London Assembly Health Committee - Thursday 13 January 2022

Transcript of Agenda Item 6 Panel 2 – The Indirect Effects of the Pandemic in London

Caroline Russell AM (Chair): Welcome to part two of the London Assembly Health Committee. We have Martin Machray [Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London] still with us, whom you have all been introduced to already, but I am also welcoming Dr Chaand Nagpaul, Chair of the Council of the British Medical Association (BMA); Siva Anandaciva, Chief Analyst, The King's Fund; and Emma Tingley, Head of Partnerships at Macmillan Cancer Support. Welcome to all our new guests.

In this part of the meeting, we are looking at the indirect health effects of the pandemic and in particular the impact on waiting times for elective and outpatient treatment. I am going to start with Martin Machray, who is, I believe, going to be leaving the meeting after he has given his input to this part. Martin, what is the scale of the problem in relation to diagnostic waiting times for cancer services and waiting times for treatment across London, and are there any specialisms or conditions that are particularly affected?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Thank you, Chair, and forgive me that I do have to leave at 12 pm but I thought it would be helpful to give you some data and context for the rest of the meeting.

As you quite rightly point out, there is a huge impact of the pandemic on those parts of the service that are not directly related to treating people with COVID-19. Just to make that in personal terms, what that means is the anaesthetist who has given their all in waves one, two and three in intensive therapy units (ITUs), looking after people who are severely ill or dying is then expected to be providing the anaesthetic support to major surgery at the same time. Of course, staff cannot do all things at all times. That is repeated at every level of the NHS, clinically with the general practitioners who make those referrals in the first place, right through to our porter staff and our catering staff who make our hospitals work. There is a massive impact.

The published data shows for London that our waiting list overall, which includes diagnostics, outpatients and waiting for surgery, has grown over the past 23 months disproportionately to the way it would normally grow seasonally. For London that meant that in the last published data, which was November [2021], there were just about 950,000 people waiting for one of those things in London. Some of those people had been waiting an inordinately long time.

Therefore, the thing we want to focus on most, is making sure that people who need urgent and life-saving surgery or treatment or diagnosis get that no matter where we are in the pandemic. I gave evidence previously to this Committee about how we failed after wave one and two of that. Now we see that the position in London has stabilised in some ways. Although the numbers are still very large for people waiting, we have continued to provide that urgent and emergency care for everyone who has needed it. If you are focusing particularly on elective care, that is people waiting for cancer surgery, for neurosurgery, for those things that save lives or stop lives being completely ruined, they have been continued.

We have been able to do that thanks to our staff, thanks to their resilience and their commitment to their patients but also because of the way we have reorganised some of our services to keep things COVID-free or

COVID-safe in some of those elective pathways, making sure that some surgical services are protected from the potential of cross-infection with COVID, and keeping what we call 'green pathways' clear. That is not always easy and in the last waves that has been increasingly stretched but we have been able to do that, which means that Londoners who needed that immediate care have had it.

It means that also people who are waiting for care that is not lifesaving have waited longer than they would normally, and those numbers are significant. People waiting over a year for an outpatient diagnostic or their surgery has grown now, and the last published data was just over 30,000 people in London who have waited over a year. The majority of those are not waiting for surgery. Given that scale of the numbers, that is still a significant number of people who are waiting for lifechanging treatment.

You can be very dismissive of some surgery and say that it is only varicose veins or only a bunion or whatever it might be, but that is lifechanging. If I cannot pick up my granddaughter because I have not had my surgery, it impacts not only on my life but on the lives of my family. I say that now as a grandfather who was a grandfather in wave one. I want to be able to look after my grandchild and if I cannot because I am waiting for surgery that is a massive impact on my life, but it is not lifesaving.

There are also a number of people waiting even longer and some of this is over two years now. Those numbers are very much smaller and the good news for Londoners is that those numbers, even though we have been in Omicron and this wave of the pandemic, have continued to come down. London as a region is starting to reduce those people waiting for an inordinately long time but that is not to dismiss the impact that has on people's lives.

Outpatients, again, has the same picture but the scale is larger, as you would imagine, and there is lots of work being done to change the way we do outpatients, but it is not black and white and either we will do it all virtually or we will not. This is horses for courses. One of the questions you asked, Chair, was around whether there are any specialties we are worried about. You have to take this specialty by specialty and person by person about what the right approach to caring for people is, particularly in outpatients. Some of our outpatient waiting times do not lend themselves to virtual consultations. They need physical consultations to do a diagnosis, to touch the patient, to listen to them and to actually see their expression on their face. It is so important. In other specialties, we have made great grounds in using digital technology to really speed up those processes.

The area that I am most concerned about is those people - and you may come on to it later - with the lumps, bumps and strange things that are happening to them that they really should get checked out that could become something lifechanging to the point of death. Those cancer symptoms do not hold back and, again, the message I gave in the previous session was that Londoners should not stop coming forward if they are concerned about their health. We are here to help them.

However, there is an enormous backlog we are dealing with. The good news is that London is dealing with it, not as quickly as I would like, but we are dealing with it now. I hope that is helpful, Chair.

Caroline Russell AM (Chair): Thank you. That is incredibly helpful and gives a context from an NHS perspective to frame our conversation. Martin, I am assuming that you are going to leave the meeting now. Thank you so much for your time this morning. It has been incredibly helpful.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): As always, thank you and stay safe. Thank you for your support.

Caroline Russell AM (Chair): And you. Thank you. I am going to move on now with a question both for Siva and for Emma. Both the direct and the indirect effects of the pandemic have not played out equally for all groups of the population. How have these inequalities shown themselves in terms of access to services and delays in diagnosis and treatment? Is this something that the Mayor could highlight given his remit to address health inequalities in London? Emma, would you like to start?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Yes, thank you, Chair. Just to give some of the context around the cancer numbers in terms of what that backlog is looking like for London, we know that there are about 4,500 fewer people who started cancer treatment between March 2020 and October 2021, which is a really significant number. Pre-pandemic somebody in London was diagnosed with cancer roughly every 15 minutes and we have around 230,000 people in the capital living with a diagnosis of cancer.

