and mental health issues.[64]

33. They added that "a high number of GPs are quitting the profession and we expect this problem to be exacerbated by the pandemic."[65] The RCGP states that the number of qualified full time equivalent (FTE) GPs in England now stands at approximately 27,900 - more than 1,500 (5.2 per cent) fewer than in 2015.[66] To address staffing shortages in general practice over the long to medium-term, the RCGP calls on the Government to implement the key recommendations outlined in its action plan for general practice. This includes ramping up efforts to deliver the manifesto commitment of 6,000 more full time equivalent (FTE) GPs, as well as eradicating unnecessary GP workload, and recruiting at least 26,000 other members of staff into the general practice workforce by 2024.[67]

34. During our evidence session on 2 November, we appreciated the Secretary of State's candour in admitting that in his view attempts to recruit 6,000 additional GPs by 2024 were not "on track", and "I am not going to pretend that we are on track when clearly we

61 The Royal College of Psychiatrists (CBP0070)
62 NHS England, NHS mental health dashboard, accessed 16 November 2021
63 Q139
64 Royal College of General Practitioners (CBP0090)
65 Royal College of General Practitioners (CBP0090)
66 Royal College of General Practitioners (CBP0090)
67 Royal College of General Practitioners (CBP0090)

are not."[68] However, we remain concerned at the implications of this shortfall, not only in tackling the backlog but also for the sustainability of our current model of general practice.

35. During the first wave, the number of appointments in general practice fell by a third from 24 million in March 2020 to 16 million in April 2020.[69] While this number had risen to 28.5 million by September 2021, we do not know how many patients who deferred seeking treatment will return, and what the impact may be.[70] According to the RCGP, NHS Digital data suggests that the number of consultations was 11 per cent lower from April 2020 to March 2021 than in the corresponding period the previous year. Assuming that those missing consultations were essential, the College estimates that there may be around 35 million missed consultations remaining to be carried out.[71] The Department of Health and Social Care's submission recognised that, while there is no "waiting list" as such in primary care:

> deferred demand […] is significant, as people who may have been reluctant to visit their GP during the height of the pandemic are now returning.[72]

36. The Department notes that general practice has actually seen increased demand resulting from the pandemic, with appointment numbers per working day for June 2021 2.8 per cent higher than they were in June 2019 (excluding Covid-19 vaccination appointments), increasing from 1.19 million in June 2019 to 1.22 million in June 2021.[73] As of September 2021, GPs and their teams had delivered over 60 per cent of all covid-19 vaccinations to date, with long covid and the treatment of patients with covid-19 expected to place further demands on practices. Although we welcome the speed and scale of the vaccine rollout, this has undoubtedly increased demand on primary care teams. Furthermore, as the Department explains, patients needing to wait longer for secondary care are "often continuing to need ongoing support from their GP while they wait for their consultation following referral, during which time their health can worsen, requiring more interim care."[74] Feedback from RCGP members also suggest that, with referral rates falling by approximately a third in the period between mid-March 2020 and January 2021 compared with the same period 12 months earlier, GPs may have been less likely to make non-urgent referrals where lists were closed or too long in secondary care. Instead, general practice cared for patients who would otherwise have moved on in the system for specialist treatment.[75]

37. To tackle the blockage in access to diagnostics, in October 2021 it was announced that 100 new community diagnostic centres across England would be launched.[76] The Department had also announced measures to boost access to GPs, including a £250 million

68 Q242
69 Nuffield Trust, Primary care, 23 September 2021
70 NHS Digital, Appointments in General Practice - September 2021, 28 October 2021
71 Royal College of General Practitioners (CBP0090)
72 Department of Health and Social Care (CBP0087)
73 Department of Health and Social Care (CBP0087)
74 Department of Health and Social Care (CBP0087)
75 Royal College of General Practitioners (CBP0090)
76 HM Treasury, Budget and Spending Review – October 2021: What you need to know, 27 October 2021

winter access fund that will "fund locums and support from other health professionals such as physiotherapists and podiatrists, with a focus on increasing capacity to boost urgent same-day care."[77]

Remote delivery of care in general practice

38. We heard that around 80 per cent of GP appointments had been face-to-face before the pandemic, but the figure was now about 50 per cent.[78] Professor Martin Marshall, Chair of the RCGP Council, Amanda Pritchard and the Secretary of State were all in agreement that there could be no numerical target for the ideal ratio across all general practices—although Professor Marshall felt that" a reduction in face to face from 80% to 56% on average across the country is probably about right."[79] He pointed out that local demographics were likely to have an impact, with more "tech-enabled" populations likely to have a higher proportion of remote consultations.[80]

39. While remote consultations will "remain an important way of delivering general practice services in the future, both as we continue to manage COVID-19 and more generally", the RCGP states that beyond the pandemic "we expect a rebalancing between face-to-face and remote consultations", with face-to-face appointments remaining a major element of general practice, and remote consultations delivered "where appropriate and useful."[81]

40. During our inquiry, we explored whether difficulties accessing face-to-face care in general practice has driven increased demand on emergency departments. Dr Katherine Henderson of the Royal College of Emergency Medicine (RCEM) told us that, while a lack of capacity to see patients face to face in general practice was indeed driving such demand, this was not the only factor. Rather than pitting one service against another, a "joined-up plan" should "work out where the right place for the patient is":[82]

> We are seeing patients, yes, who say they cannot get face-to-face appointments with primary care. We are also seeing primary care patients who cannot get their surgical treatment, their out-patient treatment or diagnostic treatment. It is not about one side of the service versus the other side of the service.[83]

41. An RCEM briefing noted that changes in the delivery of primary care during the pandemic have made accessing healthcare "quicker and easier" for many, but others risk being excluded and may be struggling to access primary care or "finding that it does not fit their needs."[84] For the RCEM:

> Maintaining the balance between virtual and in-person primary care services is integral in ensuring that people can access healthcare when and

77 Department of Health and Social Care, Plan set out to improve access for NHS patients and support GPs, 14 October 2021
78 Q123
79 Q123, Q174, Q232,
80 Q123
81 Royal College of General Practitioners (CBP0090)
82 Q35
83 Q35
84 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021

> how they want and feel satisfied with the care that they receive. In turn, they will not feel the need to turn to the urgent and emergency care system when they would be better treated elsewhere.[85]

42. Professor Martin Marshall acknowledged that where:

> patients feel perhaps that they cannot get access to their GP, maybe they will go to the emergency department because, as Dr Henderson said, the lights are on. It is a place you can go to. To me, that is a consequence of the whole system being under pressure and there being pressure points in general practice, […] In particular […] when general practice is under pressure, the rest of the NHS feels it.[86]

43. **It is not appropriate to set a numerical target for the proportion of appointments carried out remotely in general practice. Instead practices should respond to the needs of their local populations and work together with patients to establish the most fitting medium for their consultations based on clinical outcomes. Remote care is not for everyone, and it is essential to avoid unintended clinical consequences that may occur.**

44. ***NHS England has already commissioned an evaluation of the role of digital tools in primary care. We recommend that it publishes that evaluation at the earliest opportunity and uses it as a basis to produce clear and consistent guidance on best practice in***

a) ***Reducing bureaucracy and day-to-day IT administration tasks, including those associated with referrals, routine blood tests, and follow-up appointments.***

b) ***The use of remote consultations in general practice. This should include guidance on how to approach conversations with patients about remote care, considering that while patients may not necessarily always be able to have a face-to-face appointment, they should have input into the decision and the rationale for any refusal should be transparent and consistent.***

45. ***We further recommend that NHS England looks beyond primary care in its assessment of the use of digital tools and considers the impact of an increased usage of such tools not only on patients, but also on other parts of the health and care system, especially at the primary care and secondary care interface.***

Emergency care

46. In October 2021, the total number of A&E attendances was 2,167,000, an increase of 35.5 per cent on October 2020 and 0.2 per cent lower than October 2019. However, attendances in type 1 emergency departments[87] were 3.1 per cent higher than they were

85 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021

86 Q115

87 A Type 1 Emergency Department is defined as "a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients"

before the pandemic, in October 2019.[88] In emergency departments, waiting times were the worst since records began, with one in four patients waiting longer than four hours to be admitted, transferred or discharged and trolley waits at a record high.[89]

