HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce: recruitment, training and retention in health and social care, HC 115

Tuesday 7 June 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Rosie Cooper; Dr Luke Evans; Taiwo Owatemi; Sarah Owen.

Questions 306 - 380

Witnesses

I: Amanda Pritchard, Chief Executive Officer, NHS England; and Professor Sir Stephen Powis, National Medical Director, NHS England.

II: Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care, Department of Health and Social Care; Michelle Dyson, Director General for Adult Social Care, Department of Health and Social Care; and Matthew Style, Director General for NHS Policy and Performance Group, Department of Health and Social Care.

Examination of witnesses

Witnesses: Amanda Pritchard and Professor Sir Stephen Powis.

Q306 **Chair:** Good afternoon and welcome to the fifth and final evidence session of the Health and Social Care Select Committee's inquiry into workforce issues. Later today we will be joined by the Secretary of State for Health and Social Care, but first I welcome Amanda Pritchard, the chief executive of NHS England, and Professor Sir Stephen Powis, the national medical director of NHS England. Amanda, welcome, and thank you for your time this afternoon. Sir Stephen, congratulations on your knighthood, which is richly deserved. Everyone has been congratulating you recently, but I know the Select Committee would like to congratulate you as well.

Professor Sir Stephen Powis: Thank you very much.

Q307 **Chair:** You will be pleased to know that we do not have pre-appointment hearings for knighthoods in medicine, so the Committee has no say in the matter.

Amanda, I want to start with staff shortages because that is the big issue on everyone's mind. Can I ask you to kick off with your view on where we are with respect to staff shortages, because obviously it is at the top of so many people's minds and it is such a big concern for NHS frontline staff?

Amanda Pritchard: Thank you very much. It is very timely to be here today talking about workforce in particular because, as we look back over the last few years, we can see that the NHS, having done an absolutely tireless job of trying to pull out all the stops to look after patients over Covid, continuously adapting, introducing new services and scaling up critical care services overnight, is now facing what, if anything, is the even harder task of recovery. We will do that by doing many of the things we have done in Covid, taking the learning and continuing to be ambitious in doing things differently at pace and at the scale you can do only as a national service, but we will be able to do that only if we have resilience, and that means having the capacity and, critically, the workforce to do it.

You asked about workforce shortages. We recognise that at the moment the NHS is under considerable pressure. We are carrying about 100,000 vacancies at the moment, despite having more staff than we had before. We have had a significant increase in numbers over the last couple of years, but it is not enough.

Where are we now? What we are doing, as we have discussed before at this Committee, is continuing to support the staff we have, recognising what people have been through over the last couple of years as well as the incredible commitment that is there now around recovery and reform. Whenever Steve and I go out, we are always struck by the fact that every

day people continue to go above and beyond to pull out all the stops to look after our patients.

We are supporting our current staff in everything from the wellbeing services we introduced through Covid, which continue to play a role, to a lot of work now on retention. That is everything in what matters to you as an individual, be that flexible working or pensions reform. We are also making sure that, where we have particular shortages, we focus on not just domestic recruitment but international recruitment to fill some of those gaps.

Ultimately, all of this will come together in the workforce plan that we have been commissioned to work on with HEE, which we will be doing over the next few months, into the autumn. What we expect to be able to talk about in that plan is not just numbers but skills, roles and ways of working, recognising some of the opportunities. Again, we can look back through Covid at the investment we have been able to make in digital and technology to allow people to work differently, so the roles of tomorrow will not be the roles of today necessarily. It will not just be about numbers. It will also be about roles and skills, and it will be about training, development and retention. All of that is a critical moment for us as we work on the plan for the autumn.

Q308 **Chair:** Can I ask you about two specific areas which are of great interest to the Committee? The first is that since you appeared before us previously the Ockenden report on Shrewsbury and Telford has been published. Last summer, our Committee proposed that we needed an extra 2,000 midwives and about 500 obstetricians. That was echoed in the Ockenden report, but we have found out since we published that report that the NHS actually lost 552 midwives between March 2021 and March 2022. Precisely what is happening to make our maternity units safer?

Amanda Pritchard: Can I answer the workforce part of that and then talk about the wider challenge around maternity services? The important thing to say is that the increased investment in maternity services is not just a "this year" thing; it is very much something that, thanks partly to the prompt of this Committee, we have been doing over time. It was £95 million last year and another £127 million this year, and a lot of that is going directly into additional establishment.

Q309 **Chair:** I am sorry to press you. The money is going up, but midwives are going down, and that is the worry. Why is that happening, and what are you doing to stop it?

Amanda Pritchard: To finish my point on establishment, you are absolutely right to call out the distinction in the creation of additional roles. We have seen 1,692 additional midwifery roles recognised in establishments and 181 full-time obstetric roles, but there is a difference between having the role and having the skilled person available to fill that role, which I think is the distinction we are now drawing.

Q310 **Chair:** To cut to the chase, when do you think the number of midwives will start to go up?

Amanda Pritchard: The next bit is training. The commitment made a few years ago by my colleagues in HEE to increase training places by an additional 3,650 by March 2023 is on track, with 2,500 additional trainees now in process and another 1,000 joining through the next two cohorts. There clearly is a timing challenge because the people who are in training now are going through a process and they are not yet fully qualified and able to take up those roles.

Q311 **Chair:** I am not trying to rush you; it is just because of time. We said there need to be 2,000 midwives. That was endorsed by the Ockenden report and accepted by the Government. Could you write to the Committee to tell us when you expect to get that complement of additional midwives in place, because I think everyone wants to know that our maternity units are as well staffed as they should be? On obstetricians, we said 500. There has been work done by the Royal College of Obstetricians on that number, which may change slightly, but could we have an equivalent answer on that question? When do you expect to get to the complement we need? Can I leave it there on that, because we have so much to get through?

Amanda Pritchard: The reassurance I am giving is that the money has gone into establishment and training places, but of course we will write to you with further detail.

Q312 **Chair:** Thank you. On general practice, I do not want to ask about numbers of GPs, as we are going to cover that with the Secretary of State shortly. I want to ask about continuity of care. You will be aware of the research from Norway that says that if you see the same doctor over many years, you are 30% less likely to go to hospital and 25% less likely to die. I am going to ask the broadcasters to play a clip of some evidence we heard from Dr Jacob Lee, who very powerfully said that it is not just better for patients but also much better for GPs.

Video shown.

[Dr Jacob Lee: When I look at my list of patients I need to see that day, I recognise 70% of the names on that list. I have had conversations with them. The type of consultation we have is much more about what the patient wants and needs. I am able to understand their history and understand them in the context of their family. I provide six sessions a week and look after 1,200 patients, which is 400 families. That is a manageable number of people to know.

When a patient comes to me, my overriding feeling is a sense of responsibility to do the best for that patient. That responsibility gives me huge satisfaction in my role. It makes me want to talk about preventive care; it enables me to have conversations about difficult topics, about weight and smoking, with much more trust and a built-up sense of joint ownership of the problem with the patient.

The processing of blood test results and letters is no longer looking at the blood test result and having to look back through the notes about why it was done. I requested the test and I know what was happening. I can recognise when test results or letters are abnormal for the patient and that enables me to function much more efficiently.]

Chair: Steve, I know you are not a GP, but as a doctor does that resonate with you?

Professor Sir Stephen Powis: Yes, of course it does. I was a practising nephrologist, a kidney doctor, and in the latter stage of my practising career I looked after long-term transplant patients. When I spoke to them, the thing they wanted most around the service we provided was continuity of care. Why? Because it is important to have a familiar face and a doctor they know knows them. Nothing can be more frustrating than having to tell the same medical story to a different professional who is looking through a thick pile of notes from over the years and having to understand the background of a patient they have not seen before. It is incredibly important and it is important in general practice.

I have a few points. General practice, like hospital medicine, has evolved, so it is about continuity of the team providing care as well as just the individual. It is the practice nurse; it is increasingly the pharmacist in the practice; it is the team of individuals who know the patient, so it is probably less than it used to be with a single individual. There are practical ways of managing it. You cannot be there the whole time. In my practice, I used to buddy with another consultant, so there were two of us who knew the patient well. There are times for individual patients when it is probably required less.

Occasionally, urgent problems can be dealt with by somebody else rather than the person who is providing continuity. The Fuller stocktake that we published recently addresses this head-on and gives some insight into how primary care networks and neighbourhood teams can provide continuity of care at both individual and team level, and free up GPs to manage the long-term care for which continuity is required, while dealing with some of the urgent and emergency care in a different way.

Q313 **Chair:** Amanda, GPs used to have their individual lists of patients a couple of decades ago. Taking on board what Steve says about the fact that the nature of care has changed and it will be part of a team, but none the less with one person accountable for that patient's care, would you consider bringing back individual patient lists, perhaps as part of a wider reform to QOF?

