House of Commons

Health and Social Care Committee

Oral evidence: Work of the Department, HC 1093

Tuesday 31 January 2023

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Watch the meeting

Members present: Steve Brine (Chair); Lucy Allan; Paul Blomfield; Paul Bristow; Martyn Day; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

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Witnesses

I: Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, Department of Health and Social Care; Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; and Professor Lucy Chappell, Chief Scientific Adviser, Department of Health and Social Care.

Examination of witnesses

Witnesses: Rt Hon Steve Barclay MP, Sir Chris Wormald and Professor Lucy Chappell.

Q1 **Chair:** This is the Health and Social Care Select Committee inquiry into the work of the Department for Health and Social Care. We welcome Steve Barclay, Secretary of State since September. Welcome, Steve—your second stint in the job. Sir Chris Wormald is the permanent secretary, and we also have Professor Lucy Chappell from the Department. Thank you very much for joining us.

Secretary of State, strikes across the NHS are self-evidently one of the major challenges facing the service at this time. What is your plan to end them?

Steve Barclay: First, we are engaging with the trade unions. At the last meeting we had, the chair of the NHS staff council, Sara Gorton, said that our discussion had been constructive, and that is very much the tenor of our engagement with trade union colleagues. We recognise that the NHS has been under huge pressure throughout the pandemic, and that the pressures that many others in society face from the cost of living apply also to those working in the NHS. We recognise, in terms of the demand both from covid and, over Christmas, from the huge spike in flu, that the system itself was under huge pressure. More than 100 times the number of people were in hospital with flu compared with the same time last year—a very sudden spike, with a seven-fold increase in the space of a month going into December, on top of a high ongoing level of covid.

That comes in the wider economic context for society as a whole. Given the cost of the pandemic and the impact of inflation from the war in Ukraine, there have been cost of living pressures, and NHS staff are all part of that. We are engaging with trade union colleagues. I have had a series of meetings with them. We have a process through the independent pay review body; and, indeed, Opposition colleagues—certainly the Labour Front Bench—also support an independent pay review body process.

As you know, Chair, we recognised, given the difficulties, that we should accept in full the recommendations on last year's pay, which we did. That came on top of the 3% that was awarded to NHS staff, when the rest of the public sector had a pay freeze the year before. We are keen to work with trade union colleagues and, indeed, to have discussions with them in the context of this coming year's pay review, so as best to reflect the ongoing pressures in the NHS that play through in staff retention issues, which the Committee may want to explore, and so that we can reflect inflation, alongside the other Treasury equities that other colleagues in Government will want to reinforce, in terms of the wider affordability of any pay deal, given the size of the NHS workforce.

Q2 **Chair:** That is very much looking to next year's round, but of course, as

we heard this morning when Philippa Hird was before us, they will report in the spring, later in April, and that may move the dial on the industrial action, but it is still two and a bit months away. Should we expect any movement on industrial action between now and then?

Steve Barclay: The process through the pay review body is about looking at what has happened since last year. That is the tenor of the evidence that the Government and other representatives submit to the pay review body. Indeed, the witness evidence this morning referred to the fact that there is evidence from a wide field, including some trade unions. In terms of our engagement, and my evidence to them in February, that is still the timeline and the plan. One of the issues that trade union colleagues have raised with me is the length of time, often, until the final decision is taken, and the impact of that in backdating the decision of the pay review body; so we are very keen to work with the trade unions to see how we ensure that the process is completed in an expedited way. I know, and it came up this morning, that the evidence from the Department has been delayed slightly, but that is so we can take on board the representations from the trade unions and have further discussions, not just in Health but across other Departments. That has been very much a cross-government initiative, which reflected the PM's steer.

Q3 **Chair:** The Treasury has submitted to Philippa Hird's committee, but DHSC has not. It is 20 days past when they wanted it. I know she wrote to you just before that time. Are you saying that you are taking into account the Unison paper on behalf of the NHS trade unions? If you are taking all that into account, when can they expect your evidence? Right now they have a bit of a gap in their evidence base, haven't they?

Steve Barclay: I think that came up this morning, in your session. I think 21 days was the point—

Chair: They were very diplomatic, but also very frustrated.