47. There appear to be many reasons behind this increase in demand, including the impact of unmet demand elsewhere in the system. According to the RCEM, limited community mental health support alongside fewer inpatient beds had led to significant unmet need throughout the pandemic, with large numbers of people accessing services only once they are in crisis.[90] The CQC found that some emergency departments had functioned as a "first contact" for people in mental health crisis due to a lack of alternatives.[91] The RCEM believes that the elective backlog has also been a factor, with people presenting to emergency departments with complications relating to their delayed procedures, and those who delayed accessing healthcare as a result of the pandemic attending with potentially more serious issues.[92] Fear over children's health, coupled with potential difficulty in accessing other services or being streamed towards the urgent and emergency care system, had also led to a "drastic increase" of young people attending emergency departments.[93] The RCEM said that that all parts of the healthcare system–including primary care, mental health, and community care–"require additional capacity so patients can access the right kind of care at the right time."[94]

48. The RCEM believes that the "next worrying phase" of the pandemic will be the expected resurgence of flu and RSV this winter alongside rising covid-19 cases, creating further significant challenges for emergency departments during a time of year when demand increases anyway.[95]

Interface with the 111 call first system

49. On 1 December 2020, NHS England and NHS Improvement launched a new phase of its 'Help Us, Help You' campaign focussing on the NHS 111 service as a new way to access A&E/emergency departments.[96] The aim was to direct people to use NHS 111 first when they have an urgent but not life-threatening medical need, rather than going straight to A&E/emergency departments.

50. Question marks remain as to how effective 111 call first systems have been in managing demand.[97] In August 2021, the RCEM found that levels of emergency department

88 NHS England, A&E Attendances and Emergency Admissions October 2021 Statistical Commentary, accessed 18 November 2021
89 Nuffield Trust, NHS performance summary: September-October 2021, 11 November 2021
90 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021
91 Care Quality Commission, Monitoring the Mental Health Act in 2019/20, accessed 2 December 2021
92 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021
93 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021
94 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021
95 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021
96 Public Health England, NHS 111 Call First, accessed 23 November 2021
97 Q38

attendances and subsequent admissions were not only reaching pre-pandemic levels but surpassing them–with attendances to type 1 emergency departments the highest on record in June 2021, and admissions the second highest since the start of the pandemic.[98]

51. The increase in people being recommended to emergency departments coincides with a decrease in the percentage of emergency department attendances which are being admitted. In June 2021, the percentage of attendances admitted stood at 27.9 per cent, the lowest since July 2017 (27.1 per cent). For the RCEM, this implies that:

> many patients who are presenting at EDs are low acuity,[99] and the reasons why they are attending are due to inaccurate recommendations from 111 or primary care, or dissatisfaction with other services.

Dr Henderson, President of the RCEM, told us that call first services needed to have "appropriate clinical validation from someone who is able to give that level advice", along with a range of options to access care. For Dr Henderson, "if the call handler does not have anything to say other than, "Get an ambulance to A&E," or, "Try to get a GP appointment," it is not going to work."[100]

52. The RCEM states it is "currently uncertain" whether the NHS 111 call first pilot has been effective at reducing emergency department attendances.[101] At the time of writing, we are unaware of any evaluations of the pilot being published. During the pandemic, messages about how to access care have evolved along with covid-19 itself. We are concerned about how effectively changes in the 111 system have been communicated to patients. In August 2021, Health Service Journal reported that Imelda Redmond, then National Director of Healthwatch England, had cited "a real gap in high quality communication to the public," around service change. In her view, "not enough people know about it [111 call first] and the comms have not been strong enough.[102]

53. **Managed well, we see enormous potential for a beefed-up version of 111 to regulate the demands on emergency departments and ensure that patients get the right care, in the right place, at the right time. However, we acknowledge concerns that without sufficient clinical validation these objectives cannot be met. Without robust evidence from the evaluation of the pilot so far, we cannot judge its success or suggest improvements. We are already part of the way through a challenging winter—if findings are not available soon, NHS England risks missing opportunities to improve services at this crucial time.**

54. ***We therefore recommend that NHS England completes and publishes evaluations of NHS 111 call first services as soon as is practicable, including learning from those evaluations and the implications for any future iterations of the service.***

98 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021

99 Low acuity patients are those whose attendances are deemed non-urgent. NHS Digital define non-urgent attendances to EDs as "a first attendance with some recorded treatments or investigations all of which may have been reasonably provided by a GP, followed by discharge home or to GP care."

100 Q39

101 Royal College of Emergency Medicine, What's behind the increase in demand in Emergency Departments?, 6 August 2021

102 Health Service Journal, NHS' promotion of 111 First 'not strong enough', watchdog warns, 2 August 2021

Long covid

55. As of 31 October 2021, the Office for National Statistics estimated that around 1.2 million people living in private households in the UK (1.9 per cent of the population) were experiencing self-reported "long covid" (symptoms persisting for more than four weeks after the first suspected covid-19 infection that were not explained by something else).[103] This was consistent with the figure for 2 October 2021, and an increase from 1.1 million in September 2021, reflecting sustained increased covid-19 infection rates in August. There are issues with the capacity of secondary care long covid support clinics; workforce availability; services for children with long covid; understanding of long covid in primary care; and consistency of access to gold-standard services across the country.

56. NHS England recently published data showing that, between 30 August 2021 and 26 September 2021, 5,821 referrals were made to a post-covid assessment service in England. 5,182 of these were accepted, with 639 "clinically inappropriate." In the same period, there were 4,168 initial specialist appointments and 6,212 follow-up appointments in post-covid assessment services.[104] According to LongCovidSOS, long covid patients represent a "huge unmet need", although "quantifying it is challenging."[105]

57. LongCovidSOS would consider "a one-stop shop with a mix of specialties, professionals allied to healthcare and, importantly, a point of contact for the patient" to be "the benchmark" for long covid care. They stress that "interventions should be appropriate for the highly diverse needs of those suffering from this condition and should not put patients at risk."[106] However, their written submission describes a "postcode-lottery" of adherence to NHS England pathways, inappropriate referrals, lack of diagnostic tools, and "huge numbers" of people waiting many months for access to clinics—an experience which has been described as "traumatic" and can lead to a deterioration in patients' health. Even after gaining access to a long covid assessment service, navigating the system can be "profoundly bewildering."[107]

58. People living with long covid told us about the massive and ongoing impact it had on their fitness, independence, and ability to work.[108] At the same time, they had faced a battle to access diagnosis and the right treatment, "fighting" for referrals, with health professionals denying that appropriate long covid services existed.[109] Lere Fisher told us that he felt he had experienced "gaslighting."[110] Helen Lunt Davies described repeated calls to her doctor's surgery, which left her "crying" on the phone.[111] For her, the "to-ing and fro-ing between me and my GP" was "probably one of the hardest things, above being

103 Office for National Statistics, Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK : 2 December 2021, 2 December 2021
104 NHS England, COVID-19 Post-Covid Assessment Service, accessed 18 November 2021
105 LongCovidSOS (CBP0069)
106 LongCovidSOS (CBP0069)
107 LongCovidSOS (CBP0069)
108 Q66, Q70, Q74, Q82
109 Qq66–84
110 Q81
111 Q68

ill."[112] However, when she finally did access appropriate post-covid care, it was "brilliant."[113] Ondine Sherwood of support group LongCovidSOS told us that her organisation was still hearing about people "really struggling to get referred."[114]

59. We heard about insufficiently integrated responses to long covid as a multisystem disease, with one patient telling us about the "catastrophe" they experienced when "well-meaning people in the local authority long covid clinic had only limited authority to refer me to, or liaise with, specialist services" and "the hub in my case seemed to be the GP and they're already completely overloaded, so that doesn't work."[115] However, we also heard that England, had been "a bit of a frontrunner" in "defining pathways, operational standards, clinical standards and treatment approaches."[116] Dr Melissa Heightman, Clinical Lead, Post-covid Assessment Service, University College London Hospitals NHS Foundation Trust, told us that in her area, stakeholders had worked together on a pathway that ensured GPs had a standardised process to follow on receipt of a patient's positive covid test.