Amanda Pritchard: Thank you for the question, because the opportunity now, exactly as Steve says, is to get stuck into implementation of the recommendations Claire Fuller made in her stocktake, which we commissioned because we absolutely recognised that the current model of primary care is under real pressure. The need for us to continue to support primary care to be the bedrock of the health system, which it

always has been, is absolutely front of mind. We need to be really clear, as Claire is in her report, about how we deliver continuity, because it is a safety issue for patients, and because it creates roles that we have just heard about from the GP in the clip you just played. He is somebody who clearly enjoys his job and, despite the workload pressure, is able to have meaningful interaction with his patients.

That is what we want for all of our GPs, but we need to do it in the context of the team. Part of the investment we have made—£1 billion just this year—in additional roles in primary care enables us to work differently, and enables colleagues in primary care to work as part of an integrated team, but with continuity absolutely baked into that.

Q314 **Chair:** Can you give us an idea of the timing for these plans? Will you be talking to the BMA about changes in the GP contract coming up this Christmas in order to make those reforms to QOF and potentially improve continuity of care?

Amanda Pritchard: An awful lot of what we can do and what ICSs are committed to do in relation to primary care does not require contractual change. We just need to recognise that we can take forward an awful lot of this, and we are seeking to take it forward, independent of contractual negotiations. There is a process though. You are quite right. Probably less this year but more next year, towards the end of the current contract for primary care, there will be an opportunity for us to think again about how we recognise and reward the incredibly valuable roles of our colleagues in primary care.

Q315 **Chair:** You are intending to conclude what you want to do to strengthen continuity of care in time for the negotiations for next year's GP contract. I want to understand the timescale. As we both know, the NHS is very good at having lofty intentions that sit there for quite a long time. I am trying to get a sense of when patients might see something different in terms of seeing the same team of doctors on a regular basis.

Amanda Pritchard: Doctors and the wider multidisciplinary team. The expectation is that the implementation of the integrated neighbourhood team model which Claire described can start now. That does not require contractual change; it is something that the ICSs in the main will be driving, but we are intending, rather than hoping, to focus particularly on areas that are struggling with significant inequalities and where there are high levels of deprivation, because that is obviously where some of the continuity and team working will be most beneficial. That is our current intention.

The contract has a process to run through which takes us to 2024-25, so it is not my expectation that we would be seeking to do something outside the timeline of the contract, but, as I say, I do not think we need to wait for the contract to get on with this.

Professor Sir Stephen Powis: It is useful to point out that the last contractual negotiation put in place some of the building blocks for the multidisciplinary workforce that is going into primary care: the pharmacists, paramedics and nursing staff. We have made great progress in recruiting those staff. There is further to go. As I think you can see in Claire Fuller's report, the primary care networks and neighbourhood teams that have made best use of those are beginning to build free time for the continuity of care you have described. What we need is to see everybody doing that.

Q316 **Chair:** A very last question from me, if my colleagues will indulge me, is on long Covid. The Royal College of Nursing has a report out this morning which says that, even though there are 2 million people with long Covid and nearly 400,000 who have had long Covid for two years, about a third of people are still waiting more than 15 weeks for an appointment and the total capacity of the system is only 15,000 appointments a month. Are you happy that we have enough capacity in the system to address the needs of people with long Covid?

Amanda Pritchard: I know that Steve wants to come in on this. We have led the way in England with the development of specialist long Covid clinics. As you know, we have 90 up and running for adults and 14 for children and young people. We have a plan, shortly to be published, which will be the long Covid plan for 2022-23, alongside revised national commissioning guidance and a primary care toolkit for long Covid. I think that combination of things, plus the investment we have already made in the clinics, which are new and take a bit of time to get fully up and running, particularly if you think about the time it takes to recruit staff, will give us a way into reducing some of the variation highlighted this morning by the RCN.

Professor Sir Stephen Powis: As Amanda said, we put in a particular model of care around specialist clinics in England. The devolved Administrations have taken a different approach. This is a new condition and we are learning about it all the time. It is important to recognise that the National Institute for Health and Care Research—NIHR—is funding research. The outcomes of that research are eagerly awaited because that will allow us to build the service model further.

As you say, around a third are waiting more than 16 weeks. I think that just under 40% are seen within six weeks. The plan that we aim to publish soon will address some of that—for instance, by ensuring that a phone call is made to anybody waiting over six weeks to ensure that they have been directed to the right service and they have the right sort of prioritisation in the waiting list. That is being done in many places already, but we need it to be done everywhere.

Q317 **Chair:** When is that plan going to be published?

Professor Sir Stephen Powis: I cannot give you an exact date, but hopefully it will be very soon.

Chair: If it is not to be published in the next couple of weeks, maybe you could write to us specifically on the capacity point. That would be very helpful.

Q318 **Lucy Allan:** I would like to ask about regional variations in shortages of doctors and what the NHS is doing about it. Has it been identified, and what steps are being taken?

Professor Sir Stephen Powis: What we know is that where doctors train is where they put down roots and where they often end up in their long-term career. There are a number of things we are doing about it. First, when it comes to undergraduates and the training of doctors, actually under the sponsorship of the Chair when he was Secretary of State, the number of medical students increased, and there was a deliberate policy to build new medical schools and introduce new medical schools in parts of the country, such as east Kent, where we know we have recruitment and retention difficulties. We will start to see the benefits of that over the next few years. Clearly, it takes some time to train medical staff, but those cohorts are about to come out. We hope and expect that they will put down roots in those geographical areas. That is the right policy.

As I have said to this Committee before, we need to expand medical school places again. I think the right thing to do would be to continue the policy of placing those new medical student places in parts of the country where we have difficulty recruiting. Later on in training, Health Education England has the opportunity to ensure that training places are distributed around the country. We have known for some time that for a whole host of good reasons London has a lot of higher-training posts. What we and HEE would like to do is ensure that the rest of the country levels up and has the same number of posts. That is probably best done by disproportionately increasing places outside London. From time to time, there may be a requirement to move training places out of London, but growing places outside London is important. Those are just a couple of examples.

Individual organisations and systems have a role. People go to work in places that have good reputations, so the better the reputation of the organisation and the more it does around staff wellbeing and retention, the more welcoming it is.

Q319 **Lucy Allan:** That works the other way. If you have a poor reputation, you will not attract people and your reputation will deteriorate. I represent a constituency in Shropshire where it is very difficult to get people to stay and very difficult to recruit people. It may well be that they trained in Birmingham and that is the locus they identify with, but they do not want to come to Shropshire. I wonder how we overcome that, because when you are on a downward spiral it is terribly difficult to change those reputational issues if you cannot attract and retain staff.

Professor Sir Stephen Powis: Yes, and that is where our role is to support local organisations in their development, ensuring that they have the right support to improve and become organisations that people want to work for. There are examples of where that has happened; in Lincolnshire we have seen great improvements in the hospital system, and I know that people have chosen to go and work there. It is possible to have that shift.

Q320 **Lucy Allan:** What about less high-profile specialisms where we might potentially have problems in recruiting people? Is the NHS aware of the specialisms that are affected, and what measures are you taking to address that?

Professor Sir Stephen Powis: At the moment I think we have reasonably good fill rates in training programmes around specialties. It changes over time. The first thing is for specialties to make their specialty attractive, and it is important that the leaders in specialties give the—

Q321 **Lucy Allan:** What are the unattractive ones?

Professor Sir Stephen Powis: I do not think that at the moment there are any I would put as unattractive. It changes from time to time. It depends a little bit on trainees in medicine seeing what the job opportunities are, but at the moment I do not think there are any that are unattractive.

Q322 **Lucy Allan:** But less high-profile? Orthopaedics as opposed to heart surgery?

Professor Sir Stephen Powis: I don't think we have problems in the surgical specialties. We have had problems in a few specialties in the past. A number of years ago we had a problem in psychiatry, which has been resolved. Clearly, there are some specialties we are trying to increase at the moment. We have talked about obstetrics because of maternity. Anaesthetics would be another area of critical care and learning from the pandemic.

I am optimistic. The royal colleges that represent specialties often want to increase the number of specialty places because of the demand that comes through for specialties. It comes back to making those specialties attractive, and that is a combination of the specialties themselves and the organisations where those specialties work. For some of the highly specialist ones it is obviously in particular centres, but for many specialties it is across all NHS organisations.

Q323 **Lucy Allan:** Amanda, perhaps I might pick up something the Chair opened with, regarding the very high-profile Ockenden inquiry. Does it impact on morale, and does that have an effect on recruitment and retention?

Amanda Pritchard: That is an important part of our leadership responsibility. Recently, I talked to a whole group of senior midwives—

chief midwives. They could not have been more passionate about their specialty, but they reported that some of the challenge they were experiencing locally was to do with coverage of maternity services impacting on people's morale and sense of professional fulfilment.

We have to strike a balance. We have to keep saying that these are critical roles and we value the people who do them, but we have to do it safely. Where there is opportunity to improve, I have not seen any resistance at all from people wanting to be part of that improvement journey, and that is certainly how we are approaching Ockenden. It is a high-profile report. We are grateful to Donna for her work and for the generosity and bravery of the families in sharing their stories. It is important that the NHS values our staff while being very clear about the improvement challenge ahead.