In terms of the numbers of people, around 70,000 fewer people than expected are seeing a specialist with a suspected cancer diagnosis. We know that not all of those people will go on to get a confirmed cancer diagnosis, but that is down by about 13%. Again, in terms of performance and that delay, we have around 84% of cancer patients seeing their first consultant appointment within two weeks of an urgent referral, which is down on where it was previously for London. We were hitting the national target of 93% in 2019.

In terms of the inequalities that we are seeing, in all of those measures, we know that people who are living in the most deprived areas see a larger drop-off across the board, in two-week wait referrals for suspected cancer, in new diagnoses and in first treatments. That is compared to the people who are living in the least deprived areas.

We do not have the full data at Macmillan Cancer Support just yet, but our early indications certainly show lots of different variations between different patient groups as well by tumour type. We are seeing more lung cancers and colorectal cancers and also some differences in gender and deprivation. We do not have the full data yet but that is what our early indicators are telling us.

Caroline Russell AM (Chair): Thank you. Siva, would you like to come in on that question as well?

Siva Anandaciva (Chief Analyst, The King's Fund): Thank you, Chair. The first thing I would say, at the risk of sounding obvious, is that different people have had different experiences of the pandemic. My simple message is that waiting lists are worse in more deprived parts of the country. By 'worse', I mean that waiting lists are growing faster in more deprived parts of the country, and that once you are on a waiting list you wait longer in more deprived parts of the country.

Colleagues at The King's Fund did some analysis of planned elective care against deprivation of local areas, and what they found looking at how waits had grown over the course of the pandemic was that waiting lists grew everywhere for the most part. Even in less deprived areas waiting lists were up by a third. When you look at the most deprived areas, waiting lists have gone up by 55%. These are not small numbers we are talking about. If you look at extremely long waits, waits that are over a year for planned elective care, again, people are waiting in less deprived parts of the country. Some 4% of people waiting for treatment have been waiting over a year in less deprived parts of the country. That rises to over 7% when you are in the more deprived parts of the country. It is a real problem that the Assembly has identified.

The second thing I would say is there are some bright spots and causes for hope. The first is that when we looked at the analysis there were some anomalies. There were some organisations in more deprived parts of the country that were demonstrating good performance on waiting lists. When you picked at why that was happening, you heard good stories about making every contact count. You had staff from the NHS going to foodbanks to reinforce that message, "We are open for business. What are your health needs? Please come and see us." You also saw them putting in more capacity targeted at communities and more communication targeted at communities who were not using services in the way or as much as we would have hoped.

The second bright spot is that I can honestly say [in] my policy career I have never seen as strong a national focus within the NHS on understanding the different experiences and health inequalities of people on waiting lists. It is something that I had seen done in pockets but never with this strong national focus on really understanding what your waiting list looks like in terms of deprivation.

The third and final thing I will say in answer to the second part of your question over whether there is something that the Mayor and the Assembly can do, absolutely, not just in a generic sense of more focus on the issue being a good thing. When you look at some of the wider determinants of health, some of the things that make us healthier, it goes beyond access to services. When you look at some of the barriers that prevent people accessing services, it is more than choice of appointment. It is whether you can have childcare arrangements, whether you can have support, whether you are allowed to leave your employment to attend an appointment during office hours. Having the Mayor and the Assembly focus on the wider population and the things that matter to people will be absolutely essential because this is not something that the NHS can do by itself if it is going to successfully tackle health inequalities.

Caroline Russell AM (Chair): That is very powerful. You say that there is making every contact count, which is a different approach to thinking about, if you are working in healthcare, how you are engaging with people so that there is more chance that you are going to pick up issues that people need to get help with. Is that what you mean by making every contact count?

Siva Anandaciva (Chief Analyst, The King's Fund): Yes, Chair. Part of the issue is absolutely making sure you have the supply and capacity available so that services are operating when people need them, but that is just not going far enough. In a lot of the places, we have spoken to both within this country and internationally, the sense I get is of proactivity. The best phrase I heard was from someone who works in the Bronx in New York. He said, if you really want to serve your most deprived and most needy populations, you have to go out and find them. There is much more focus on going into communities and understanding their needs rather than saying, "We are open for business. Come and use us if you need to."

Caroline Russell AM (Chair): That is a bit like what the NHS has been doing around the vaccine rollout and the tackling vaccine hesitancy. Martin was talking, in the first section of our meeting, about being in and of the community to try to get the messages across rather than having a paternalistic, top-down healthcare approach. That is very helpful.

Is there anything else that either of you two want to say before I move on to Emma [Best AM], who is taking on the next question, in particular about the inequality side and either good things that have come out of the pandemic approach, or challenges that have come through that particularly relate to inequalities? Emma?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Certainly, in personalised cancer care and how we meet people's needs not just beyond diagnosis, there has been a really positive focus on inequalities over the last 12 months. It is the first time since I have been in this

role over the last four years that we have had a pan-London personalised care cancer inequalities board really focusing in on this. There are some definite positives that are happening, yes.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): On this issue, I just wanted to say that a lot of effort has been made but we still are suffering huge inequalities when you look at the data around intensive care. You still have such a stark disparity with three times more likelihood of being in intensive care if you are from a deprived social class 5 compared to social class 1. That is recent data. Similarly, in terms of ethnicity, you have all been aware how much the pandemic shook us all when we saw the disproportionate impact on ill health and death. In intensive care now, again, you carry on seeing that disparity of disproportionate numbers of ethnic minorities in intensive care, especially those of a black background. That of course also then leads into the other debate around vaccination and the levels of uptake among some communities. I know this is about waiting lists, but all of this does impact on the health service. On those inequalities we are making a lot of effort, but we really do need to do better collectively.

Caroline Russell AM (Chair): Thank you. Siva?

Siva Anandaciva (Chief Analyst, The King's Fund): I have two final brief points from me. The first is there is a lot of changes going on to how health and care is delivered in this country. In the near term, having an eye on how those changes are impacting different people across the health and equality spectrum will be incredibly important.

To pick two examples, a lot more care is being delivered digitally rather than face-to-face, and there are plans to change how outpatient care is accessed as well. Rather than a routine follow-up appointment, there is more choice for the patient over how and when they access services. Both of those can be absolutely key innovations and help the NHS. Both of those also need to have appropriate safety-netting and monitoring to make sure we are not losing people out of the system, particularly people from lower-income or more deprived populations.