60. **The response to long covid shows both the kind of integrated, patient-centred care the NHS can provide when systems work effectively, and the frustration and detriment experienced by patients who have to "fight" to access to the right care when systems do not work effectively. We heard that long covid provided an opportunity to develop truly integrated services, and that care—although variable—was excellent in the best centres. We welcome NHS England's commitment to provide effective long covid services. However, during our inquiry we heard heart-rending testimony from people who had struggled to access the care they needed, and who did not feel believed or cared for. This is simply not acceptable. We note that NHS England's current plan for long covid extends to 2022. With covid-19 set to become endemic, NHS England must ensure that its plans to tackle long covid continue. We understand that knowledge of covid-19 and long covid is constantly evolving, and that plans will therefore need to adapt over time, but we are likely to see increasing numbers of people living with this condition. We cannot afford to let them down.**

61. ***We therefore recommend that NHS England publishes, before the end of this financial year, a long covid plan covering the period until 2023. The plan must be developed in consultation with a wide range of stakeholders, including patient groups. NHS England should integrate this into its wider health and care recovery plan, as long covid is likely to have implications for demand and workforce across a range of services.***

Communication with patients, service users and the public

62. The experiences reported to us by patients with long covid highlight wider issues with regards to communication with patients. We heard about the importance of actively engaging patients while they wait, not least to prevent conditions worsening in the meantime.[117] Sarah Lambrechts, waiting for endometriosis care, described her experience as "like walking down a dark corridor", not knowing when she would get to the end of it.[118]

112 Q71
113 Q69
114 Q86
115 Transcript of Patient A (CBP0094)
116 Q101
117 NHS Confederation (CBP0058), Centre for Perioperative Care (CBP0032)
118 Q141

63. However, we did also hear about individual professionals and teams who had managed to provide "absolutely fantastic" communication despite the challenges.[119] In addition, patients had valuable support from voluntary sector and peer support organisations.[120] We heard that it was not sustainable for health services to rely on the voluntary sector alone for this, with National Voices warning that while:

> signposting to voluntary sector-provided services is one option, […] such requests for support have already increased significantly throughout the pandemic while, at the same time, charities' incomes have dropped. So, charities cannot simply pick up the pieces left by the absence of statutory services without additional Government financial support.[121]

64. We welcome support from voluntary sector and peer support organisations but are concerned at what might happen to patients who are unable to access this, or who may not be equipped to fight for care with the same tenacity as the patients who spoke to us. The Secretary of State has reflected on the "social backlog" in mental health and public health, which he described as "less evenly spread" than waiting lists.[122] We are aware of rumours that the elective recovery plan will include "slashing out-patient follow-up appointments after treatment for a range of illnesses", with patients being told to contact teams only if there is a problem. Should these prove to be true, we would be gravely concerned about the potential for entrenching health inequalities should only the sharpest-elbowed patients be able to access follow-up care.[123] Similarly, should patients need to leave their local area for treatment, it will be crucial to ensure that any plans take into account potential barriers for the most vulnerable patients, and ensure that access to treatment remains fair overall.

65. **It is not acceptable for patients awaiting planned treatment or feeling the debilitating effects of long covid to feel "abandoned" by the NHS. We appreciate the uncertainty about the length of future waiting lists, but this is no excuse for lack of communication—whether this be confirmation of a patient's next round of treatment or simply a conversation to assure them that they have not been forgotten. We heard that waiting lists are not static, that conditions can worsen, and that active management is recommended. A commitment to keeping in touch would not just benefit individual patients, but also help local systems actively to manage their lists and inform decisions about prioritisation.**

66. ***The national health and care recovery plan must set out a clear vision for what 'success' in tackling the backlog will look like, and what patients can expect their care to look like in their local area in the coming years. The plan must include minimum expectations for ICBs in managing waiting lists actively and communicating with patients awaiting planned care. The Department of Health and Social Care, NHS England and local ICBs must share responsibility for communicating the 'offer' to the wider public, considering the "social backlog" facing many members of the public. We request the Department of Health and Social Care to report back to us on how this will be delivered.***

119 Q142,
120 Q78, Q142
121 National Voices (CBP0088)
122 Rt Hon Sajid Javid MP, The hidden costs of COVID-19: the social backlog, 16 September 2021
123 The Times, Patients to travel for NHS treatment, 23 November 2021

67. **Lastly, we heard that patient involvement in services was important to tackle long covid. It should also be taking place in other areas. We have previously called for the Care Quality Commission's assessments of Integrated Care Systems (ICSs) to include consultation with patient groups and patient outcomes, and we continue to believe in the importance of this.**

68. ***We again recommend that the Care Quality Commission includes consultation with patient groups and details of patient outcomes in its assessment of ICSs.***

2 Funding and policies to tackle the backlog

69. The November 2020 Spending Review committed £3 billion, in addition to the long-term NHS funding settlement, to support health service recovery in the wake of covid-19, with £1 billion of this to tackle backlogs and address long waiting lists.[124] Over the lifetime of our inquiry, there have been more Government funding announcements aimed at tackling the backlog.

September 2021: Backlogs, Build Back Better and Health and Social Care Levy

70. On 6 September 2021, the Government announced that the NHS would receive an extra £5.4 billion over six months to support its response to covid-19 and help tackle waiting lists.[125] This includes:

- £2.8 billion for covid-19 costs including infection control measures,
- £600 million for day-to-day costs,
- £478 million for enhanced hospital discharge, and
- £1.5 billion for elective recovery, including £500 million capital funding (£250 million for increasing operating theatre capacity and hospital productivity and £250 million for an elective recovery technology fund)[126]

71. On 7 September 2021, the Government announced its Build Back Better plan, which pledged to invest £36 billion in health and social care over the next three years.[127] This is to be funded by a new, UK-wide 1.25 per cent Health and Social Care Levy[128] which will be introduced from April 2022. The plan includes an aim to increase elective activity in the NHS by 30 per cent by 2024–25, compared to pre-pandemic levels. The Health and Social Care Levy Bill was introduced on 8 September 2021 and was fast-tracked through the Commons on 14 September 2021, receiving Royal Assent on 20 October 2021.[129]

October 2021: Spending Review

72. On 27 October 2021, the Chancellor of the Exchequer, Rt Hon. Rishi Sunak MP, formally announced spending plans for the health and social care sectors into 2024–25.[130] On top of September's announcements for backlog-related funding and the Health and Social Care Levy, further funding was earmarked for capital spending on equipment, IT, and infrastructure. A sum of £5.9 billion was announced which will see:

124 HM Treasury, Spending Review 2020, 15 December 2020
125 Department of Health and Social Care, Additional £5.4 billion for NHS COVID-19 response over next 6 months, accessed 19 November 2021
126 The King's Fund, The Health and Care Levy: what was announced and what does it mean for health spending?, 11 October 2021
127 Cabinet Office, Department of Health and Social Care, Prime Minister's Office 10 Downing Street, Build Back Better: Our Plan for Health and Social Care, 19 November 2021
128 HM Revenue and Customs, Health and Social Care Levy, 9 September 2021
129 UK Parliament, Health and Social Care Levy Act, accessed 1 December 2021
130 HM Treasury, Autumn Budget and Spending Review 2021, 27 October 2021

- £2.3bn invested in diagnostic services, such as the further development of diagnostic hubs,
- £1.5bn for increased bed capacity, equipment and new surgical hubs to tackle waiting times for elective surgeries, and
- £2.1bn in technology and data to improve efficiency and data security.

73. In combination with the previous announcements, the Spending Review pledged an increase in day-to-day spending on the NHS of 3.8 per cent between 2021/22 and 2024/25.[131] Capital spending will also see an annual average increase of 3.8 per cent in real terms to 2024/25.[132] This capital spend covers a range of commitments, including building and upgrading hospitals, community diagnostics, elective surgery hubs and digital technology.[133]

74. In public health, the Government decided to maintain, rather than increase, the public health grant over the next three years. The Government provides the public health grant to local authorities to deliver crucial preventive and treatment services such as children's health, smoking cessation, sexual health, and drug and alcohol services.[134] In social care, £3.6bn of the pre-announced £5.4bn from the Levy will go directly to local government to implement changes to the care means test, bring in a cap on care costs, and move towards paying a "fair rate" for care.[135] The remaining £1.7bn will go toward wider system-level improvements.[136]

Responses to the announcements

75. On 19 October 2021, Ben Zaranko of the Institute for Fiscal Studies noted that the announced funding for the NHS

> looks like enough to deal with the problems in the short term, but in the medium term that may no longer be the case. Either savings from elsewhere or future top-ups could well be needed.[137]

76. Siva Anandaciva of the King's Fund also said the increase in funding could be "in the right zone", but commented that the targets and timeframes attached could be unrealistic, stating

> if you are looking at putting the NHS on the path to delivering that level of performance in five to seven years, not clearing the backlog in three to four years—[the backlog funding announced] over the next three years is in the right zone[138]