Q324 **Lucy Allan:** If you were a newly trained midwife, would you choose to go and work for Shrewsbury and Telford hospital trust?

Amanda Pritchard: I think Shrewsbury and Telford is doing very well at the moment in leading the way in implementing some of the recommendations, which is as you would expect given the experience they have been through. They have been very serious about investment in additional staff posts, both midwifery and obstetrics, and about meeting compliance with quality standards. I think people are choosing to go there. On Steve's point, people in more challenged parts of the NHS in England can turn it around and we are here to support them to do that.

Chair: We are expecting the Secretary of State at about 4.45, so perhaps we could be fairly brief in our questions. We started a bit late, so that is just the way it is.

Q325 **Rosie Cooper:** I am looking at this overall in a general way. My first question is to Amanda. You talked about 100,000 vacancies. Today, we hear that 50% of doctors want to retire before the age of 60. The Chair spoke to you about the number of midwives going down. In response, you talked about 3,500 training places. Every time we ask questions about workforce planning we cannot get numbers. We get talk about roles and the difference between having a vacancy and a person who is able to fill that vacancy. I was a former chair of a women's hospital, and we were forever hearing that we had too many gynaecologists and obstetricians this year; three years later we did not have enough.

Amanda, you offered the Chair reassurance. The word I am desperately looking for is "assurance". If I am a patient, GP or healthcare professional listening to this debate I do not know where there is assurance that actually we are going to make a difference, and we are actually not just going to talk about it. Where are the incentives for them to believe that this will be different? We are in different desperate straits right now, right across the piece. We start with 100,000 vacancies. It needs to be so much more than I can desperately hear right now.

Amanda Pritchard: Thank you for your question. The first thing to say—I would say it if I was talking to my NHS colleagues right now—is that we should not forget we also have more staff than we have had before. We still have significant numbers of vacancies, but that is on the back of three years of significant growth in staff. We are on track for 50,000 additional nurses. We are slightly ahead of trajectory. The same goes for the 26,000 additional roles in primary care. I know that you will talk about GP numbers in a minute. We have more people. It is brilliant that people want to come and work in the health service and still see it as a meaningful career. That is the first point.

The second point is that we have to look after the people we have, but we have to have a pipeline of new people coming into the NHS. That has to be both domestic and international.

The third point is that this is where the workforce plan is such an important opportunity for us. We have had the people plan which set out very clearly ambitions and requirements around culture, behaviour and values. How do we make the NHS a great place to work? That is a hugely important piece of the jigsaw.

Framework 15, which you spoke to Navina about the other day, talks about some of the bigger strategic thinking about the future of work and what that will mean for the NHS future shape of care, but it needs to come together now in the commission we have been given, jointly with HEE, to work on the workforce plan. Recognising that it becomes more uncertain the longer we go out, that needs to give us the numbers so that we can make decisions now about what we need to be training for in the long term. It also recognises that it will look at different skills and roles, and will need to reflect the work on retention and so on, but it is critical for our immediate purposes, as well as giving confidence to colleagues over the longer term, that we have a workforce plan that looks out five, 10, 15 years. I know that the Secretary of State has committed to sharing the headlines of that plan in the autumn.

Q326 **Rosie Cooper:** Is it a secret? I do not mean the outcome of the plan, but I genuinely do not understand why we cannot share the numbers. People may not agree, but are they not facts? Why is it a secret? That makes everybody suspicious. If I am an ordinary person sitting at home wanting an appointment with a GP and I cannot get it, all of this sounds vacuous because I cannot get a GP; I cannot get my hospital appointment, or whatever. That is the gap we need to travel together.

Amanda Pritchard: In terms of transparency in the publication of data and figures, we are completely committed to that. We can talk about the 1.3 million people who see their GP every day—62% of them face to face. You are absolutely right that transparency for the public on what they are getting from the health service and what their taxes are going to is crucial.

On workforce, the reassurance I can give you is that the plan we will be developing with HEE will have numbers in it. I suspect there is a conversation you will want to have with the Secretary of State about what will then be made public off the back of that, but I know he is on record as committing to sharing the outputs.

Q327 **Rosie Cooper:** You mentioned ICSs, and ICBs almost. I want to deal with the difference between reassurance and assurance. I know you absolutely understand it, so forgive me. Every day I talk to people who are in the fledgling ICSs. As long as you have a policy for A, B and C, or whatever it is, it is a tick-box exercise. If you can say you have a policy, you get a tick and you move on. An example I commonly hear about is the scheme for regulation and delegation, which could put billions into the hands of places, some of which may not inspire confidence in terms of leadership and certainly are not mature. Does that tick-box operation offer you assurance or reassurance? I am really worried about that. Where is the assurance? What they do affects all of the stuff we have been talking about today, because it cannot operate if that bit is not right. We need assurance about these tick boxes and it has to be real.

Amanda Pritchard: ICBs will come into existence next month. ICSs are still new organisations, and ICBs are yet even to take form. It would be fair to say that a lot of the work the future ICBs will do, which ICSs have been doing, has been on governance, the very important process of getting constitution sorted out and being very clear about how roles will look in the new system. The things we have been doing we will continue to do, to make sure that we support the transition from planning to action. I know that the enthusiasm the ICB chairs and chief executives share is to get beyond this stage so that we see the impact in outcomes, because that is ultimately what this is all about.

The work we have been doing behind the scenes with partners such as the CQC is on things like what a system oversight framework would look like so that we have the right processes, as you say, to ask not just whether we have the reassuring bits of governance in place, but whether they are delivering the things that are needed for our patients and our communities. That system oversight framework, jointly with the CQC, will look at a whole range of different things, from quality to experience and outcomes. We will need to look at inequalities and workforce as part of that picture. The CQC's role is also important because it is shifting to think about how it looks at systems as well as how it looks at individual components of the system.

Q328 **Rosie Cooper:** Now that you have elected members and chief executives on the board, how do you see conflicts of interest being handled, and how would you reassure—no, take that back—assure yourself that provider collaboratives do not become cabals of self-interest? It is all about integration and doing the best for the patient, but how do we get assurance that that is not happening?

Chair: A brief answer if possible.

Amanda Pritchard: Some of the way ICSs are set up is intended to design in some of those checks and balances. Provider collaboratives ultimately, if they get funding, are commissioned through the ICB layer, so it would be very difficult for them to go off without oversight and a clear mandate. Ultimately, accountability is still up through the NHS England structures. This is one for us to come back to another day as we think about how we can support the evolution of ICBs, but the assurance I give you today is that all of the statutory levers we now have remain in place beyond 1 July, to intervene, if necessary, at system level as well as organisational level if things are not going right.

Chair: Thank you. Sorry to rush everyone along a bit.

Q329 **Taiwo Owatemi:** My question is about flexibility in the workforce. We heard in previous evidence that there is a move towards people working less than full-time hours. What plans is the NHS making so that there is more flexibility—for example, with regard to rotas and the workforce in general?

Amanda Pritchard: I am sure that Steve will want to come in on that. Part of the work we are doing at the moment on retention is about flexibility. We have heard a lot from people at different stages of their lives wanting different things, so it is the ability for us to support, through things like electronic rostering, much more flexibility at a local level as well as thinking about how contracts are designed. That is not just about nurses and AHPs but doctors being able to work on a sessional basis in a way that suits them much better.

With colleagues across the system we are also thinking a lot about the people approaching retirement age. We know that for a lot of people to work or not work is not a binary choice; what they are looking for is more flexibility. That is a hugely important part of our retention strategy at the moment.

Professor Sir Stephen Powis: That allows me to build on the answer I gave Lucy. I was first focusing on hospital specialties there. In the general practice workforce, it is important to acknowledge that there are concerns around recruitment, but some of the solution to that is exactly the flexibility Amanda just described in answer to your question. The more flexibility we can provide, the more likely it is that people will want to go into specialties and will be retained in specialties.

The additional multidisciplinary workforce that is going into primary care is one way of trying to provide that flexibility. Critical mass is another way of providing it. When you have critical mass around primary care networks, rather than small individual practices with only a few partners, it is much easier to give flexibility in working practices. There are multiple ways into it, but flexibility is the thing that I hear probably most often about what staff want, particularly new staff coming into careers.

Q330 **Taiwo Owatemi:** I want to ask about workplace culture. A previous

panellist, Professor Woodhams, described NHS culture as "certainly sexist" and said there was "a lack of equality in promotion" for women. Dr Wen Wang described a culture where black and minority ethnic NHS workers were treated by managers and co-workers in a way that was "demeaning, disheartening and destroyed their confidence," and was "a direct cause of burnout." What is being done to create a more inclusive culture so that we are able to retain valuable members?

Amanda Pritchard: The absolute core of our people plan published a few years ago was recognition that, while some parts of the NHS had incredibly healthy cultures, that is not uniformly the case. Our staff survey tells some of the same stories you have just described and has done every year.