The second thing is, hand on heart, genuinely, there has been more focus on understanding waiting lists and the relationship with deprivation than at any other point in my career but, at the same time, it is still in that mode of trying to understand what is going on and what the relationship is. We are not yet at the point where the rubber has hit the road and how are we going to use that information to change how we deliver services. There are some really knotty issues that will be coming up in the future. For example, where you have two patients of equal clinical need and they come from different backgrounds, could deprivation be used as prioritisation criteria? That is a huge topic to unpack. We have a near-term need to focus on changes to how health and care is delivered but there are some longer-term, almost medical-ethical issues to consider as well, both of which the Assembly can bring a helpful focus to.

Caroline Russell AM (Chair): The medical-ethical challenges of that are flashing through my mind, but I wanted to pick up on the digital point that you just made. I have found it really convenient having my GP now working much more digitally and sending me text messages with appointments and a link to click to be able to change the appointment. That makes communication with my healthcare provider much easier. I have a smartphone. I can click the link. I can change my appointment. I have older constituents who do not have smartphones or who have very basic phones that can receive text messages from the NHS but do not connect to the internet. The challenge of a digital exclusion, which also relates to deprivation, is clearly something that needs to be kept at the forefront because, if we end up with everything being digital, then there is a huge number of people who fall out at the bottom.

I am going to bring in Assembly Member Best here, who is going to be asking the next question.

Emma Best AM (Deputy Chairman): Thanks, Chair. It is incredibly depressing with the highlighting of those cancer figures and those misdiagnoses and late treatments. The NHS and charities such as Macmillan are world-leading really in our support in the UK for cancer sufferers. I know everybody will have a case that is close to them or even more personal where the NHS and Macmillan have been there. We have a long way to come back from where we now are.

My question is for Dr Nagpaul. What is your assessment of NHS staff resilience to deal with this growing backlog for treatment and diagnosis, and what measures should or have been put in place that you have seen to deal with this and cope?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Thank you. I am also a GP and I represent doctors across the United Kingdom (UK). I am a GP in London and so I have a London perspective.

It is just important to remind ourselves - and I am not trying to sound negative - that when we went into the pandemic in January 2020, we actually at that time had record waits in the NHS. We had actually the longest waits for cancer treatment. We had problems prior to the pandemic that have just been exacerbated during the pandemic.

In fact, when we talk about waiting lists, the scale of wait is much higher than the figures suggest. We talk about 6 million patients nationally waiting for treatment, in London 870,000, but in actual fact, that is only for elective planned care. Our own estimates have shown that 26.8 million fewer outpatient appointments took place during the pandemic from March 2020 to October 2021. All of those patients are also waiting. They may not be waiting for an operation, but they are waiting to see a specialist with regards to an abdominal problem, a specialist regarding a neurological issue and so forth. In fact, the burden of waiting and illness that is not being dealt with is much bigger than simply looking at crude figures around operation waits.

That is actually quite a challenge for us in the health service for those of us who provide care because our own surveys show that there is a sense of wondering if there is going to be an end in sight and that we hope we are getting over a pandemic and we have this huge, accumulated backlog that we have never faced before. What that has meant for the workforce is that many are planning to leave, and in fact our stats show about a third of doctors are saying that they want to retire in the next three years. Many have limited the amount of work they are doing already to try to protect themselves.

There is something called moral injury that we are describing in the BMA (British Medical Association), which is when doctors - and this applies to all healthcare workers - cannot do their best for patients and feel quite morally injured that they are not able to do the right thing for patients. This applies both in general practice but also in hospital services. We are seeing patients waiting now at record levels for more than 12 hours being unable to admit them or being a doctor or a healthcare professional knowing that there is an ambulance outside unable to admit the patient and the patient may be deteriorating or knowing that patients are now waiting 40 minutes for category 2 ambulances - and that is a London statistic - when they have a suspected stroke. There is this moral injury, this fatigue and also the very real fact that we have been working for nearly 23 months. Of course, we have worked throughout lockdowns, we have not stayed at home and it has been a very gruelling time for the profession.

That sounds really challenging. What needs to be done? First of all, it is really important to start with the workforce because the NHS really is nothing without its workforce. At the moment we know how important

the workforce is with the absence figure of around 10,000 staff absent in London on a daily basis due to Omicron. We know that staffing is vital. What we need to do first and foremost is make sure that the workforce is looked after, that it is valued and that in fact when people go to work there are simple things like making sure they have adequate rest breaks and that they can have food. Those little things cannot be taken for granted. There is no hot food provision for thousands of doctors and healthcare workers when they are doing overnight shifts, for example. Valuing your workforce and making sure that they are looked after is important.

The second is making sure that they are protected. We are still in an environment of a highly infectious virus and we know that spread occurs in healthcare settings. We are calling for much better levels of infection control. You will need that if you want the workforce to be able to deliver care. There are no clear specifications on ventilation in hospitals. There is no routine carbon dioxide (CO_2) monitoring. That sort of thing should be done. In terms of masks, it does not make sense that we are using masks that do not filtrate viruses for large numbers of healthcare workers when they are seeing people who are infected. We do not know whether they are getting infected as a result of their work. Those sorts of things need to happen.

We need to also - and this was said previously when I caught the tail end of the previous discussion - make sure that we are efficient. At the moment, there is a huge amount of bureaucratic work that is going on because when patients are on waiting lists they are actually coming to their GP and asking them questions around, "When will I be seen? Can you expedite my appointment? I have not heard. I tried calling but I do not know. I was told I would be treated in three months. It is now four months. I still have not heard". All of those are taking up GP appointments and that really should be avoided. We should have some sort of helpline, so people know where they are in the queue. It should not be wasting clinical time because that is reducing access for other people.

Other measures around the interface between hospitals and general practice could be much more efficient such as reducing the number of patients who need to see a GP to get a prescription. That should be electronically possible through an outpatient appointment where the patient can go to collect the prescription at their local pharmacy. Similarly, for diagnostics, too many appointments are being wasted and of course that means that patients themselves also are inconvenienced in going to see two healthcare professionals when all of this could be done in one visit.

The role of technology is important. I really would urge that we do not get into a binary debate around whether face-to-face is better than remote. They both have a place and, in fact, the more efficiently you use both, the better your access will be. Also, we should not be too simplistic around which categories of people may not be able to use digital technology. I have been very surprised at some people. Many of our older population have been amazing at using technology. Some of it is also about resourcing people to have the right technology. It should not be an excuse that you do not have a smartphone. There should be investment in that.