131 Health Foundation, Spending Review 2021: what it means for health and social care, 1 November 2021
132 The King's Fund, The Autumn Budget and Spending Review 2021, 1 November 2021
133 The King's Fund, The Autumn Budget and Spending Review 2021, 1 November 2021
134 The Health Foundation, The public health grant has been increased but is still too low, 30 March 2020
135 Department of Health and Social Care, Policy paper: Build Back Better: Our Plan for Health and Social Care, 19 November 2021
136 The King's Fund, The Autumn Budget and Spending Review 2021, 1 November 2021
137 Q148
138 Q151

77. We join Amanda Pritchard, Chief Executive of NHS England, in welcoming this "certainty on the revenue funding for the next few years."[139] We give credit where it is due for the resources, and capital investment, which the Government has made available. We were also pleased to hear NHS England set out how some of that funding will translate into action, with their commitment to "9 million additional checks, treatments and tests" over the next few years.[140]

78. However, public health, social care and workforce were not adequately accounted for in the Spending Review. The Health Foundation stated that the decision to maintain the public health grant "does not reverse the 24% real-terms cut to the grant since 2015/16" and fell "well short of what is required." It estimated that "an additional £1.3bn a year in 2021/22 price terms is required by 2024/25", implying an average real-terms growth in spend of 13% a year over the next three years. The Health Foundation described social care as having "lost out", commenting that the settlement was "barely enough to meet future demands, let alone address the challenges social care faces."[141]

79. **The pandemic has had a negative impact on health inequalities and highlighted the crucial importance of effective public health services in supporting local populations. Public health services are therefore vital allies in tackling the backlog, and we are surprised at the decision merely to maintain current public health grant funding levels.**

80. ***As part of its national health and care recovery plan, we recommend that the Government sets out the contribution that public health services will make, and ensures that this contribution is backed with a level of funding that acknowledges their crucial role.***

Workforce

81. During our inquiry, we heard many times that workforce shortages were the "key limiting factor" on success in tackling the backlog.[142] Several witnesses told us that no financial settlement would be sufficient without enough action on workforce. Ben Zaranko, for example, stated that "if there is no one actually to deliver the care, we will not get on top of the issue."[143] We agree that the best-laid plans to increase and sustain capacity in the system will fail unless the system can recruit and retain enough staff with the right mix of skills.[144]

Shortages, recruitment and retention

82. Pre-existing NHS capacity issues have been a common theme throughout the pandemic. During our inquiry, we heard about workforce shortages across areas as wide-ranging as emergency medicine, pathology, anaesthetics, mental health and neurology, dentistry, echocardiography, and oncology.[145]

139 Q162
140 Q162
141 The Health Foundation, Spending Review 2021: what it means for health and social care, November 2021
142 Royal College of Physicians (CBP0001)
143 Q149 Ben Zaranko
144 See for example, The Nuffield Trust (CBP0078), Policy Exchange (CBP0040), Royal College of Nursing (CBP0086)
145 Royal College of Emergency Medicine (CBP0007), The Royal College of Pathologists (CBP0011), Royal College of Anaesthetists (CBP0017), Parkinson's UK (CBP0020), Faculty of Dental Surgery at the Royal College of Surgeons of England (CBP0022), Heart Valve Voice (CBP0029), Cancer Research UK (CBP0051)

83. In its annual report, *The state of health care and adult social care in England* 2020/*21*, the CQC found that recruitment and staff retention continue to be severe problems, particularly in adult social care and primary care. The report outlines that by mid-2021 there were fewer full-time equivalent GPs in total per 100,000 patients than there were in 2017. A British Medical Association survey in February 2021 found that around 50 per cent of doctors were more likely to reduce their working hours in the following 12 months. Moreover, one in four doctors were more likely to take early retirement and another fifth were more likely to leave the profession.[146]

84. Amanda Pritchard, Chief Executive of NHS England, told us that the NHS had "29,000 more full-time equivalents now than we had a year ago"[147] but added that was "not enough."[148] With 93,000 current NHS vacancies and shortages across specialities, we remain unconvinced there are sufficient plans for the recruitment and retention of staff ahead of April when the funding from the new Levy begins.[149]

Training

85. Professor Stephen Powis, National Medical Director of NHS England, explained that funding for Health Education England (HEE) was "absolutely critical" to clearing the backlog but also for the future of the NHS:

> The training and the supply of future clinicians is critical. It is not just doctors; HEE supports the training of all clinicians. It is really important that we have our mind on the medium and the long term as well as the short term because, unless we get that supply right, we will be in a perpetual circle of worrying about the future workforce. The funding of HEE is absolutely critical.[150]

86. Both Professor Powis and Amanda Pritchard commented that any reduction or freezing of funding for HEE would be "a real concern" to them.[151] It was therefore particularly disappointing to see the funding settlement for HEE absent from the Spending Review that took place the week after they gave evidence.

87. It is unacceptable that the budget for HEE, which funds training places for new doctors and nurses, remains unresolved. We understand that prior to the NHS England merger announcement, HEE were being asked for large cuts and that at best current doctor and nurse training levels will be maintained. It is extremely disheartening to say the least that there appears to have been no discussion about any increases in the numbers entering training.

146 Care Quality Commission, The state of health care and adult social care in England 2020/21, 23 October 2021
147 Q163
148 Q164
149 NHS Digital, NHS Vacancy Statistics England April 2015 – June 2021 Experimental Statistics, 26 August 2021
150 Q166
151 Q167, Q168

Workforce planning

88. Our inquiry into *Workforce burnout and resilience in the NHS and social care*, which reported in June 2021, recognised the need for effective workforce planning and the impact that working through the covid-19 pandemic has already had on staff across the sector. Without better short and long-term workforce planning, we do not believe the 9 million additional checks, tests and treatments will be deliverable.

89. In July 2021, the then Minister of State for Care, Helen Whately MP, commissioned HEE to work with its partners and review long-term strategic trends for the health and social care workforce. The Long-Term Strategic Framework for Health and Social Care Workforce Planning[152] will review, renew and update HEE's Framework 15 published in 2014.[153] HEE state that this will "help ensure we have the right numbers, skills, values and behaviours to deliver world leading clinical services and continued high standards of patient care." The framework will also include regulated professionals working in social care, like nurses and occupational therapists.

90. Revisiting Framework 15 is a potentially important step in the right direction, but without independent regular updates no workforce plan can be robust. By the time the refreshed Framework 15 arrives in Spring 2022, funding from the Spending Review should already be in the system.[154] Furthermore, we are particularly concerned that the recently announced merger of HEE into NHS England may delay the publication of the refreshed Framework.[155] In any case the review will come too late for any short-term measures that could help source more staff before the start of the financial year.

91. Staff wellbeing continues to be a major concern, with submissions setting out the risk that staff will leave the service altogether or cut their hours without light at the end of the tunnel.[156] We hope that the delay to the Government's response to our report on *Workforce burnout and resilience in the NHS and social care* is not indicative of a lack of attention to this area.

92. **We note that the Government decided to resist an amendment to the Health and Care Bill that would have required it to publish independently verified assessment of health, social care and public health workforce numbers at least once every two years, leaving a gap between its rhetoric about supporting frontline staff and the biggest single long-term measure that would relieve that pressure. Without an independent forecast of future workforce needs, it remains impossible for anyone to know whether enough doctors, nurses or care staff are being trained. We still believe that giving an assurance to NHS staff that the appropriate number of new staff will be trained in the future is the biggest single long-term measure the Government can take to gain the confidence of frontline staff that it has a grip of this problem. Unless it can do that, the risk is that generous taxpayer-funded settlements for services or capital are wasted.**

152 Health Education England, Long-Term Strategic Framework for Health and Social Care Workforce Planning, accessed 17 November 2021

153 Health Education England, Framework 15, accessed 17 November 2021

154 Q203,

155 Department of Health and Social Care, Major reforms to NHS workforce planning and tech agenda, 22 November 2021

156 See, for example: Cancer Research UK (CBP0051), The Health Foundation (CBP0066), The Royal College of Psychiatrists (CBP0070)

93. ***We repeat our recommendation that HEE must be required (whether in its own right or as part of NHS England) to publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years, including an assessment of whether sufficient numbers of staff are being trained. These projections must cover social care as well as the NHS given the close links between the two systems. We urge NHS England to ensure that workforce planning is included in any future iterations of the elective recovery plan.***