What we have done in trying to put together the people plan is pull in all of the threads of what it takes to make the NHS a great place to work. Quality, diversity and inclusion are absolutely at the core of that. That is everything from specific schemes like WRES and WDES, which focus on some of the protected characteristics around, in those cases, ethnicity and disability, as well as a broader theme around respect. Everyone in the NHS makes a contribution and plays an incredibly valuable role, more so if they play as a team. Part of what we are trying to do in promoting and supporting implementation of the people plan is to keep at the forefront of our mind that the NHS has to continue to be a learning culture and a place that is very honest about what it gets right and what it gets wrong, so that it can continue to learn and develop and put people at the heart of that. It has to be right.

Q331 **Taiwo Owatemi:** How are you ensuring that all hospitals understand that message?

Amanda Pritchard: It is part of our people promise, which we have signed up to across the whole of the NHS; it is part of what we monitor and measure. It is one of the things that is called out not just by us but by the CQC as well in looking at what you would define as a well-led organisation. Something we are increasingly thinking about with colleagues is how we can do it in areas like primary care that do not have quite the same way of measuring it at the moment. Certainly our commitment is to say that the NHS is absolutely a people business, so we need to make sure that, just as we are talking about numbers, we are also talking about culture, behaviours and values, and we do not see that as an optional extra.

Taiwo Owatemi: Thank you.

Chair: Thank you very much indeed. I am sorry we have had a bit of a rush today, but we have covered a lot of ground. Thank you for your answers on continuity of care. We will do our best to provide continuity of scrutiny so that you have the same friendly faces around the table every time you come back. Thank you very much, Amanda and Sir Steve, for joining us. It is much appreciated.

Examination of witnesses

Witnesses: Sajid Javid, Michelle Dyson and Matthew Style.

Q332 **Chair:** For our second panel, I welcome the Secretary of State for Health and Social Care, Sajid Javid; the director general for adult social care, Michelle Dyson; and the director general for the NHS Policy and Performance Group, Matthew Style, who both join us from DHSC. I really appreciate you joining us. I am sorry for the late start, so I will crack straight on, if I may.

Secretary of State, I want to start with GP numbers. We are focusing our questions broadly on our inquiry into the future of general practice and workforce, but there is quite a lot of overlap between them. I want to play you a clip from one of our earlier evidence sessions. This is Dr Hayward, who gave evidence to this Committee at the beginning of March.

Video shown.

[Dr Emma Hayward: I have never worked harder or faster in my whole career, and this was coming before Covid. We cannot blame Covid for this crisis. This has been coming for a number of years. It has an impact obviously on our patients who cannot get hold of a GP in a timely manner, and that is so frustrating for us as GPs because we want to follow up our patients, we want to provide continuity of care, and there simply are not enough hours in the day for us to get all the patients through. It is incredibly stressful that, despite us working as hard and as fast as we can, we still cannot keep up.

There are other impacts. It impacts our ability to be good trainers. It impacts our ability to be good role models for medical students. Medical students are coming through and seeing a stressed and burnt-out workforce, and are deciding against general practice. I spoke to my tutees yesterday—year 1 and year 2 students. Many of them have already dismissed general practice as a career because of what they have read and experienced personally. This is a massive problem that we have to address, and I have some suggestions that perhaps I will share later.

The other thing I have seen is the human cost of GPs having to work in this—[Interruption.]]

Chair: I don't know why it cut off so quickly, but we will leave it there. Can I have your reaction to it? Dr Hayward went on to say that a day in general practice is like being pelted with rocks. That is quite a strong phrase. I wonder what your reaction is because I am sure you hear that from lots of GPs as well. Could you give a reaction to that?

Sajid Javid: First of all, thank you very much for this opportunity and for your Committee's focus on the hugely important issue of workforce for the NHS and social care.

Turning to primary care, and in particular GPs, I very much agree with Dr Hayward about the incredible pressures that GPs face. She said, I think, at the start that there were significant pressures before the pandemic. Undoubtedly, during the pandemic the pressures were huge as well. GPs could not work in the normal way. They were asked to do many other things, not least vaccinations, especially of some of the most vulnerable in society. Now, GPs are facing huge pressure because there was delayed demand in some cases and people stayed away, and now they are all coming in force.

I want to take the opportunity to thank not just Dr Hayward but all GPs for everything they do, especially over the last couple of years. I cannot imagine a more demanding environment in which to be a GP, and to be in the NHS generally, than during the pandemic. I recognise much of what she shared with your Committee around the pressures that GPs are facing. We are seeing that in some of the latest numbers around the lack of retention, and some GPs are cutting their working hours as well.

I have visited GP practices and individual GPs that have come under completely unacceptable pressure, with attacks on GPs, sadly. Some have been reported publicly and others have not. I recognise that pressure. Of course, no GP should fear for their safety and wellbeing in any way. One of the most important things we can do is continue our focus on getting more GPs and providing support to the GPs who are there, not just directly as GP support but also broader primary care support.

Q333 **Chair:** Thank you. Let me talk about a couple of solutions. The first, which you just mentioned, is getting more GPs into the system. I famously failed to make progress on my promise to get 5,000 more GPs into general practice by 2020. In November, you told us that you did not think we were on track to get an extra 6,000 GPs by 2024, which is the new target.

Sajid Javid: Yes.

Q334 **Chair:** What have you done since then to help get us on track in getting more GPs into the system?

Sajid Javid: We are trying to recruit GPs at the fastest rate we possibly can. It is fair to say that we are doing all that we can. As well as getting more GPs into general practice, we try to focus with our friends in the NHS on retention and look at some of the issues that GPs may consider for leaving early.

I will give you some of the latest numbers that I have. In March this year versus March 2019, the headcount of doctors in general practice had increased by 2,389. The total full-time equivalent of that is 1,672. That means around 36,000 in total full-time equivalent GPs. The 6,000 target that you just mentioned is still going to be incredibly tough. I have always been very straightforward with your Committee. It is a very

difficult target to reach. We are doing everything we can and being very focused not just on that, but more broadly on primary care.

If I look at the other target around primary care professionals—broadly, the support professionals, going beyond GPs—we had set a target of 26,000 over the same time period you mentioned. There are currently around 18,000, so that is on target. We also set a target of 50 million new appointments, and that is on target as well. When I talk about appointments, that excludes vaccinations.

Q335 **Chair:** Thank you. I do not think we have time to go into this in detail today, but one of the other things that would help general practice would be to improve the models of care that we offer and to modernise the way we deliver care to reduce stress and the workload. We have heard a lot of evidence about the value of continuity of care—patients seeing the same doctor over many years—and the way that it reduces mortality rates and the likelihood of going to hospital.

We had very powerful evidence from Dr Jacob Lee from Bristol, who is in one of the fewer than 10% of surgeries that still has individual lists of patients for every GP. I wonder whether I could bring him to see you at some stage in the next month or so to explain how that model works in detail, because we found his evidence very persuasive. Would that be possible?

Sajid Javid: I would be very pleased to meet Dr Jacob Lee and listen more.

Q336 **Chair:** Excellent. I have a couple more things, and then I will move on to colleagues. One is on workforce and one is on long Covid. On workforce, you said that Framework 15 would come out in the spring. We are now in June. Do you know when Framework 15 will be published?

Sajid Javid: It is important to take the time to get the work right. That time has been taken, with over 1,000 conversations and meetings with healthcare professionals, academics, trade union leaders and others. The short answer to your question is this: it is at the absolutely final stages, and I would expect it is something that we can publish—it is a very important document on the drivers of workforce change—within the coming weeks.

Q337 **Chair:** Thank you. Definitely before the summer break?

Sajid Javid: That is my plan. Yes.

Q338 **Chair:** Thank you. You said in November that "we will set out"—the extra doctors and nurses we need—"in terms of actual numbers." Will we get that in Framework 15?

Sajid Javid: No, not quite. What you will get in Framework 15 is not numbers, if by that you mean actual doctors, nurses and other key professions for the health service. Framework 15, as I think I said at the previous Select Committee where we discussed this, is looking at the

drivers of the workforce: the skills that are needed, the values, the behaviours, taking into account changes in patterns of care, looking at the use of latest technology and looking at how disease has changed.

Q339 **Chair:** I understand that, and all that is really important, but for doctors on the ground, if you are an obstetrician and there are not enough obstetricians, or if you are an orthopaedic surgeon and there are not enough surgeons, what you want to know is that the Government and the NHS have worked out what the shortfall is in orthopaedic surgeons and when we are going to recruit them by. Will the Government be publishing a document that says, "Specialty by specialty, this is the number of doctors we are short, this is the number of doctors we think we are going to need in 15 years' time, and this is what we are going to do to fill the gap"?

Sajid Javid: That is what we are working on. Perhaps I could take a minute to explain how we are approaching this. There are three very important elements, and they go in this order. One is Framework 15, which is being done by Health Education England, looking at the drivers of the workforce, the kinds of things I mentioned.

The second important thing is what I refer to as the refresh of the NHS long-term plan. Why are we refreshing it? A refresher was going to come anyway, but it is more important than ever because of the impacts of Covid, taking that into account and looking at what the service priorities are for the NHS in the next few years ahead and long-term demand for the services the NHS provides. That is important because it then feeds into the ultimate result that you are rightly very interested in, which is the actual numbers.