We have also learned a lot in the pandemic around how we can make better use of healthcare staff time through self-empowerment. Things like, for example, patients routinely now being able to measure their blood pressures and sending information to their GP practice has reduced not just GP time, but it has empowered patients. There is something to be looked at in that regard.

Ultimately, as a GP, I would want to reiterate that anyone who needs to be seen face-to-face - and that is when we feel they need to be seen face-to-face as well - should be seen face to face but we need to do this in a much more intelligent manner as well.

Finally, of course, we know that vaccinations will protect staff and so that also needs to happen. I hope that has given you a picture.

Sorry, just one more thing about diagnostics, which you mentioned earlier. People forget that the waits for diagnostics also result in delays in cancer treatment or other diagnoses. In fact, at the moment 26.1% of patients wait more than six weeks for a diagnostic test. The national target is 1%. Before the pandemic, 3.8% of people waited more than six weeks for a diagnostic test. We now have huge delays in diagnostic waits, which also impact on diagnosis of serious illness.

Emma Best AM (Deputy Chairman): Thanks so much. You mentioned there the morale of staff quite heavily. One of the issues I have found talking to nurses and frontline staff is their issue in actually getting to work. We have known for some time the difficulty with parking at hospitals and that sort of thing but now there is the added stress with the Night Tube still not running for shift workers. Do you think there is a push here really from the NHS that the sooner we can get the Night Tube up and running in full, it will help with our staff who need to get to and from work?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Yes. This goes back to valuing your workforce. What needs to be happening much more amongst managers and in fact in terms of those who are responsible for running our health services, is to always think from the perspective of those who provide care. What are their obstacles and what are the issues that affect them? That is how you will have a workforce that will feel valued. Getting to work is critically an important part of that. If they cannot, then there are other ways to get to work that should be supported.

A small thing that we have mentioned for a long time as the BMA, is that it seems a little perverse when a member of staff has to come into work and pay more for carparking charges in their hospital than perhaps the charge on the road outside. There is that sense of feeling devalued and that you are not even being given the provision to come to work and park your car. It would be a small investment to give people the ability to park without feeling perhaps ripped off in that charge. I mention again about when you come into work making sure you have the right facilities to feel supported and rested and looked after.

Emma Best AM (Deputy Chairman): Thank you. I absolutely could not agree more with that point as well.

Finally, one of the big resilience issues is going to be the vacancies that we see. The Mayor launched the Mayor's Academies Programme, which allowed people to make bids to help people get into good work. One of the areas that focused on was health and social care. I wondered whether you or perhaps any member of the panel had interacted with that fund at all.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): I have not personally interacted or known about it directly in my line of work, but I would be very interested to know what others may say. It seems a very good idea.

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): I just wanted to build on a couple of points that have been made there, particularly around the impact on the workforce.

One of the things that the backlog is presenting in cancer and what we are seeing is that people when they get to the diagnosis point are coming in with a much more advanced and complex disease and are entering the

pathway at different points. Many more people may be diagnosed and then go straight into a palliative care or end-of-life care pathway, sadly. That is having an impact on the cancer nursing workforce and the cancer workforce in general. There is lots about resilience but, even pre-pandemic, the workforce was quite fragile and did not have much of that bandwidth for dealing with all this additional work that is coming in.

What we are calling for at Macmillan is really a fully funded workforce strategy. We know we are across the UK at least 3,000 cancer nurses short. Also, what we are doing is looking at the skills mix that is needed to work for people with cancer. We heard from Dr Nagpaul around a lot of people phoning their GPs for some of those administrative questions. One of the things we are doing in cancer is putting in navigator roles and support worker roles because we realise that when you get a cancer diagnosis, it sometimes can become a full-time job just navigating through the system with all the different appointments that you are getting. Cancer – just like many health conditions – is not just a medical diagnosis. It has an impact on your finances, on your mental health, on your wellbeing, on your ability to work. Taking a much more holistic approach and having a skills mix in the team that really addresses that is one of the things I wanted to talk about.

Also, how are we developing our workforce and within London what does that look like? I know there is work going on with Health Education England and our lead cancer nurses. We have a group of lead cancer nurses from across all of the London Trusts working together on what a career pathway looks like for cancer. We are leaking people out of one end, and we are not having that succession planning or the succession of people coming into those roles. Cancer nursing is a very specialist role. It needs investment. It needs development. We need to have a much more long-term view on this, not just short-term answers now. Those are some of the things that we are supporting, and we are working on. Thank you.

Emma Best AM (Deputy Chairman): Just very briefly – and it is more a point for our Committee – is that the Mayor's Academies Programme, by the way it is set up or it is suggested it is set up, could look to tackle a lot of the issues that both Emma [Tingley] and Dr Nagpaul have mentioned and so I would really appreciate if we could delve into that outside of this meeting and get some more information on how that is helping build those good standards of work.

Caroline Russell AM (Chair): Yes, that sounds very sensible. Siva, you wanted to come in on this.

Siva Anandaciva (Chief Analyst, The King's Fund): Thanks, Chair, if that is all right. I would also like to hear more about the academy. I do not know. I have not heard of it before, but it did make me think.

It is quite clear that the NHS nationally and in London does not have the number of staff it needs to deliver the volume and quality of care it wants to. There are nationally 100,000 staffing vacancies that need to be filled. Part of the solution is absolutely recruiting more staff and getting those pipelines in of new people, but someone who knows a lot about staffing issues once said to me that there is no point building that pipeline if it leads people to a place they just do not want to work and you are losing people, the leaky bucket syndrome. There needs to be as much of a focus on how to create the right environment that will retain staff as well.

For me, there are three things. The first is absolutely what Dr Nagpaul was saying. Are you doing what I would call the no-brainers? Do you have the break rooms? Do you provide the hot meals? Do you do what you would expect a good employer to do? Local employers and local organisations in the NHS have the agency to do that. That does not need a national strategy.

The second thing is also probably for local agency, which is responding to changing patterns of work. Certainly, the junior doctors I speak to have a different approach. They want much more of a portfolio career and greater flexibility over how they work. How as an employer are you responding to that agenda?