94. ***We recommend that the Government undertake an urgent review of short-term recruitment and retention issues within the health and care workforce, including productivity improvements, sharing of best practice through data, removal of professional demarcation, use of technology, additional training places and additional immigration measures. This should be published before the arrival of the funding due in early 2022.***

95. **Investing resource in our health and care workforce will ultimately save money—for example through reduced locum and agency fees over time—and help build a better, safer health service. It will also give hope to staff—who are feeling increasing desperate and who face yet more challenges on top of those posed by the early phases of the pandemic.**

96. ***We call on NHS England to demonstrate its ongoing commitment to staff wellbeing by publishing a refreshed People Plan to cover the financial year 2022/23 as soon as is practicable.***

Capacity

97. NHS capacity issues and their consequences, particularly in the winter, have long existed but have been further exacerbated by the pandemic. The Nuffield Trust noted that "even if demand simply resumes its pre-pandemic trend, this would still result in a steady growth in the backlog, because it was already outstripping capacity."[157] The Trust further noted that "expanding hospital and diagnostic capacity is a priority for many countries" and warned that, while the UK ranks average for waiting times among the health systems it had analysed, its position is "likely to deteriorate given that many parts of the NHS will be working with an outdated estate and chronic staff shortages to deliver health care with stricter infection control measures."[158] Dr Katherine Henderson, President of the Royal College of Emergency Medicine, told us that "we have patients waiting hours and hours for a bed."[159]

98. **An NHS running too 'hot' for patients to move from crowded emergency departments into wards cannot provide safe, efficient or effective care in the long-term. Furthermore, the advent of ICSs offers an opportunity to provide patients with more integrated care so that they can leave hospital promptly once medically fit.**

157 The Nuffield Trust (CBP0078)

158 The Nuffield Trust, Resuming health services during the Covid-19 pandemic What can the NHS learn from other countries?, accessed 30 November 2021

159 Q65

99. ***As part of its broader health and care recovery plan, the Government must produce an independently-verified analysis of how many, and what type, of extra beds the NHS needs in order to provide safe and effective everyday care for patients, whilst also responding to need directly created by the pandemic. This plan must be accompanied by sustainable, long-term plans to tackle delayed discharges.***

100. Along with the need to increase bed capacity, we heard that outdated buildings pose a challenge to effective care and productivity. The King's Fund noted that "years of constrained capital investment have led to a growing backlog of safety issues with NHS buildings and equipment"–with the ability of NHS leaders to plan improvements hampered by a lack of "a coherent and sustainable multi-year capital investment plan."[160]

101. Policy Exchange noted that "the NHS must scale up elective diagnostic capacity significantly … [as its current] diagnostic capacity is insufficient, [noting that] the UK has similar numbers of MRI and CT scanners as Hungary and Costa Rica, putting us in the bottom five countries in the OECD for this metric."[161]

102. **We welcome the £2.3bn pledged in the Spending Review to create around 100 new community diagnostic hubs, but we are yet to see detailed plans for their implementation.**

103. ***Ahead of the arrival of the new funding from the Spending Review in Spring 2022, we recommend that Government provides more details on the 100 new community diagnostic hubs, including where they will be placed, who will staff them and how they will contribute to service improvement within and beyond the covid-19 landscape.***

Role of independent sector

104. The Health Foundation noted that "the NHS will need to think and act innovatively in how it redesigns pathways to address the elective care backlog." Independent sector capacity will be a part of the answer "although… this is not a perfect match for the need, and risks exacerbating inequalities in access to care."[162] The use of independent sector capacity to clear the backlog raises issues of potential disparities in healthcare provision. Anita Charlesworth of the Health Foundation told us that covid-19 had had a bigger impact in certain parts of the country, particularly in more deprived communities.[163] The North-West and the Midlands had been "highly impacted" by covid-19, and their waiting lists had "grown the most."[164] With 60 per cent of independent sector capacity in London, Anita Charlesworth said that «the ability for us to mobilise extra care and take patients off the waiting list is not distributed based on where need is greatest."[165] Professor Neil Mortensen of the Royal College of Surgeons of England noted that workforce also limited the potential contribution of the independent sector:

> The independent sector relies on nursing staff very often from the local NHS hospital doing shifts and so on. There is a finite resource, and you cannot

160 The King's Fund, The Comprehensive Spending Review – what more for health and care spending?, 12 October 2021
161 Policy Exchange (CBP0040)
162 The Health Foundation (CBP0066)
163 Q40
164 Q40
165 Q40

> just shift it to the independent sector, although during the pandemic, and now subsequently, the independent sector has provided a safe haven to a degree.[166]

105. **Access to care should not be dependent on where you live in the country. Regional and national co-ordination will be necessary to ensure that strategies aimed at tackling the backlog do not have the unintended consequence of increasing health inequalities.**

106. ***We recommend that NHS England, together with ICBs and the new Office for Health Improvement and Disparities (OHID), work together to deliver regional and national coordination as the system tackles the backlog in elective care. If the independent sector is to prove an effective partner in tackling that backlog, the Government must ensure that plans take into account people living in those areas with less access to independent care. The goal must be equity of access to care on waiting lists regardless of geographic location.***

Patient safety

107. Our inquiry has explored the risk that a single focus on clearing waiting lists might pose to quality of treatment and patient safety. Professor Neil Mortensen of the Royal College of Surgeons of England told us he was worried that pressure on "getting the numbers–the volumes–done" could influence safety. Instead, "balance" was needed:

> It is the balance between getting the targets, getting the numbers, getting the activity and getting the throughput and capacity, and balancing that with the necessary welfare of the staff and the space for training.[167]

108. Siva Anandaciva of the King's Fund said that a return to the previous targets culture would be a "real concern." He noted that "there are certain hygiene things that will not go", such as surgical checklists. However, he worried about "some of the conversations on clinical effectiveness and what matters to patients being dialled down, as activity, and that pressure and focus, is dialled up."[168]

109. Focussing on numerical targets alone risks the kind of perverse incentives seen at Mid Staffordshire NHS Foundation Trust, where Sir Robert Francis QC's report found that "finances and targets were often given priority without considering the impact on the quality of care",[169] in a workplace culture which ultimately contributed to the "appalling suffering of many patients." The Government cannot afford to deprioritise patient safety or compassionate leadership. Instead, it must take a more holistic view of what success in tackling the backlog looks like. The Government should further explore measures for achieving this balance, including the role for a tripartite NHS payment tariff blending fixed, activity, and quality elements.[170] With such a tariff, in addition to a fixed payment, providers would receive an activity payment to incentivise delivery of care, and an additional payment based on the quality of that care.

166 Q31
167 Q63
168 Q152
169 The Mid Staffordshire NHS Foundation Trust Public Inquiry, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary, 6 February 2013
170 Q49

Innovation

110. While the pandemic has resulted in unprecedented pressures on health and care systems, it has proved a fertile opportunity for service innovation and reform. The NHS Confederation noted that the pandemic "has shown how the system can work together effectively across primary and secondary care, independent sector providers and specialist care. It has also exposed the importance of working effectively with social care providers."[171]

Integration with social care

111. To tackle the backlog in a truly integrated way, the Government, NHS England and ICSs must be mindful of interdependencies outside the NHS—most pressingly with social care. We heard from NHS England's own Medical Director , Professor Stephen Powis, about the importance of "good functioning social care" in supporting effective hospital discharge, for example.[172] The Secretary of State told us that there were "natural linkages" between the care and healthcare sectors, and that he would like to see "more work, even more than we see today, between them"."[173] Yet we also heard that, given the "lessons of history", there were doubts that "money for social care will actually materialise on the scale at which it is being promised, or at least implied."[174] We give credit to the Government for grasping the nettle of social care reform and publishing its White Paper on 1 December 2021, and are in broad agreement with its aims to provide choice, quality and fair access. However, we are concerned that the "ambitious 10-year vision" fails to acknowledge the scale of resource required by the sector to navigate the crisis it faces right now.[175] There are welcome commitments on workforce, and we were pleased to see the experiences of unpaid carers, who have faced extra pressure during the pandemic, acknowledged.[176] We now need to see a comprehensive ten-year plan for social care.