What is the actual workforce strategy? That is something that NHS England is doing, taking Framework 15 as the driver, taking what it comes up with in its long-term plan, putting that all together in its 15-year NHS workforce strategy, which it has already clearly started work on—something I do not think the NHS has ever done before—and which will include the numbers for different professions.

It is not just about the numbers. The numbers are important, but it is also about understanding the drivers of those numbers and how, as well as numbers, just because you might need a certain ratio of numbers to a patient in radiology today, perhaps with future technology those ratios may—

Q340 **Chair:** I totally understand, but on a very practical level, doctors and nurses want to know if we are training enough people in our medical schools.

Sajid Javid: Yes, of course.

Q341 **Chair:** When will we have gone through that whole process and know the number of nurses you think we are going to need in 10 years' time?

Sajid Javid: That strategy is being worked on as we speak. It will take into account the output of Framework 15. It will take into account what is ultimately published as the refreshed long-term plan. I have asked the NHS to complete that strategy by the end of this year and I have no reason to think that that request will not be met. Once that is complete, we will certainly publish the conclusions of that outcome.

Q342 **Chair:** By the end of this year, you think we will know those hard numbers.

Sajid Javid: Yes, that is what I have asked for.

Q343 **Chair:** Okay. Can I ask you another question? This might sound like I am trying to pin you down, but I am not.

Sajid Javid: I am sure you are not trying to do that.

Chair: As you know, I would never try to do that. It is just a very practical point. The academic year starts in September.

Sajid Javid: Yes.

Chair: If there is a gap in the number of doctors and nurses we train, will you undertake, as Secretary of State, to make sure that any changes we need in the number of doctors and nurses we train are pushed through in time for next academic year—in other words, September 2023—because otherwise, as it is obviously a long process, we are going to have to wait until September 2024, which is a really long way off to start the process of tooling up the NHS? I am talking about doctors in particular because that is the longest timeframe. Will you undertake to make sure that it is all implemented so that the numbers that we start to train next September are the right numbers for the long-term future of the NHS?

Sajid Javid: I completely understand that. I think it is a vital piece of work. Whatever the output of this work is—I do not want to try to pre-empt it now—and whatever profession it is for, I will want to make sure that I am doing everything I can to help meet that. You talked about medical places, and I will certainly, off the back of this work, want to review that. I am anticipating some of that already. I have to plan now even though I do not have the final product.

You will know that we have already increased the total number of medical places available in the last two years for medical training for doctors. We have the cap in the last two years for the entry of 2020 and 2021, and we will keep that under review looking forward. I anticipate that there will be an increased need—actual numbers, as well as what I was referring to earlier about how the work is done as well. When the final document is ready, I will do everything I can to make sure that what is in the strategy is met.

Q344 **Chair:** I am going to take that as a yes just because I think we all very badly want this problem to be solved, and it would be so depressing to think it is going to take another year.

A Royal College of Nursing report out this morning says that a third of people with long Covid are waiting more than 15 weeks for an initial assessment. We think there are probably 2 million people with long Covid. Are you satisfied that we have enough capacity in the system to deal with the needs of people who have long Covid?

Sajid Javid: The NHS is working on a plan. The ONS is what I look at in terms of the best estimates we can reasonably get of the number of people who may have long Covid. As you say, they estimate that it is 3.1% of the population—around 2 million. It may increase or it may not, but that is what the NHS has taken as the guidance in coming up with a plan. The whole purpose of that plan is to make sure that we have the workforce we need and the type of workforce that will be necessary. It is something we take incredibly seriously. There is already a huge amount of investment specifically into researching long Covid, and part of that research work is making sure that we are looking at the workforce need.

Chair: Thank you.

Q345 **Dr Evans:** Secretary of State, would you set out your understanding of the issue of senior doctors and pensions?

Sajid Javid: First of all, what I would say about pensions in healthcare is that, generally, we can say we have a generous system of pensions; nine out of 10 healthcare workers across the board, not just doctors, join that pension system. As you know, it is voluntary for them. My first interaction with this particular issue was that in certain circumstances a senior doctor, because, as you know, they are typically the highest earners in the NHS, can reach their threshold in the allowance—especially linked to the taper rate of the annual allowance, which has historically been the biggest issue—and/or they can have a challenge with the total lifetime allowance.

The first time I properly looked at that was not in this role; it was when I was Chancellor. I was persuaded then by my predecessor that something had to be done because it was having an impact on the number of hours worked, and that was crucial. I accepted that we had to make a change, and that was implemented by my successor as Chancellor. The taper was certainly considered by the previous Secretary of State. My understanding was that that was the main issue, and we increased the point where it kicks in—I think—from £110,000 to £200,000 a year salary. That has had a dramatic impact.

I remember the Department said at the time that something like 96% of GPs and doctors were inside the £200,000 level. Only a very few were left after that change affected by the taper rate in a negative way. It cost the Treasury £2.2 billion. That was the estimate at the time. That is important because the change had to be made for everyone—not just health workers—for equality reasons. Whether you worked in private equity or you worked in the NHS, if you were at that income level, you received the benefit of that. In that sense, it was a very expensive

change. I think it was the right change. To finish on this, because the pension issue is important, we are still looking at what further flexibilities there could be to make sure that pensions are not getting in the way of work effort.

Q346 **Dr Evans:** It has not escaped my notice that that was your previous role before you stepped into the Health Secretary role. I see from the doctor's side and the politician's side the balance in getting taxpayer value, because doctors are well-paid by comparison, but, to be frank, we are facing a huge backlog, and senior doctors are choosing not to work because of the worry about their pension and their pay, especially now with inflation. One solution when this happened similarly in the judicial system was that a system was put in place for judges. Is that a consideration that you have had, or in conversation with the Treasury, about having an unregistered scheme? Is it something that has crossed your desk?

Sajid Javid: I am aware of that scheme, and we are looking at further flexibilities and what those ultimately will be, because of joint work between ourselves and the Treasury. If they are tax changes, clearly that is ultimately for the Treasury. The Treasury takes this seriously. One thing that plays on my mind—to be very open about this, as I always am—is that you are talking about senior doctors and some of the highest paid, not just in the NHS but in society. I think I am right in saying that anyone earning more than £200,000 a year is probably among the top, highest paid 1% or 2% in society.

In terms of workforce and paying fairly for the NHS workforce, there is a lot of demand on the budget. While it is right to think about what changes might be necessary for some of the highest earners to create the right incentives, I also want to make sure that it is well balanced with nurses, for example, who are earning much more average wages.

Q347 **Dr Evans:** That is a really good point. I definitely concede that. That is why I opened my question with it. When it comes to healthcare, there are only certain things that certain people can do, because they are, by definition, the experts in what is needed. We have such a big backlog, the likes of which we have never seen before. You may not have the answer yet, but a useful steer is what the compromise is in determining paying that money for the experts to make sure that there is no disincentive to get the backlog dealt with. Are we dealing with a principled position or a practical position, or something in between the two?

Sajid Javid: Of course, we want to be practical. For example, one thing that we did recently was publish guidance for NHS trusts, because they are ultimately the employers of these doctors, around flexibility—the option for them in many cases to give salary in lieu of pension contributions. Instead of an employer's pension contribution, they could offer the doctor the equivalent amount but in salary. Of course, it is taxed, but the doctor still gets that income. Some trusts are doing that. Other trusts are not, and that is why we issued guidance recently to

make it clear that it is something that we, at the centre, are happy with. Ultimately, the trusts are the employers. We want to make sure that they understand that they have these flexibilities, and where that is happening, it is certainly helping.

Q348 **Dr Evans:** Thank you. We have dealt, through the Chair, with people coming through the bottom. I have just dealt with the people at the top. We have heard about the middle people. Would you consider, or are you considering, mandating list sizes for GPs—1,500 patients per GP or 2,000 patients per GP—to try to control the workload and manage the difficulties that we heard about in the evidence given? If you are not considering that, what other considerations have you made about managing the day-to-day workforce?

Sajid Javid: The important work that has been done broadly in that area very recently, and something I am taking incredibly seriously, is what we call the Fuller stocktake—Claire Fuller's recent report commissioned by the NHS broadly on primary care. She looked at the whole issue of what we started the session with today: the workload for GPs, the flexibilities for GPs, and even the issue that the Chair referred to at the start about continuity of care. She had a lot of very sensible stuff to say on that. I am looking carefully at that report. I know the NHS, which commissioned it, has taken it very seriously. I am also looking, using that report, at what further changes we need to make in primary care to make sure that it is better, most importantly, for patients, but also that there is a better work environment for GPs.

Chair: Thank you. Sarah Owen.

Sarah Owen: Do you think I will get four questions in?

Chair: You could try.

Q349 **Sarah Owen:** We have heard evidence around international workers, particularly shortages in social care. How do you respond to those who say that the salary requirement is too high and the one-year limit, which we heard repeatedly, is too short for the health and social care visa to be attractive to international workers?