The third bit, to just re-emphasise what Emma [Tingley] said, we do not have a national workforce strategy that is fully funded in this country. Given how long it takes to train a nurse, given how long it takes to train a doctor, the single biggest thing we can do if we want to retain more staff is have enough people working in the health and care system to give you a shot at feeling like you have a reasonable job and that you can deliver the quality of care you want to. The continued absence of the national workforce plan is a huge blind spot, and we can see the playing out of that day in and day out in the pressure on NHS services. That is the point I wanted to make.

Caroline Russell AM (Chair): Thank you and that is very helpful. I also just wanted to come back myself on one of the points about carparking. We also need decent public transport options for people. Not everyone can afford to run a car. While I absolutely take the carparking point, if we had a really reliable and affordable public transport option for everyone to access the hospitals, it would also help staff a lot as well as the parking point. Dr Sahota?

Dr Onkar Sahota AM: Thank you. First of all, I want to put on record the hard work of the NHS doctors and nurses and frontline staff and, Dr Nagpaul, to you particularly for how much you have been working hard both in your job in the BMA but also as a frontline GP. I also want to acknowledge the tremendous amount of work the nurses are doing in supporting our cancer patients. Let me put this on record and how much of an important contribution you have made to the NHS, particularly during the pandemic.

Let me come to the question. Look, we know that the whole system is really stressed. We went into the pandemic with a stressed NHS system and the pandemic has merely exaggerated and impacted more adversely on those inequalities that already existed. We have talked about workforce planning and I did not think I would ever say this, but I am going to say this. I was very impressed that Jeremy Hunt [MP], Chair of the Health [and Social Care Select] Committee in the House of Commons, wanted a national workforce order taking place independent of the Government, but the Government has refused that. What are your views on that, Dr Nagpaul?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Thank you, Onkar. As you know, there is a Health Bill at the moment going through the [House of] Lords. One of the key elements that we at the BMA have been pushing for alongside other organisations is exactly what you describe, for it to be embedded in the Health Bill for there to be a workforce plan where there is an independent analysis of what is needed for the service, and then to put in place the measures to achieve that. Now, we are starting at the moment in an NHS where we do not have even an understanding of what the workforce needs are. That would be a basic thing that you would do in even a small employment arrangement. You would know what staff you need to deliver your service.

Just so you know, our own figures show - these are facts - that the UK has around 50,000 fewer doctors across the population, in comparative terms, than France, Germany or Organisation for Economic Co-operation and Development (OECD) averages. That is a huge number of fewer doctors and that has an impact. That applies also for nurses and others.

We need to have a workforce strategy that is open and honest about our starting position, open and honest about where we need to get to in order to provide a service, and then put in place a plan. Without doing that

you will never have a plan because you are starting with no information. That is why we believe that should absolutely be something that should happen, and it should happen independent of Government because it needs to be an honest, independent analysis that is ongoing, with clear recommendations, and have a workforce strategy to deliver. That is our position, a very clear position.

Dr Onkar Sahota AM: Thank you. Of course, you will know that once upon a time there was a link between GPs and the population in any given area. That link was broken and now we have no correlation between patient sizes, practice sizes and the number of doctors in there. Getting an independent audit would be very helpful and I hope the Committee will take this on board, Chair. This is a very important recommendation if we can make this, and it will be a shift changer.

The other thing I want to talk about is that it is very good to have more recruitment and more people entering the profession, but the best advocates of the profession are the people who are already working in the profession, and if they themselves are complaining about their lot then they are not going to be a very good advocates for new entrants coming in. Retention is also very important. How do you judge the morale of the workforce? I know the answer, or I think I know the answer because I have been a frontline GP, but I want to get this on the record. How do you judge the morale of the profession, of the nurses and of the doctors on the front line?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): What we have been doing at the BMA throughout the pandemic is running some tracker surveys so that we have an understanding of the realities facing doctors, and we have had thousands of responses.

The most recent survey has reiterated what we have seen throughout, that morale is low. In fact, 51% of doctors are telling us that they are suffering with some sort of mental ailment or stress disorder. What they are also saying is that about 50% are considering reducing their hours, and I suspect by the time I am saying this a lot have. I know many doctors who have reduced their hours in order to cope, and if you reduce hours you may still be retained but in fact the capacity of care being provided has reduced.

The second is that we know that people are retiring early. About one third of doctors are saying they intend to retire before completing their tenure. That will have a huge impact.

There is a specific issue for doctors - and for some other workers as well - around pensions because we have a very perverse pension and taxation system where, for many doctors, if they work additional hours or they carry on working, they in some instances end up paying more than they are earning. There is a huge disincentive that needs to be tackled.

There is no doubt our figures are showing that significant numbers are reducing their hours and wishing to retire early, and a certain proportion, about 20%, are saying they want to leave the NHS altogether. These are people who want to be in the NHS, they have become doctors because they want to care, but they are feeling that those external pressures are so great that they have little option but to make these career decisions to protect themselves.

Dr Onkar Sahota AM: Thank you. Dr Nagpaul, just one more thing. I know we have an increased waiting list and of course the whole system is under stress. I know that work that used to be done in the hospitals is now coming out into primary care. The journey of the patients is now much more complicated. I have to run through hurdles. When I started general practice 30 years ago, I could get an investigation for my patient, get them referred and get them seen, but now I have to run hurdles behind the scenes to get an X-ray or

ultrasound done because the hospital is using these things as a way of controlling their workflows. For example, if one of my patients sees a respiratory physician and they need to see, say, a gynaecologist, they cannot do a direct transfer. They have to come through to me. If they miss one appointment, they get discharged by the hospital system and I have to go make a re-referral. This is all adding to the work of general practice. Should not this now be the Government, if the Government really wants to resolve this?

Also, we heard earlier on that every contact should count and that patients should not have to go through hurdles, through the GP, to reach their care. They should be looking at the patient pathway to make sure that the patient gets the right treatment, right time, right person, every time, and every contact does count. Can you put some suggestions of what we can do to make the journey easier and life easier for the professionals also?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): I could not agree with you more. The interface between general practice and hospitals is one where there is a completely unhelpful divide, which is meaning that thousands of patients every day are suffering the results. In fact, our own BMA surveys have shown that the majority of GPs think that the divide between hospital and general practice is harming patient care, and 75%, as you say, think it is increasing administration. The more time we spend on bureaucratic tasks, the less time we have to look after patients. The hours that you and others are spending - and myself - in trying to get people to respond to queries, getting them to be referred and trying to jump through hurdles, is time that we should be being doctors, treating patients.