112. **We have heard much about how a robust social care system that can support hospital discharges and free up capacity is essential to clear the backlog. We welcome the inclusion of the social care workforce in the refreshed Framework 15. Social care, however, did not receive an adequate settlement in the spending review, with the £5.4 billion over three years falling well short of the £7 billion annual increase we have previously recommended. Even after the spending review period, there is no guarantee of additional funding from the Health and Social Care Levy, so we remain very concerned that social care will remain the poor relation. Without the right support for social care, a recovery plan for the NHS is doomed to failure.**

113. ***In light of the Government's commitment to reform social care, we again recommend that it publishes a ten-year plan for social care, setting out how it in detail how it will tackle the structural and financial problems the sector faces in the short-term, and operationalise its longer-term ambitions. The Government must also acknowledge the needs and wellbeing of staff working in the social care sector by publishing a People Plan for social care, aligned to the ambitions set out in the NHS People Plan.***

171 NHS Confederation (CBP0057)
172 Q181
173 Q220
174 Q139
175 Department of Health and Social Care, People at the Heart of Care: adult social care reform, 1 December 2021
176 Rethink Mental Illness (CBP0085)

114. ***To encourage better integration and mutual understanding across health and social care, we again recommend that a duty is placed on ICSs so that where a decision by an ICS affects carers and the social care sector, the ICS must undertake a formal consultation with the groups and sectors affected.***

Technology

115. Dr Andrew Goddard of the Royal College of Physicians said that the pandemic had provided "lots of opportunities to transform", but highlighted that IT architecture in particular posed challenges for innovation:

> We want to improve practice, but there is the IT. If I lose my job, it is most likely because I am going to throw my computer out of the window, given the amount of time that doctors, nurses and other healthcare professionals waste waiting for IT to work, or for systems to talk to each other so that I know what is happening in my ED. Primary care and secondary care can easily communicate. That is where innovation really needs to happen. An effective IT system throughout the NHS and social care would work wonders.[177]

116. We welcome the Spending Review commitments of £2.1bn in technology and data and believe it is a step in the right direction. We note the publication of the Wade-Gery report on 23 November and agree with its finding that "now is the moment to put data, digital and technology at the heart of how we transform health services for the benefit of citizens, patients and NHS staff."[178]

117. We urge the Government to use the Wade-Gery report as a platform to make further progress on the digitalisation of NHS and care services. As Amanda Pritchard, CEO of NHS England, pointed out "about a fifth of trusts in the NHS are still largely paper based."[179] This is not acceptable.

118. **There is enormous potential for technology to support a transformation in NHS care that will bring benefits for patients and staff alike. However, this potential will not be realised while many providers still struggle with basic IT infrastructure. The Wade-Gery report calls for a roadmap for the delivery of its recommendations.**

119. ***NHS England must produce its roadmap in response to the Wade-Gery report on Putting data, digital and tech at the heart of transforming the NHS at the earliest opportunity so that we and others are able to scrutinise it ahead of implementation.***

177 Q50
178 Department of Health and Social Care, Putting data, digital and tech at the heart of transforming the NHS, 23 November 2021
179 Q185

Leadership

120. The importance of strong leadership both at local level and systems level has been reiterated throughout the inquiry. Anita Charlesworth of the Health Foundation noted that

> We need to allow local leaders to act, with proper support and skills, and to work out in their area how to make that happen safely and at the appropriate pace. There just is not one answer across the country. Part of what we have done too often is treat the NHS and the people of this country as if they are all uniform. They are not. Context will be so very different. What to prioritise will need to be very different.[180]

121. In October 2021, the Secretary of State announced that he had asked Sir Gordon Messenger to lead a review of leadership and management in health and social care, partly in the context of growing backlogs. On 23 November, the terms of reference for the leadership review were published. The review aims to report back to the Secretary of State after four months and will be followed by a delivery plan with clear timelines on implementing agreed recommendations.[181]

122. The drive for accountability and leadership in clearing the backlog was underlined further by the announcement that the Government's integration White Paper may propose that one person be accountable for planning health and social care services in each local area.[182] We welcome the Government's intention to focus on effective leadership as a tool in effectively clearing the backlog and await the results of the Messenger Review with interest.

Integrated practice and care

123. The role of integrated practice and care, and innovative models to achieve this, was highlighted during the inquiry. Dr Melissa Heightman stated that "a good long COVID pathway provides us with quite an exciting opportunity" to work

> across organisational boundaries to achieve integrated care. I think that is something that we are striving to do in other long-term conditions. This is like a blank canvas; we could try to do it better than we have done before.[183]

124. Examples of innovative service and integrated care will be core to effectively tackling the backlog. The upcoming deadline for ICSs to have a legislative basis in March 2022 will be an opportunity to truly integrate health and social care, while providing a platform for innovative practice. In our report on the Health and Care White Paper,[184] we called for a core duty on ICSs to have regard to public health and mental health. We believe that this truly integrated approach will remain crucial as the NHS seeks to clear the backlog and deliver care in new ways.

180 Q64
181 Department of Health and Social Care, Review of health and social care leadership in England, 23 November 2021
182 Health Service Journal, Government considering single leader for local NHS and care services, 24 November 2021
183 Q102
184 Health and Social Care Committee, First Report of Session 2021–22, The Government's White Paper proposals for the reform of Health and Social Care, HC 20, para 128

125. **The upcoming national introduction of ICBs provides the opportunity for local integration and innovation. This opportunity must not be wasted, particularly in the context of the backlog. There must be clear incentives for ICBs to deliver integrated and innovative care, with ICSs held accountable for the care they deliver.**

126. ***We have previously recommended that Care Quality Commission ratings include an assessment of the progress ICBs make on the integration of information technology between primary care, secondary care, and the social care sector. We repeat this recommendation here. Although the CQC is an independent body, we believe that including the delivery of integrated care and the effective use of technology within the domains it inspects would encourage further progress on integration.***

127. ***We recommend the Government creates a platform to share examples of good practice and innovation at ICB level so that lessons can be learnt, and practices adapted in ways that reflect the health needs of local areas. Without this, the risk of regional inequalities in waiting lists and postcode lotteries will continue.***

128. ***We again recommend that a duty be placed on ICBs for them to have regard to mental health and public health.***

129. Our key new recommendation is that, by April 2022, the Department of Health and Social Care works with NHS England to produce a broader national health and care recovery plan that goes beyond the elective backlog to emergency care, mental health, primary care, community care and social care. It should be sensitive to the needs of local populations, incorporate the plans already announced in the ten-year plan, and explain how they will be delivered by the new ICSs. That plan must also set out a clear vision for what 'success' in tackling the backlog will look like to patients. In setting those metrics for success, the plan must take account of the risk that a reliance on numerical targets alone will deprioritise key services and risk patient safety. Instead, it must embrace a range of indicators to demonstrate that hidden backlogs are also being tackled and compassionate cultures encouraged.

130. Tackling the backlog caused by the pandemic presents a major—if unquantifiable—challenge. There is potential for that challenge to catalyse service transformation. The evidence suggests that an effective response needs a coherent plan, taking into account key factors such as workforce planning and interdependencies with social care. Without that plan, the Government risks squandering this opportunity.

Conclusions and recommendations

Scale and impact of the backlog

1. *Our key new recommendation is that, by April 2022, the Department of Health and Social Care works with NHS England to produce a broader national health and care recovery plan that goes beyond the elective backlog to emergency care, mental health, primary care, community care and social care. It should be sensitive to the needs of local populations, incorporate the plans already announced in the ten-year plan, and explain how they will be delivered by the new Integrated Care Boards (ICBs). That plan must also set out a clear vision for what 'success' in tackling the backlog will look like to patients. In setting those metrics for success, the plan must take account of the risk that a reliance on numerical targets alone will deprioritise key services and risk patient safety. Instead, it must embrace a range of indicators to demonstrate that hidden backlogs are also being tackled and compassionate cultures encouraged.* (Paragraph 12)

2. It is not appropriate to set a numerical target for the proportion of appointments carried out remotely in general practice. Instead practices should respond to the needs of their local populations and work together with patients to establish the most fitting medium for their consultations based on clinical outcomes. Remote care is not for everyone, and it is essential to avoid unintended clinical consequences that may occur. (Paragraph 43)

3. *NHS England has already commissioned an evaluation of the role of digital tools in primary care. We recommend that it publishes that evaluation at the earliest opportunity and uses it as a basis to produce clear and consistent guidance on best practice in*

    - *Reducing bureaucracy and day-to-day IT administration tasks, including those associated with referrals, routine blood tests, and follow-up appointments.*

    - *The use of remote consultations in general practice. This should include guidance on how to approach conversations with patients about remote care, considering that while patients may not necessarily always be able to have a face-to-face appointment, they should have input into the decision and the rationale for any refusal should be transparent and consistent.* (Paragraph 44)