Sajid Javid: Are you thinking about just social care, not healthcare?

Sarah Owen: Yes.

Sajid Javid: If I remember correctly, in the recent changes we were adding this to the shortage occupation list. In doing so, there was also a reduction in the salary requirement. Is the salary £20,400 or something? Is that right?

Michelle Dyson: It is £10.50 an hour.

Sajid Javid: I think that is the right level. If you are asking me whether I think it is the right level, I do.

Q350 **Sarah Owen:** Also, the one-year limit was a major limiting factor for people wanting to uproot and come to this country and settle down.

Sajid Javid: It is important to keep these things under review. I pay a lot of attention to both workforces, but in adult social care there is an acute problem; we absolutely need more workforce. I am not convinced at this stage that the one-year limit is stopping people from abroad applying to come and work in the UK as adult social care workers.

Q351 **Sarah Owen:** Okay. I want to move on to the backlog. The BMA estimates that there are—

Sajid Javid: Are you going on to the NHS now?

Sarah Owen: Yes, I am.

Sajid Javid: I am just making sure. There are lots of backlogs.

Q352 **Sarah Owen:** There are lots of backlogs, which is what I was about to get on to. The BMA estimates that there are 6.1 million people waiting for treatment at the moment. During the Committee's recent inquiry, we heard repeatedly—

Sajid Javid: Did you say 1.6 million?

Sarah Owen: I said 6.1 million.

Sajid Javid: Okay.

Q353 **Sarah Owen:** During the Committee's recent inquiry, we heard repeatedly that workforce shortages were the key limiting factor when it comes to reducing the backlog caused by the pandemic. How is workforce planning taking the need to tackle the backlog into account?

Sajid Javid: First of all, the backlog is 6.3 million. I just want to share that with you. I have been clear ever since I have had this job that because of the impact of Covid, the number of people who stayed away, the NHS estimates, is somewhere between 11 million to 12 million. I want as many as possible of those people to come back, and to know the NHS is there. That massive increase in demand above normal will mean that however hard the NHS is working—you will know that under its Covid backlog plan it plans to take activity up to 130% of pre-pandemic—even then the backlog will go up before it comes down. I wanted to state that.

How important is workforce? It is crucial. I made a big speech on what I think is the future of healthcare in this country and the things we need to focus on. I talked about the four Ps, and one of them was people. I said at the time that that is the most important of all, and it is crucial to dealing with the backlog. We have specific new funding. For NHS and social care in total over the next three years, there is around £39 billion of new funding.

You asked me about electives and the backlog. Over the next three years, there is an additional £8 billion, and probably most of it is on

workforce as well as other things like technology, the digital side of this. I referred earlier, when the Chair asked about the NHS workforce strategy, to the fact that that clearly will be something that will set out what numbers we need and what areas we need workforce in, including dealing with the elective backlog.

Q354 **Sarah Owen:** My last couple of questions are around whether we should have been much more prepared for protecting our workforce from pandemics and building resilience. Do you agree with your Cabinet colleague who was very critical of our Chair during his time as Secretary of State around preparedness for pandemics, or do you think the current Prime Minister's delays at the start of the pandemic have actually had more of a role in creating the perfect storm that we have seen with workforce burnout and backlogs?

Sajid Javid: I came into this job almost a year ago, and I really do not know the detail of what was done prior to my time about pandemic preparedness. Certainly, it is my responsibility to deal with this pandemic and absolutely to prepare for the next one, but I cannot answer your question about how prepared we were, what exercises were done and things. I will point out that pretty much the whole world, including every country in Europe, had a pretty similar experience to us with the pandemic. I cannot think of a particular country that you could point to and say, "They were definitely more prepared, and we should have done that."

While I accept broadly that in the pandemic, clearly, we did not get every single decision right—no country in the world did that—we got the big decisions right, not least how the country responded with its vaccine programme, which has been world-leading; our antivirals programme; and our diagnostics, the home-testing programme. I am sure that the broader questions around pandemic preparedness will be looked at by the independent statutory inquiry.

Q355 **Sarah Owen:** My last question is around maternity and maternity safety. We have talked a lot about midwife shortages. Pregnant women really suffered during the pandemic, and we saw the number of stillbirths increase. They doubled in some places. When are we going to see that it is just as safe for a white pregnant woman and a black pregnant woman to give birth in this country? When are we going to see parity of safety when it comes to pregnant women in this country?

Sajid Javid: I want every woman, no matter what her background, to feel that the NHS is a safe place to give birth. You rightly, Ms Owen, talk about where that has not been the case. Ms Allan will know that particularly in Telford, as we know from the recent independent report, that certainly was not the case.

In terms of what we do about it, even before the final Ockenden report was published, we accepted all the recommendations in the interim report. We started implementing all those recommendations, both the

local ones and the national ones to benefit beyond that local area, and put in the new funding that was necessary and that was asked for both to hire more maternity workers, nurses, and to support more in training. We will leave no stone unturned to make sure that we improve maternity care in this country and every woman feels safe, no matter what her background.

Sarah Owen: Thank you.

Q356 **Chair:** There is a particular recommendation about 2,000 more midwives and 500 more obstetricians in the Ockenden report. You have accepted those recommendations in full. Could you write to us with a date by when the workforce elements of those recommendations will be implemented because it is of great concern to—

Sajid Javid: Yes, we are committed to that, and I will write to you.

Q357 **Taiwo Owatemi:** Secretary of State, my first question is around staff retention. As you are aware, one of the biggest factors affecting staff retention is unsatisfactory pay and working conditions. For example, in my local hospital the car parking charge currently is £600 per year. Given the fact that we are in a cost of living crisis, what exactly is being done to address that? That is a substantial amount for the staff who have to pay it, given that their pay is not satisfactory, if you ask many of them.

Sajid Javid: First of all, staff retention, of course, is hugely important. It is something that the NHS and, actually, for that matter, adult social care providers spend a lot of time focusing on. We look at a broad range of factors. You have taken one particular example. That can be important, but I do not think that is the only thing that will go into it. When it comes to car parking charges, specifically to answer that particular point, you will know that during the pandemic there was much broader support given for car parking charges for all healthcare workers, including nurses. It was always going to be temporary. We have replaced that with support for specific workers who need it most—for example, workers on night shift. There will be other vulnerable cohorts, including certain patient groups as well, who would get car parking support.

Q358 **Taiwo Owatemi:** I recognise that, but for many staff who work full time, that would go a long way in terms of creating a working environment in which they would want to continue to work.

I want to quickly move on to ambulance services. In the west midlands, we face an ambulance shortage, and we are having more NHS 999 calls than we have ever had before in the history of the west midlands. In my city, a woman who suffered a heart attack had to wait two hours for an ambulance to show up. Many constituents and many people here are very concerned about the fact that we are hearing from experts that in August, if nothing changes, ambulance services in the west midlands will collapse. I want to know exactly what is being done to address that.

Sajid Javid: First of all, it is a very worrying situation that we see not just in the west midlands, but it has been acute there. I accept that, not least as it is my ambulance service as well as yours and Ms Allan's. By the way, I recently met the chief executive of that service, and the chairwoman with him, to understand more about what was particularly going on with that service. As I say, it is not unique. Part of me would love to say it is just one area and we can focus on that, but it is a problem in many parts of the country.

What is being done? First of all, what is the general cause? Why are we having this challenge? Much of it is directly related to the impact of the pandemic. I talked earlier about the delayed demand that is now coming back. It has made the flow through hospitals much more difficult than pre-pandemic. When there are more delayed discharges, the flow from A&E cannot happen. It is often not about a shortage of ambulances; it is more about getting the flow, so that the ambulances do not get stuck waiting to release patients into the care of the A&E Department.

The NHS has set out and published a 10-point A&E plan. As part of that plan, they worked on things like the 111 call handlers—we now have more than ever before—and provided the funding for that, as well as funding for ambulance trusts, with some £55 million of new funding. There was also funding last year of over £450 million to expand certain A&E facilities, and for workforce.

Q359 **Taiwo Owatemi:** I understand that, but we are being told that the ambulance services in the west midlands will collapse by August. We are currently in June. That is two months away.

Sajid Javid: I am aware that some people have said that. That does not make it true. What is true though is that there is a significant amount of pressure on A&E and ambulance services in the west midlands and elsewhere. What I have set out is what we are doing about it. The changes the NHS is making are having an impact. I wish it was even more of an impact. Ambulance waiting times are still very high. They are not on target, but they have been significantly improving in recent weeks.

Q360 **Taiwo Owatemi:** I want to move to ambulance services in the north-east of the country. Two weeks ago, we had a UQ, and some of the answers were a bit vague, so I hope that you will be able to help today. Is an investigation into the negligence and cover-up at North East Ambulance Service being launched? Is an investigation going to happen into what the *Sunday Times* exposed about the negligence and the cover-up at North East Ambulance Service?