I think the solution, ultimately, is about changing the current system, which is very siloed. It is a system where you have separate budgets to hospitals, separate budgets to general practice/community, and you have vested interests that work against each other. We need to have pathways where patients are seen, and their care concluded as quickly as possible with the fewest number of interactions.

Specific recommendations we have made as the BMA and I have made are: first, that patients should have access to a central or local helpline with regards to information about their wait; they should not be coming to a GP practice. The second I have made is that there should be a system where prescriptions in hospitals should be electronically enabled to allow the patient to collect them from their local pharmacy. That is something we can do as GPs, but what is happening every single day is that GP practices are being inundated by patients who have been told to come to their GP simply to get a prescription that has been initiated by a hospital doctor. The third is investigations. Investigations that are requested in hospitals, where the patient is told, "Have an X-ray in four weeks", inevitably result in a GP consultation and the GP having to then make that referral again.

These are things that need to end so that there is not that inconvenience for patients and to reduce the bureaucracy for general practice. That needs a pathway care. We do not currently have that system. I have some ideas, which I can send to the Assembly later on, about a different model of the way in which we deliver care that brings primary and secondary care together. That, I believe, has been long overdue but is even more important now with this huge backlog of care.

Dr Onkar Sahota AM: Dr Nagpaul, thank you very much. For the sake of saving time - I know that the Chair is very keen to continue - if you would kindly write with that plan to the Committee. I would be very interested if you could send it to me also, please. Thank you.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): I will do that. Thank you.

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): I would like to just quickly build on those points that have been made around how we measure morale. One of the ways we see the impact of staff morale is on the patient experience. There are good measures in cancer care. There is the National Cancer Patient Experience Survey where we can pick up some of those issues. Particularly around that integration between what happens in a hospital and what happens outside of hospital in primary care, it is really important that we look at that, are challenged by that and think very differently, think out of the box around how we are providing care and the different models of care that we can bring.

Macmillan published a report called *Cancer Nursing on the Line* which I can share with the Assembly afterwards. There is some data in there that a third of Londoners with cancer in the last five years said that the healthcare professionals working on their care had unmanageable workloads. A quarter of those people felt a lack of support because of that. How do we respond to that? How do we make sure we get the right skills mix in, the right professionals seeing the people at the right time, really focusing clinical skills where they are needed as well as some of those other skills around how we navigate people through a system and support those holistic needs? They need to come together and work better together.

Dr Onkar Sahota AM: Emma, it would be very helpful if you would share that. I just want to make a point that all these people who go into the healthcare profession, when they went for their interviews, would say, "We want to go there to help other people. We want to help the sick. We want to help the suffering". They worked very hard, they worked long hours, they worked harder than their other colleagues, and then something happens to them in the system that demoralises them, and we need to address those issues. I would be very grateful if you could share the feedback you have had. Thank you very much.

Caroline Russell AM (Chair): Thank you. Siva, if you wanted to come in.

Siva Anandaciva (Chief Analyst, The King's Fund): Yes, thank you, Chair. A few points on this topic of morale and retention.

The first is that you should not take vocation for granted. There is a generalised assumption that people who work in health and care services have a strong sense of vocation. They do still reach a breaking point. If you are a clinical professional trained in the UK, you are gold dust. You have internationally deployable skills and there is a worldwide shortage of healthcare professionals. You absolutely have opportunities to go elsewhere if we do not appropriately value our staff.

The second thing is that there are absolutely issues of the moment that have contributed to poor morale, including the management of staffing pressures during COVID, as well as the longer-term issues of staff shortages that we have already talked about. The main point I wanted to make is about culture. Even before the pandemic, if you look at the NHS Staff Survey, it does tell a worrying and variable story. Other 20% of staff were experiencing bullying and harassment. There are separate figures from the Workforce Race Equality Standard about the different experience of ethnic minority staff in the workforce. There are issues of how much control you have over your professional life. Alongside the issues of the moment, there are some deep-rooted underlying cultural issues about the NHS as an employer that also have to be tackled if we are going to support good morale and good recruitment of health and care staff. Thank you.

Dr Onkar Sahota AM: Thank you for that, Siva, and also thank you for all the work the King's Fund does in highlighting those issues.

Caroline Russell AM (Chair): I am now going to bring in Krupesh.

Krupesh Hirani AM: Thank you, Chair, and thank you to all the guests for their contributions so far and the wider work that you do as well. First is a question to all, really. What action is required to meet the needs of those whose access to healthcare has been reduced because of the pandemic, both in the short term and in the longer term as well? We will start with Siva.

Siva Anandaciva (Chief Analyst, The King's Fund): Thank you, Assembly Member. I would say four things.

The first is: understand their needs. Work is already underway in the NHS through the national initiative Core20PLUS5. Basically, understand the profile of your waiting list, including the needs of the most deprived populations.

The second thing is, at the risk of sounding reductive, to do more. Where staff capacity allows it, put on extra surgical lists and weekend lists, expand community diagnostic capacity; all the things that are being done to provide more healthcare.

The third is: do differently. Again, in health and care services there is a lot of work going on to separate out where planned elective care happens from more-hot emergency care. Make greater use of things like social prescribing to meet the wider needs of people where the core root is not a medical issue, it is a social issue. Do things differently.

The fourth thing is: communicate more effectively. The reality is that tackling the waiting list is not going to be a two to three-year job. It is a five to seven-year job. There is a lot of work going on over how you can make waiting for your care a more active process, whether that is through better information, more interaction outside of the waystation of coming in for an outpatient appointment, or more options for self-care. The phrase that keeps coming into my head is, "Make waiting a more active process", which is the advice someone gave me. We absolutely have to do that if we are going to manage the waiting list rather than just view the waiting list as a set of numbers that ticks up and down over the next five to seven years.

Krupesh Hirani AM: Just very quickly, what role do you feel the private healthcare sector can play in that?