4. We further recommend that NHS England looks beyond primary care in its assessment of the use of digital tools and considers the impact of an increased usage of such tools not only on patients, but also on other parts of the health and care system, especially at the primary care and secondary care interface (Paragraph 45)

5. Managed well, we see enormous potential for a beefed-up version of 111 to regulate the demands on emergency departments and ensure that patients get the right care, in the right place, at the right time. However, we acknowledge concerns that without sufficient clinical validation these objectives cannot be met. Without robust evidence from the evaluation of the pilot so far, we cannot judge its success

or suggest improvements. We are already part of the way through a challenging winter—if findings are not available soon, NHS England risks missing opportunities to improve services at this crucial time. (Paragraph 53)

6. *We therefore recommend that NHS England completes and publishes evaluations of NHS 111 call first services as soon as is practicable, including learning from those evaluations and the implications for any future iterations of the service.* (Paragraph 54)

7. The response to long covid shows both the kind of integrated, patient-centred care the NHS can provide when systems work effectively, and the frustration and detriment experienced by patients who have to "fight" to access to the right care when systems do not work effectively. We heard that long covid provided an opportunity to develop truly integrated services, and that care—although variable—was excellent in the best centres. We welcome NHS England's commitment to provide effective long covid services. However, during our inquiry we heard heart-rending testimony from people who had struggled to access the care they needed, and who did not feel believed or cared for. This is simply not acceptable. We note that NHS England's current plan for long covid extends to 2022. With covid-19 set to become endemic, NHS England must ensure that its plans to tackle long covid continue. We understand that knowledge of covid-19 and long covid is constantly evolving, and that plans will therefore need to adapt over time, but we are likely to see increasing numbers of people living with this condition. We cannot afford to let them down. (Paragraph 60)

8. *We therefore recommend that NHS England publishes, before the end of this financial year, a long covid plan covering the period until 2023. The plan must be developed in consultation with a wide range of stakeholders, including patient groups. NHS England should integrate this into its wider health and care recovery plan, as long covid is likely to have implications for demand and workforce across a range of services.* (Paragraph 61)

9. It is not acceptable for patients awaiting planned treatment or feeling the debilitating effects of long covid to feel "abandoned" by the NHS. We appreciate the uncertainty about the length of future waiting lists, but this is no excuse for lack of communication—whether this be confirmation of a patient's next round of treatment or simply a conversation to assure them that they have not been forgotten. We heard that waiting lists are not static, that conditions can worsen, and that active management is recommended. A commitment to keeping in touch would not just benefit individual patients, but also help local systems actively to manage their lists and inform decisions about prioritisation. (Paragraph 65)

10. *The national health and care recovery plan must set out a clear vision for what 'success' in tackling the backlog will look like, and what patients can expect their care to look like in their local area in the coming years. The plan must include minimum expectations for ICBs in managing waiting lists actively and communicating with patients awaiting planned care. The Department of Health and Social Care, NHS England and local ICBs must share responsibility for communicating the 'offer' to the wider public, considering the "social backlog" facing many members of the public. We request the Department of Health and Social Care to report back to us on how this will be delivered.* (Paragraph 66)

11. Lastly, we heard that patient involvement in services was important to tackle long covid. It should also be taking place in other areas. We have previously called for the Care Quality Commission's assessments of Integrated Care Systems (ICSs) to include consultation with patient groups and patient outcomes, and we continue to believe in the importance of this. (Paragraph 67)

12. *We again recommend that the Care Quality Commission includes consultation with patient groups and details of patient outcomes in its assessment of ICSs.* (Paragraph 68)

Funding and policies to tackle the backlog

13. The pandemic has had a negative impact on health inequalities and highlighted the crucial importance of effective public health services in supporting local populations. Public health services are therefore vital allies in tackling the backlog, and we are surprised at the decision merely to maintain current public health grant funding levels. (Paragraph 79)

14. *As part of its national health and care recovery plan, we recommend that the Government sets out the contribution that public health services will make, and ensures that this contribution is backed with a level of funding that acknowledges their crucial role.* (Paragraph 80)

15. We note that the Government decided to resist an amendment to the Health and Care Bill that would have required it to publish independently verified assessment of health, social care and public health workforce numbers at least once every two years, leaving a gap between its rhetoric about supporting frontline staff and the biggest single long-term measure that would relieve that pressure. Without an independent forecast of future workforce needs, it remains impossible for anyone to know whether enough doctors, nurses or care staff are being trained. We still believe that giving an assurance to NHS staff that the appropriate number of new staff will be trained in the future is the biggest single long-term measure the Government can take to gain the confidence of frontline staff that it has a grip of this problem. Unless it can do that, the risk is that generous taxpayer-funded settlements for services or capital are wasted. (Paragraph 92)

16. *We repeat our recommendation that HEE must be required (whether in its own right or as part of NHS England) to publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years, including an assessment of whether sufficient numbers of staff are being trained. These projections must cover social care as well as the NHS given the close links between the two systems. We urge NHS England to ensure that workforce planning is included in any future iterations of the elective recovery plan.* (Paragraph 93)

17. *We recommend that the Government undertake an urgent review of short-term recruitment and retention issues within the health and care workforce, including productivity improvements, sharing of best practice through data, removal of professional demarcation, use of technology, additional training places and additional immigration measures. This should be published before the arrival of the funding due in early 2022.* (Paragraph 94)

18. Investing resource in our health and care workforce will ultimately save money—for example through reduced locum and agency fees over time—and help build a better, safer health service. It will also give hope to staff—who are feeling increasing desperate and who face yet more challenges on top of those posed by the early phases of the pandemic. (Paragraph 95)

19. *We call on NHS England to demonstrate its ongoing commitment to staff wellbeing by publishing a refreshed People Plan to cover the financial year 2022/23 as soon as is practicable.* (Paragraph 96)

20. An NHS running too 'hot' for patients to move from crowded emergency departments into wards cannot provide safe, efficient or effective care in the long-term. Furthermore, the advent of ICSs offers an opportunity to provide patients with more integrated care so that they can leave hospital promptly once medically fit. (Paragraph 98)

21. *As part of its broader health and care recovery plan, the Government must produce an independently-verified analysis of how many, and what type, of extra beds the NHS needs in order to provide safe and effective everyday care for patients, whilst also responding to need directly created by the pandemic. This plan must be accompanied by sustainable, long-term plans to tackle delayed discharges.* (Paragraph 99)

22. We welcome the £2.3bn pledged in the Spending Review to create around 100 new community diagnostic hubs, but we are yet to see detailed plans for their implementation. (Paragraph 102)

23. *Ahead of the arrival of the new funding from the Spending Review in Spring 2022, we recommend that Government provides more details on the 100 new community diagnostic hubs, including where they will be placed, who will staff them and how they will contribute to service improvement within and beyond the covid-19 landscape.* (Paragraph 103)

24. Access to care should not be dependent on where you live in the country. Regional and national co-ordination will be necessary to ensure that strategies aimed at tackling the backlog do not have the unintended consequence of increasing health inequalities. (Paragraph 105)

25. *We recommend that NHS England, together with ICBs and the new Office for Health Improvement and Disparities (OHID), work together to deliver regional and national coordination as the system tackles the backlog in elective care. If the independent sector is to prove an effective partner in tackling that backlog, the Government must ensure that plans take into account people living in those areas with less access to independent care. The goal must be equity of access to care on waiting lists regardless of geographic location.* (Paragraph 106)

26. We have heard much about how a robust social care system that can support hospital discharges and free up capacity is essential to clear the backlog. We welcome the inclusion of the social care workforce in the refreshed Framework 15. Social care, however, did not receive an adequate settlement in the spending review, with the £5.4 billion over three years falling well short of the £7 billion annual increase we have previously recommended. Even after the spending review period, there

is no guarantee of additional funding from the Health and Social Care Levy, so we remain very concerned that social care will remain the poor relation. Without the right support for social care, a recovery plan for the NHS is doomed to failure. (Paragraph 112)

27. *In light of the Government's commitment to reform social care, we again recommend that it publishes a ten-year plan for social care, setting out how it in detail how it will tackle the structural and financial problems the sector faces in the short-term, and operationalise its longer-term ambitions. The Government must also acknowledge the needs and wellbeing of staff working in the social care sector by publishing a People Plan for social care, aligned to the ambitions set out in the NHS People Plan.* (Paragraph 113)