Sajid Javid: I am very concerned about what I read and what I understand to be the situation. There has been a review by NHS England of this. What I am considering though, perhaps for the same reasons you have raised, is whether there should be a more independent review of the allegations that have been made, because they deeply concern me. Until

I have the final evidence, they are best referred to as allegations, but those allegations deeply concern me, especially around potential cover-ups, including of deaths, and that is something I take incredibly seriously. I am seriously considering at this point whether—I have asked for advice—we should have an independent review.

Q361 **Taiwo Owatemi:** I think that would be the right direction. Are you looking into how many parts of the NHS are still using non-disclosure agreements?

Sajid Javid: There is no specific review of that. You are probably asking because of the particular trust you mentioned. There were people who said that there were NDAs. I do not just want to assume that everything I read on this, especially in the media, is exactly the case. I think it needs to be properly investigated.

Q362 **Taiwo Owatemi:** Thank you. My last question is about the women's health strategy. Over 600,000 women in this country have been waiting for the women's health strategy for quite a long time. How long will women in this country have to wait to have a clear women's health strategy? Currently, there are long waiting times. There are backlogs in gynaecological care. I had a constituent write to me about how her next appointment is in about a year and a half, which is a very long time. When will the women's health strategy be published?

Sajid Javid: It is almost complete. It will be published very soon. I do not want to suggest, as I think you may inadvertently be suggesting, that nothing is happening in terms of women's health until a strategy is published. Of course, women's health has always been a priority. There are some very specific health needs for women. You referred to a couple. Recently in my Department, we had the whole issue around HRT and access to and supply of those drugs. All those issues are being taken seriously. I think it is right to have a joined-up strategy across Government.

One of the purposes of the women's health strategy is that, while of course my Department takes the lead on healthcare for women, there are important roles played by many other Departments in Government, and it is the first time that any Government has taken the initiative to look at every Government Department that covers a cross-Government women's health strategy. That is how it is really going to make a difference.

Q363 **Taiwo Owatemi:** I will just say that many women have been waiting for a long time. We were expecting it in December and we are now in June. It would be great to know when exactly that is going to come out.

Chair: Maybe you could write to us with an update if there is a plan.

Sajid Javid: I would be happy to do that.

Taiwo Owatemi: Thank you.

Q364 **Lucy Allan:** I congratulate you, Secretary of State, on your response to the Ockenden inquiry, which is very much appreciated.

The Chair of our Committee, when he was Secretary of State, used to read a letter from a patient every day. I wonder if I may read to you a letter from one of my constituents struggling to access a GP practice called Teldoc in Telford, which services 60,000 patients in my constituency: "Please help me with Teldoc. I would like your help and advice. I had a heart attack and I have spent three days trying to contact them and I gave up. On numerous occasions, as of this morning, 30 seconds into the call the phone system closed down, and it is still locked down. I have been to the surgery, got turned away and told the only way that I can book is through the phone. This is not a one-off; it is a daily occurrence. Trying to get basic healthcare is a joke in Telford. Maybe I would be better off in Turkey, a third-world country where the health system is second to none. Please, please, Teldoc needs sorting out."

I get an email about Teldoc probably several times a week. Secretary of State, how are you supporting GP practices with pronounced workforce shortages, such as Teldoc, to maintain access for patients?

Sajid Javid: Thank you for that. I cannot speak about Teldoc specifically—I do not know enough about Teldoc—but I can answer your question more generally, which I think is relevant based on what you said. First of all, if I heard you correctly, if the individual who wrote to you talked about a heart attack, that is very serious. I hope your constituent would have tried calling 111 as well.

Q365 **Lucy Allan:** He wrote to me today, but people write to me every day about difficulties in accessing a GP practice with pronounced—

Sajid Javid: I just want to mention the 111 service for anyone listening. Obviously, everyone knows about the emergency service 999, but the 111 service is also very important and can play an important role. As I said to Ms Owen earlier, we have added more call handlers, and many clinicians are often available to give advice. I mention that as it might be relevant for someone listening.

On your question about what is being done, including in Telford, to help with access more broadly to GPs, one thing is that, as we talked about earlier, we need more GPs. We are hiring more GPs. We have more GPs in training in medical school than ever before. As I mentioned earlier, we removed the caps on that as well.

Also of crucial importance is that when it comes to primary care, it is not just about GPs; there are many other very important, valuable primary care staff professions, and we are hiring those at a record rate as well. I may have mentioned earlier that we have a commitment as a Government to get 26,000 more by the end of this Parliament, and we are on track with that, with 18,000 more. That is crucial. Alongside that, we want to increase the number of appointments, and we are increasing

the number of appointments. It might not feel like that in many areas because demand to see GPs has also increased.

The final area, which is where I want to see much more work, and we have capital allocated for more investment, is more use of technology in GP surgeries. There are some quite basic diagnostics and things that could take place in GP surgeries, and we are making those investments. We want all GPs to have electronic patient records as well—not all do—and make those interoperable with the local NHS trusts and other local health facilities so that patients can get a more seamless and often quicker service.

Another thing that is important and has not come up is training. We need to do more on this because it was in the Claire Fuller report that I mentioned earlier to Dr Evans. We need to look at how we train GPs today. Is it still the best way given the types of diseases they are dealing with and some of the ageing populations that many of them are dealing with, and are there more things that GPs can provide themselves? I gave diagnostics as an example, but are there others in that area?

I know I said that was the last area, but there is another important one, and I know you are going to want to hear it because it will be really important, and that is pharmacists. What further role can pharmacies play? I have asked my team to do a review, which is progressing very well, of having a bigger role for pharmacists to play in local communities. They did a brilliant job with vaccinations. They really stepped up to the challenge. I believe pharmacists can do more, like they do in Scotland, and that is also part of the answer of reducing pressure on GPs so that they can focus on what they really need to be doing, and maybe diverting some of that demand to other qualified professionals.

Q366 **Lucy Allan:** Thank you. On backlog, is it right for a hospital trust not to be carrying out orthopaedic surgery at this point in the recovery from Covid? Orthopaedic surgery was stopped, and it still has not restarted. How are we going to tackle the backlog?

Sajid Javid: Why? For what reason?

Q367 **Lucy Allan:** It stopped during Covid because it was deemed non-urgent. If someone has been waiting several years for a hip or knee replacement, is it right that they are still not operating?

Sajid Javid: The situation you describe generally should not be happening. When Covid was at its height and hospitals were full of Covid patients, the situation was very different. As of today, there are around 4,000 patients in English hospitals who are Covid positive. Over 50% of those are not there because of Covid. Covid is thankfully becoming less and less of an issue. We have removed all of the Covid-linked infection protection controls.

I was going to say that hospitals are getting back to normal. It is not quite normal. Of course, they are facing record levels of demand and

having to deal with that and prioritise based on patients' needs. The NHS has asked hospitals, when they are dealing with those on waiting lists, whether it is waiting for orthopaedics or other services, to prioritise the longest waiters first. Earlier this week, I was pleased to announce that the numbers of those waiting longest, who have been on the two-year waiting list, have halved in the last four months. We have set a target to get that to almost zero by July, and we are on target to do that.

Q368 **Lucy Allan:** The Princess Royal Hospital in Telford is still not doing orthopaedics. What pressure can we bring to bear to get them to start?

Sajid Javid: I am happy to look into that particular hospital and that issue and write to you.

Q369 **Lucy Allan:** That would be very good. Can I suggest that, if you do not already, you read a patient's letter every day and write back personally because I know how important that is?

Sajid Javid: It is about reading patients' letters but also listening to patients in every way possible, whether that is meeting them or even sometimes on social media. I know the Chair is very good at social media; I saw his TikTok video earlier about the questions he was going to ask today, and I was very impressed by his TikTok skills. It is about listening to patients in whatever—

Chair: Before I take any credit, that was my very first ever TikTok video.

Sajid Javid: It was excellent.

Chair: Thank you.

Q370 **Rosie Cooper:** Secretary of State, could I go right back to the very first question the Chair asked, just to test my understanding of what you have said? Workforce planning, Framework 15, refreshing the long-term plan, looking at demand assessments, and accepting that the numbers are not going to be set in stone and will be constantly reviewed: am I right in saying that you have agreed that the figures for the workforce that we require will be published by specialty so that everybody can see them, and almost that you would do the gap analysis and tell us the training places you are going to commission as a result? That is my understanding.

Sajid Javid: Thank you for asking that, because I want to be clear. When the NHS workforce strategy is complete, we will certainly publish the conclusions of that. If you are basically asking, "Will you publish the full report?" because it will include gap analysis and what is needed in each profession, which is a perfectly good question, that is something I would like to do. It is subject to cross-Government agreement. I do not want to pre-empt any cross-Government agreement, but that is something I would like to do.

Q371 **Rosie Cooper:** It is really important because the confidence of

everybody sitting behind you will be right in there.

Sajid Javid: Linked to that, you might recall that in the Health and Social Care Act there is a duty on the Secretary of State to publish at least every five years what was referred to as a healthcare workforce accountability report, and a similar report for adult social care. I really want to make something of that. It is a new thing and has not been published before. You will have the NHS 15-year strategy, but it is important to have periodic accountability reports on workforce that talk about progress, numbers, gaps and all of that.