Siva Anandaciva (Chief Analyst, The King's Fund): With the caveat that private healthcare is a wide market so includes things like mental healthcare and community care, particularly for the planned elective backlog, it has two functions. One is extra capacity during periods of surge, which we are seeing at the moment is needed. Then the second is, as during the New Labour period, playing a more stable role in delivering, particularly, planned, routine knee and hip operations, that type of work. I honestly cannot see a way that we are going to tackle this 6 million waiting list backlog without the independent sector playing a strong role.

As always, the thing that we have to be very conscious of is that any time you poll the public, the concept of an NHS that is free at the point of use, comprehensive and universally accessible is close to their hearts and they absolutely will fight for it. When you have this sort of pressure of an unprecedented level, you have to be constantly monitoring the risk of a two-tier system developing. There are some constraints in the way healthcare works in our country that make that less likely, the principal one being that it is largely the same clinical staff who work in private and NHS hospitals. You do not have a hermetically sealed private sector that can take on loads of work with a few paying clients because it will be limited by the pressures on the NHS.

It absolutely will have a role in tackling the backlog. As always, we need to monitor that we are not developing, either consciously or unconsciously, a two-tier healthcare system in the UK.

Krupesh Hirani AM: Thank you for that. To Emma [Tingley], the same question but if you could reflect, maybe, on how the voluntary sector can also play a part in this as well.

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Yes, thank you. That would be my build on the four really clear points that we have just heard from Siva. Absolutely, the third sector/charity sector has a role to play as partners in healthcare. We have seen it at Macmillan Cancer Support in terms of the increase of people coming to our support line and the increase in people accessing our welfare benefit support. That is the same across all of the charities. How do we work, as a charity sector, better in partnership with the NHS? There is definitely more work to do that, but we want to be part of the solution.

Sometimes we have the agility to think differently and try things differently. We have some examples across London where we have put funding into different ways of working. There is a great programme in Hammersmith and Fulham that we have done in partnership with the primary care network there, led by the GP federation, looking at how we integrate services across acute settings and primary care settings using social prescribing. We have been a core partner and a funder in that. Sometimes our role is to facilitate what that might look like to start with, so that we get the data, and we can work out what the sustainability plan might look like. That is something about the way that we work across the sector. Yes, the third sector has a definite partnership role to play.

Krupesh Hirani AM: Dr Nagpaul, if you could also just go into what you would like to see in a Department of Health and Social Care's forthcoming elective recovery plan as well.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Sure. Thank you. We must not forget that at the moment, one of the reasons why we cannot clear the waiting list as quickly as we should be able to is because of continued levels of Omicron or COVID. I know it is not as bad as in previous waves, but we still have 20,000 people in hospital at the moment compared to about 7,500 a month ago. It is still having a real impact. It has an impact on the workforce with staff absence. Those things must not be forgotten as a precursor to what I am going to say.

In terms of the recovery plan, that is one of the things that we have been really concerned that we have not seen. We should have seen, in my view, months ago a clear plan of how you tackle the backlog. As Siva said, waiting should be an active process, not just, "We have a waiting list. We must somehow now clear it".

One of the things is prioritisation. Within those 6 million waiting for operations - remember there are probably more than that number who are waiting for outpatient appointments and they also are people who are waiting for medical care - there should be a process of making sure that those for whom further waits could be dangerous for their health - and some conditions deteriorate as a result of waiting - should be prioritised. You need to have a system where you may have to prioritise those who may be towards the later stage in their lives, where every year of an extra wait may reduce their quality of life considerably. At the moment we do not have any systematic approach to clearing the backlog or even assessing what that backlog is, who is waiting and who needs to be prioritised.

We have a retired doctor workforce. There are, I think, about 30,000 who volunteered in the pandemic to come back to support the NHS, and it has been a shambles. They have not been able to come to work because

of lots of bureaucracy. However, if they could, for example, be contacting patients, trying to find out how they are, explaining to them the backlog and checking to see which would need to be prioritised, that would make a huge difference. It would also reduce, as I said earlier, the impact on us as GPs - and, for that matter, I am sure, hospital services - in just those queries that keep coming and taking up a lot of our time.

The recovery plan is vital. Part of that recovery plan should include improving access to diagnostic equipment. We still have much lower levels of magnetic resonance imaging (MRI) scanners and computed tomography (CT) scanners than other European nations. It should also include what Onkar had asked for earlier, making sure we are efficient in the use of our clinical staff so that we reduce the bureaucracy that wastes a lot of outpatient appointments and wastes a lot of doctor time.

Krupesh Hirani AM: Thank you. Emma, anything to add on the elective recovery plan?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Not specifically. We just really need one, and to make sure we are thinking about where we are deploying the staff because it is not just about getting people in to diagnosis, but what happens beyond. We are really interested and keen to support that and input into that.

Krupesh Hirani AM: Thank you. Siva, anything to add? There were some interesting things I picked up in some of the answers around the plan, which should have come a few months ago. I know waiting lists were growing worryingly before the pandemic as well, so there is an argument that maybe, in any case, we would have needed some sort of immediate or urgent action on waiting lists and an elective recovery plan. Now that has been exacerbated exponentially. Is there anything from your perspective to add to that?

Siva Anandaciva (Chief Analyst, The King's Fund): Yes, I agree with that. Three things for me.

One is the workforce component. We need some detail on what level of care you want to deliver, what workforce you will need, and what your plan is for getting them. That is the first one.

The second one is the signal over what happens after the next three years. I understand the political cycle and, nationally, I understand that three years' worth of funding has been given, but if this a longer than three-year job, what are you signalling about what happens after that period?

The third thing is: what are your expectations over performance? We have a very broad target for increase in activity over the next three years, and we have a very short-term target of reducing the number of people waiting over two years for care. What is in between? I know it sounds quite technocratic to have a target, but it is remarkable how quickly poor care can become normalised. What is the plan to get us back to a level where 92% of people are being seen in 18 weeks? I think the public will understand, if COVID comes back in several waves, if that plan goes off-track, but you need the plan in the first place.

Those are my three things, Assembly Member.

Krupesh Hirani AM: Thank you, that is the end of my questioning.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): A very small point about the use of the private sector. The real limitation is workforce. We saw this with the Nightingale hospitals. You built the hospitals, but the staff could not be in two places at once. That is the limitation, the workforce.