28. *To encourage better integration and mutual understanding across health and social care, we again recommend that a duty is placed on ICSs so that where a decision by an ICS affects carers and the social care sector, the ICS must undertake a formal consultation with the groups and sectors affected.* (Paragraph 114)

29. There is enormous potential for technology to support a transformation in NHS care that will bring benefits for patients and staff alike. However, this potential will not be realised while many providers still struggle with basic IT infrastructure. The Wade-Gery report calls for a roadmap for the delivery of its recommendations. (Paragraph 118)

30. *NHS England must produce its roadmap in response to the Wade-Gery report on Putting data, digital and tech at the heart of transforming the NHS at the earliest opportunity so that we and others are able to scrutinise it ahead of implementation.* (Paragraph 119)

31. The upcoming national introduction of ICBs provides the opportunity for local integration and innovation. This opportunity must not be wasted, particularly in the context of the backlog. There must be clear incentives for ICBs to deliver integrated and innovative care, with ICSs held accountable for the care they deliver. (Paragraph 125)

32. *We have previously recommended that Care Quality Commission ratings include an assessment of the progress ICBs make on the integration of information technology between primary care, secondary care, and the social care sector. We repeat this recommendation here. Although the CQC is an independent body, we believe that including the delivery of integrated care and the effective use of technology within the domains it inspects would encourage further progress on integration.* (Paragraph 126)

33. *We recommend the Government creates a platform to share examples of good practice and innovation at ICB level so that lessons can be learnt, and practices adapted in ways that reflect the health needs of local areas. Without this, the risk of regional inequalities in waiting lists and postcode lotteries will continue.* (Paragraph 127)

34. *We again recommend that a duty be placed on ICBs for them to have regard to mental health and public health.* (Paragraph 128)

Formal minutes

Tuesday 7 December 2021

Members present:

Jeremy Hunt, in the Chair

Paul Bristow

Dr Luke Evans

Barbara Keeley

Taiwo Owatemi

Dean Russell

Laura Trott

Draft Report (*Clearing the backlog caused by the pandemic*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Executive summary agreed to.

Paragraphs 1 to 130 agreed to.

Resolved, That the Report be the Ninth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 15 December 2021 at 4.15 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 07 September 2021

James Wilkinson, expert by experience; **Shirley Cochrane, expert by experience** Q1–20

Professor Neil Mortensen, President, Royal College of Surgeons of England; **Dr Andrew Goddard**, President, Royal College of Physicians; **Dr Katherine Henderson**, President, Royal College of Emergency Medicine; **Anita Charlesworth**, Director, Research and REAL Centre, the Health Foundation Q21–65

Tuesday 21 September 2021

Helen Lunt Davies, Expert by experience; **Lere Fisher, Expert by experience** Q66–84

Dr Adrian James, President, The Royal College of Psychiatrists; **Professor Martin Marshall CBE**, Chair, Royal College of General Practitioners; **Ondine Sherwood**, Co-Founder, LongCovidSOS; **Dr Melissa Heightman**, Clinical lead, Post-COVID assessment service, University College London Hospitals NHS Foundation Trust Q85–138

Tuesday 19 October 2021

Ben Zaranko, Research Economist, Institute for Fiscal Studies; **Siva Anandaciva**, Chief Analyst, The King's Fund; **Sarah Lambrechts, Expert by experience** Q139–160

Amanda Pritchard, Chief Executive, NHS England; **Professor Stephen Powis**, National Medical Director, NHS England Q161–197

Tuesday 02 November 2021

Rt Hon Sajid Javid MP, Secretary of State, Department of Health and Social Care Q198–276

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

CBP numbers are generated by the evidence processing system and so may not be complete.

1 #CatchUpWithCancer campaign; and Action Radiotherapy (CBP0073)

2 Professor Alan Champneys (Professor of Applied Nonlinear Mathematics , University of Bristol); and Professor Christine Currie (Professor of Operational Research, Univeristy of Southampton) (CBP0074)

3 AMRC (CBP0075)

4 Alzheimer's Research UK (CBP0083)

5 Alzheimer's Society (CBP0026)

6 Association of Anaesthetists (CBP0067)

7 Association of British HealthTech Industries (CBP0030)

8 Association of Dental Groups (CBP0014)

9 Association of Medical Insurers and Intermediaries (AMII) (CBP0002)

10 Asthma UK and the British Lung Foundation (CBP0033)

11 Bartholomew, Mr Leonard (Retired health care planner/architect, n/a) (CBP0060)

12 Breast Cancer Now (CBP0080)

13 British Dental Association (CBP0034)

14 British Heart Foundation (CBP0081)

15 British Orthopaedic Association (CBP0008)

16 Cancer Research UK (CBP0051)

17 Cancer52 (CBP0045)

18 Centre for Perioperative Care (CBP0032)

19 Crohn's & Colitis UK (CBP0076)

20 Department of Health and Social Care (CBP0087)

21 Diabetes UK (CBP0042)

22 Digital Healthcare Council (CBP0043)

23 Edwards Lifesciences (CBP0039)

24 Endometriosis UK (CBP0049)

25 Faculty of Dental Surgery at the Royal College of Surgeons of England (CBP0022)

26 Faculty of Pain Medicine of the Royal College of Anaesthetists (CBP0046)

27 GRANTHA NEER; and National Health Action Party (CBP0003)

28 Galen (CBP0044)

29 Glaukos (CBP0041)

30 Guardant Health (CBP0054)

31 Health Tech Alliance (CBP0018)

32 Heart Valve Voice (CBP0029)

33 Independent Age (CBP0063)
34 Independent Healthcare Providers Network (IHPN) (CBP0024)
35 Janssen (CBP0050)
36 Knight, Mr Richard (Head of Policy, Local Optical Committee Support Unit) (CBP0052)
37 LongCovidSOS (CBP0069)
38 LongCovidSoS, (CBP0089)
39 MS Society (CBP0092)
40 MSD (CBP0068)
41 Macmillan Cancer Support (CBP0047)
42 Medical Technology Group (CBP0053)
43 Morgan, Samantha (Consultant Nurse, Mesothelioma UK) (CBP0084)
44 Myeloma UK (CBP0006)
45 NHS Confederation (CBP0057)
46 NHS Confederation (CBP0058)
47 NHS Providers (CBP0027)
48 National Physical Laboratory (NPL) (CBP0059)
49 National Voices (CBP0088)
50 Novo Nordisk (CBP0072)
51 Nuffield Health (CBP0028)
52 Paediatric Continence Forum (CBP0038)
53 Parkinson's UK (CBP0020)
54 Patient Experience Library (CBP0004)
55 Philips UKI (CBP0064)
56 Policy Connect (CBP0093)
57 Policy Exchange (CBP0040)
58 Ramsay Health Care UK (CBP0031)
59 Rethink Mental Illness (CBP0085)
60 Roche Products Ltd (CBP0061)
61 Royal College of Anaesthetists (CBP0017)
62 Royal College of Emergency Medicine (CBP0007)
63 Royal College of General Practitioners (CBP0090)
64 Royal College of Nursing (CBP0086)
65 Royal College of Paediatrics and Child Health (RCPCH) (CBP0056)
66 Royal College of Physicians (CBP0001)
67 Royal College of Physicians and Surgeons of Glasgow (CBP0009)
68 Royal College of Surgeons of England (CBP0035)
69 Royal National Institute of Blind People (RNIB) (CBP0019)

70 Sanofi (CBP0065)

71 Spire Healthcare (CBP0015)

72 Strang, Dr. George (Retired Consultant Physician, Former employers: Dept. Of Health, Eastern Province, South Africa, Cwm Taf Health Board, Wales.) (CBP0023)

73 The Chartered Society of Physiotherapy (CBP0082)

74 The College of Optometrists (CBP0037)

75 The Company Chemists' Association (CBP0021)

76 The Faculty of Intensive Care Medicine (FICM) (CBP0012)

77 The Health Foundation (CBP0066)

78 The King's Fund (CBP0016)

79 The Neurological Alliance (CBP0062)

80 The Nuffield Trust (CBP0078)

81 The Royal College of Pathologists (CBP0011)

82 The Royal College of Psychiatrists (CBP0070)

83 The Royal College of Speech and Language Therapists (CBP0010)

84 University Hospitals of Leicester NHS Trust (CBP0005)

85 Urology Trade Association (CBP0048)

86 Versus Arthritis (CBP0036)

87 Virgin Care (CBP0013)

88 eConsult Health Limited (CBP0025)

89 Transcript of interview with Participant A (CBP0094)

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