Q372 **Rosie Cooper:** Absolutely. You must collect that information annually. That could be FOI-ed annually, couldn't it?

Sajid Javid: Why don't you try it and see what happens?

Q373 **Rosie Cooper:** That's down the road. I am making the point that it cannot be a secret, because we are all in it together and we all want to make a difference. I respect what you have said. Thank you very much.

If I have time, I will pick up on comments that my colleagues have made. Another big area that we have not talked a lot about is social care. It is going to take many years for the national insurance increase that we have seen recently to show up in the social care system. In just the three months between August and October 2021, 1.5 million hours of commissioned home care could not be delivered.

I have to ask you, Secretary of State. What are your plans? How are you going to ensure that there is enough commissioned provision? You have talked about hospitals and delayed discharges. It is all connected. The front door is connected to the back door, flow, and all of it. I get it. You talked about ambulances. You talked about £55 million going in, but that is non-recurrent money. For the ambulance services, it is always stop/start. Where can we have a sausage machine, a factory, where it all comes in and flows? That will enable people to deliver what you want. How do you see us making real changes in social care now?

Sajid Javid: First, you are absolutely right to point to the link between adult social care, healthcare, A&E and all of that, especially because of delayed discharges. That is one of the reasons why we recently published the integration White Paper. It is all about how we can get better integration between the two.

You started by asking about resourcing for adult social care. While you are right that, with the health and social care levy, £5.3 billion of that is specifically for adult social care over a three-year period, there are important elements of it for dealing with some of the long-term challenges—for example, the £1.36 billion of it that is dedicated to moving towards a fairer cost for funding and the £500 million that is for workforce training, which has never happened before. It is a fivefold increase on anything that has ever happened before. It is also important to point out that last year total adult social care funding was £20.7

billion. That is the funding from the centre and council tax with the precept included. That is the highest ever.

I believe I am right in saying that this year an additional £3.7 billion was given to local authorities, and, of that, £1 billion has been ringfenced for adult social care, so that is additional support this year as well. There is more resourcing going in. It is not all about resources. It is about training and a better mix of skills in the workforce. If a general point you are trying to make is about the challenge of workforce in adult social care, you are right to talk about it. It is hugely challenging.

Before this Committee, I was trying to remind myself of the vacancy rate. The latest figure we have, from last year, was something like 6.6%, but I must say I think it is much higher than that. Skills for Care has reported something like 10% to your Committee, and I think that is probably closer to where the situation really is. Some of those gaps are filled by temporary care, but it is not in anyone's long-term interest to have temporary workers doing that. It is something we are very focused on.

Q374 **Rosie Cooper:** Secretary of State, you will already know this, and you have been asked to read a patient's letter. What I ask you to do is just think, if you were a family member of a household where care has not been commissioned and you have no way of getting it, how you would look after a loved one. Perhaps supermarkets are paying more than social worker agencies. The CQC is closing down various residential homes and those people cannot make ends meet. Local authorities are pulling out of them. This is more than a curate's egg. It is really serious. You talk about it in general. The Prime Minister says this is going to be fixed. How is it going to be fixed right now?

Sajid Javid: It is important to point out, Ms Cooper—I know you know this, but for everyone's benefit—that, unlike the NHS, the adult social care workforce is not a national public workforce. It is around 1.5 million people. Roughly 1.3 million of them are employed by the independent sector, which is basically almost all of them. There are some 18,000 employers that are small businesses, and they are employed under usual, regular employment law and contract. I point that out because it means Government do not have any direct control. We at the centre set out guidance and part of the funding. As you know, it is a mixed model of funding. Some people get support and others do not if they have the means.

Local authorities have a statutory duty of intervening, and for buying the care packages for people who are entitled to support. When they buy them, the fees that they set have to take into account salary levels in their local market. I point that out because the relationship the Government have with that is indirect. That said, it is hugely in the national interest and the Government's interest that the system works well and that people get the packages of support they need. That is why we are putting in the record amounts of funding. That is why we gave it record levels of support during the pandemic. There is also NHS money.

When I mentioned the £20 billion figure going in, it does not include the NHS money that goes in, when the NHS directly buys packages of support to help with some of the delayed discharge issues.

Q375 **Rosie Cooper:** Secretary of State, what if you have a really disabled member of the family or perhaps a dying relative, and you hear the Prime Minister say, "We are fixing social care," yet you see that social care is not fixed? I absolutely accept that it is a mixed model and we cannot control all of it, but we are telling people that they can get that care. How are we going to provide it? How do we make that market attractive? How do we make people want to be involved? If you fix this, you fix a lot of the problems that will happen in A&E and that will happen with delayed discharges. You will get the front door connected to the back door and you will have the system working. It is central to where we go. In terms of humanity, we cannot sit back and allow this.

Sajid Javid: Of course, I agree that it is a hugely important area. That is why our approach has been what we do short term and then longer term. In the short term, especially because of the pandemic, everyone knows that, like the NHS, the care sector was strongly impacted, and it is still recovering from that, whether that is residential care or domiciliary care. In the short term, there are record amounts of funding going in. We worked with the sector on the biggest recruitment and retention campaign they ever ran. In the winter, we provided £462.5 million for their retention and recruitment programme. We gave extra funding directly to the NHS to buy care packages, which meant that there are more fees, and therefore more support for salaries could go in.

In the long term, when you talk about the Prime Minister's commitment, and he is delivering on this commitment, some of the longer-term reforms around the new means-testing system, as we set out in the adult social care White Paper, will be much more generous than the previous one, taking the upper limit from something like £20,000 to £100,000, so many more people will get financial support. Of course the £86,000 cap on costs to stop people from experiencing catastrophic costs is something new as well.

Q376 **Rosie Cooper:** How do you see the ICS and the new models of integrated care making a difference in this regard?

Sajid Javid: I think it is hugely important. It is a very positive development. For the first time, you have statutory bodies—that is important—that have a statutory role to work with local authorities, the care sector and their local NHS trusts in coming up with an integrated plan. The detail of how I see that working is in the integration White Paper referred to earlier, which talks a lot about the importance of the ICSs.

Q377 **Rosie Cooper:** How do you see conflicts of interest being managed on ICBs where you have chief executives and local authorities? I used to be a local authority member. I have chaired hospitals. Often local authorities

see healthcare as a cash cow, with a lot of money in there. How can you stop provider collaboratives not becoming almost cabals of self-interest? How do you make sure we get the best? I described to Amanda Pritchard that we almost have a tick box; providing you have a policy, you get a tick.

Sajid Javid: The people on the ICBs—the individuals—whichever organisations they represent, will have statutory duties, and the CQC will oversee the ICBs in the work that they do. That is important oversight. We need to keep oversight of conflict of interest, but it is not something that is particularly of concern at this point. There is no evidence of that.

Q378 **Rosie Cooper:** I suppose I was talking about the fact that these bodies are not mature. They are working their way through, and there will be conflict.

Sajid Javid: Although they have just become statutory for the first time, some of them have existed in non-statutory form before, so there is experience, and some of them have been extremely well run. It is also about leadership. It is about getting the right quality of leadership, and that applies equally to adult social care and the ICBs as well as the NHS. As you know, I have separately commissioned an independent report on NHS and adult social care leadership, and I hope to be able to publish that report imminently. Judging by what you have said, you will love it.

Q379 **Chair:** Thank you very much indeed. I have a final couple of quick ones. It has been reported widely that you told the Cabinet that the NHS is like a Blockbuster video store in the age of Netflix. What did you mean by that?

Sajid Javid: First of all, you will know from the Cabinet that you never talk publicly about what is discussed privately in Cabinet. What I will say, and hopefully this answers your question, is that I have talked publicly many times about the importance of modernising the NHS. The NHS is absolutely fantastic and we all rely on it, but much of how it is set up is still very much 1948. We need to be thinking about 2048 and how we get from here to the health needs of the British population in 2048. That means modernisation of structures and systems, using much more digital and technology, for example, to make sure that it is still there for us free at the point of use: world-quality healthcare but a modernised system. I do not know whether you were a member of Blockbuster, but at some point you must have given that up and taken up Netflix. If so, maybe you understand that even more.

Q380 **Chair:** Indeed. We just happen to have a number of NHS England clinical fellows watching this session sitting behind you. Do you have a message for them and other young doctors, given the massive pressures in the NHS today that are worrying so many people about the profession that they have decided to make their life?

Sajid Javid: Hello. Am I allowed to turn around?

Chair: We need the microphone.

Sajid Javid: Thank you very much for what you are doing and what you have taken on. It is hard to think of any better employer than the NHS. If you think of the people you will help and support day in, day out and the friends you will make, I cannot think of anything better to do. Even in the last year I have certainly learnt—as I know, Chair, that you would have over the years when you had my job—how the NHS, as we said when we started this session, is all about its people. That is the most important thing. Without new, skilled people coming in, the NHS would not be able to deal with this demand, so thank you very much.

Chair: On which note, Secretary of State, Matthew Style and Michelle Dyson, thank you for joining us.