Caroline Russell AM (Chair): Thank you. Andrew, our final two questions, and if you can keep the pace up that would be brilliant.

Andrew Boff AM: Yes. Very quick replies to this if you can. What could the Mayor do to raise the profile of this issue? Do you think he has a role in this?

Siva Anandaciva (Chief Analyst, The King's Fund): Alongside the tackling of the elective backlog, the single biggest thing the Mayor could do is raise the profile of the wider things that contribute to our health because the NHS is balancing -- sorry, I know you wanted to be quick. I will be quicker. The NHS is trying to do two huge strategic things: tackle the biggest backlog in recent history for care, and also transform how it delivers services and the role it plays so that it moves from being a world-class treatment service to a world-class treatment service and a service that supports the things that keep us healthy. One of my big concerns is that there will be a relentless focus on tackling backlogs, getting people in and out of hospital and GP surgeries quickly, and the focus on the wider things that keep us healthy will be lost. The office of the Mayor is one of the most powerful agencies to say, "In the longer term, over the next 10 to 15 years, we do not want to look back and say we missed a chance to reduce health inequalities and improve the health of the population". A focus on the two aspects of what the NHS is trying to do would be very welcome.

Andrew Boff AM: Do I take that as being increasing the priority of public health and the Mayor's role in public health?

Siva Anandaciva (Chief Analyst, The King's Fund): Yes.

Andrew Boff AM: Thanks. Very good, very economical. Anybody else want to contribute before I move on to the next question?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): From my end - and the Mayor has been doing this - we are still not only in a pandemic with Omicron rates affecting the capital to a very significant degree, but there may be new viruses and new variants coming along the way. The Mayor has a role and has taken decisions such as mask-wearing on public transport that preceded national policy of late. There is still, I cannot emphasise enough, a need to bring down COVID rates in order for the NHS to be able to be free to carry on doing its elective work to a greater capacity.

The other issue is, as we heard earlier, the disparities in health are disproportionately impacting on the health service and on individuals. Those should be tackled through public health measures. London is a very diverse capital, and those disparities are pretty glaring within London itself. Much more, I believe, should be done. This comes under the Mayor's portfolio and I know that he is very dedicated to that but that should be very much up front.

The third is what we discussed earlier. I do think there are ways in which the hospital sector, community, general practice, social care, and the public themselves can work in a much more holistic manner. Even if national policy does not allow us to make those changes, in London we should just get on and try to create a model that really does integrate, in the best possible terms, the way in which both public, patients and those who work in the service can work in a seamless way.

Andrew Boff AM: Sorry to interrupt but the Mayor's role in that should be to promote that, is that right?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): He should promote that because it is in the interests of those who live in London to have a better experience of the health service, improving their health as a result.

Andrew Boff AM: My final question is, Mr Anandaciva, how do we monitor the effect on health outcomes of the delayed diagnoses and treatment due to the pandemic so that we can assess measures to rectify the backlog in care? You are the data man.

Siva Anandaciva (Chief Analyst, The King's Fund): I am the data man. It is a great data question. I would say, first of all, develop a framework or a structured way for how you are going to look at it. For me that would include one component, which is looking at the different aspects of quality: measuring experience, safety, clinical effectiveness, and outcomes. All four are important. Again, going back to that earlier point, I do worry that we will focus on access and getting people in and out quickly without looking at balancing measures of clinical effectiveness like, "Did the person re-attend within 31 days or seven days because they got fast care but not good care?"

I would say looking at all four of those and, realistically, looking at how long some of these outcomes will take to manifest, bearing in mind this will take ten to 15 years. There will be some leading indicators like experience that you can look at and see decreasing rapidly. There will others, like mortality and morbidity, that may take some time to show up.

Just a final point. We did some work looking at how other countries had responded to disasters, not necessarily the pandemic but things like earthquakes, floods, and typhoons, and pretty consistently they said, "The one thing we wish we had done more to measure, in hindsight, was the mental health and wellbeing of children". They said, "That was the one indicator we probably didn't pay enough attention to". When you look back over such a shock to a country's system, that is the thing that can sometimes fall between the cracks. Alongside that framework I would pick particular groups, and from that previous work I am particularly concerned about the mental health and wellbeing of children and adolescents.

Andrew Boff AM: It is funny -- it is not funny at all, actually, but it does seem that on almost every health issue that we discuss there is this obvious question. The health of the children is a pretty strong indicator of the health of the adult, and yet we are still trying to make that point. I just find it ironic, after years and years of that being established. Ms Tingley, could you perhaps come back on that as well, about how we can retain this information or this experience?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Absolutely. There are some measures that are already being used and have been for years. Certainly, that Cancer Patient Experience Survey that I talked about previously is a key area of information, looking at the ongoing impact with people.

More recently, Macmillan Cancer Support and NHS England have worked on quality-of-life measures and that is now a live tool that we are using. We are looking at somebody's quality of life with cancer 18 months after diagnosis. London's a bit lower in the uptake of that survey so we are doing some work on why that is, and we are looking at that in the Inequalities Group as well.

However, I am not sure if it will tell us the whole story, particularly bearing in mind the point that I made earlier around delays to diagnosis, perhaps because somebody has been too frightened to enter the healthcare system although we have been clearly saying, "We are open for business, please come and tell us if you have signs and

symptoms". A number of people are coming in with much more complex and advanced disease and we are sadly seeing them entering that end-of-life care pathway much sooner, so we may not be capturing all of the data. We do need to think a bit more around what it is that we are using to look at this in the long term.

The backlog is a huge ongoing challenge. Ten to 15 years was mentioned previously. We would love to be able to come back to you and talk more about that and the third sector response to it at some point, please.

Andrew Boff AM: Thank you very much. Thank you, Chair.

Caroline Russell AM (Chair): Thank you, and thank you, everybody. Clearly, we have just scratched the surface of all of this, but it has been really helpful to have so much input. We have this big backlog, we have the impact of the pandemic and this latest Omicron wave which has really put health service staff under huge pressure, partly from just the staff sickness levels, but the thing I have particularly taken is the importance of thinking carefully about how we focus on getting through the backlog so that we do not have unintended consequences that potentially worsen people's health. I have written pages of closely written notes, there is going to be a transcript, we will be looking at all the evidence you have given us and coming to some conclusions, but for now I would just like to thank you for your contributions to our session today.