Steve Barclay: No, it is fair, but there is a reason—a very constructive reason—for that. As the Prime Minister said a few weeks ago, we did not want to take anything off the table. We wanted further engagement with trade union colleagues. I had those discussions, along with the Minister of State for Health, on behalf of the Department of Health and Social Care, but they were also taking place across other Departments. We completed ours some time ago, but there has been a need to wait for other Departments also to have those discussions. That is a cross-government process co-ordinated by the Treasury. Once the Treasury is happy for the Department to submit, obviously we are ready to do so.

Q4 **Chair:** On the timeline, Ms Hird said this morning that what has happened in the past is that in September they would get the remit letter and early in the year they would produce their report in time for the Budget, and it would then be accepted or otherwise, in lieu of 1 April, to inform April pay packets. Now they have their remit in November. That

has happened for the last two years. Their aim now—the best they can do, they say—is the end of April, which obviously means some backdating. There may be some more, if they are over-generous and that is accepted. Can we have some acceptance from you that getting back to the September remit letter would be a good place to be?

Steve Barclay: Yes. I think the point you raise, Chair, is a very fair one, and I have had constructive engagement on it with the trade unions. I do not think that either party wants the final conclusion of the pay review body to be as late as it has been in recent years. I think there is common cause on that. There has been a constructive reason why the remit letter went in on 16 November, and why there have been further discussions on evidence before submitting it, not least so that we could take on board some of the trade union concerns. As you know, Chairman, a number of the trade unions have expressed concern about engaging with the pay review body process as a whole, so we wanted to make sure that the evidence best reflected the wider economic circumstances.

Obviously, inflation forecasts have moved significantly, both ways. If you go back to when the SR21 agreement was reached, the forecast peak was 4%. We then ended up peaking at 11%, which is very different. That is a key factor that trade union colleagues have been raising in their representations. It has been right to have those discussions. It is also reasonable that they are across Government, because the centre will want to take on board the discussions that the Education Secretary is having with the teaching unions, other Ministers, and so forth. That is the process we have engaged in.

Q5 **Chair:** Other colleagues are probably going to return to the subject. A final one from me: last week in your topical statement at oral questions you announced the major conditions strategy. I think it is fair to say that it has caused some concern in the cancer community.

I have three quotes. Cancer Research UK: "It's extremely disappointing that ministers have opted to publish a 'catch-all' major conditions strategy rather than the ambitious #10YearCancerPlan they had originally promised." Pancreatic Cancer UK: "We struggle to see how the urgent and detailed action we need on pancreatic cancer and other less survivable cancers can be achieved within a strategy spanning six enormous health areas." Macmillan: "At a time when cancer services are already under immense pressure, Macmillan are worried that the focus on cancer will be diluted or downgraded in light of this change."

Secretary of State, what can you say to the cancer community to relieve their concerns that cancer has been downgraded as a result of its inclusion in the major conditions strategy?

Steve Barclay: First, I can absolutely reassure you that that is not the case. It is very much a central part of our focus. In fact, if you go back to the statement I gave to the House on the day it resumed after the Christmas recess, I talked, as has the CMO, Professor Chris Whitty, about our three-stage response. The first bit, which is the £250 million I was

talking about, was the immediate A&E pressure that we had seen. The second part was what I announced in the House yesterday about the urgent and emergency care recovery plan. That is about building resilience into next year. The third bit is about prevention. That is what we also need to lean into if we want to shift the dial in terms of the NHS.

I know that, not least from your time as a Minister in the Department, this is something on which you have taken a leadership position. The reality on cancer is that a quarter of us are living with more than one health condition, and two thirds of cancer patients have at least one other condition. To understand why we are looking at it holistically, we need to start to reflect the fact that many patients have more than one condition. The tendency has been for a medical system with greater specialisation but more siloed operating. We need to look more holistically at how we treat the whole, rather than single conditions; even more so with an older population where people tend to have more than one health condition. This is particularly targeted on, among other things, the cancer community, because, as I said, two thirds of cancer patients have at least one other condition. Hopefully, that gives some reassurance about the more holistic way of looking at how we approach those major conditions.

Q6 **Chair:** It does, Secretary of State, but we want to be sure: when you look at the two-week wait, 78.8% of people are seen by a specialist within two weeks, and the target is 93%; and when you look at the 28-day faster diagnosis standard, which, to declare my interest, I implemented as a Minister, 69.7% were told definitively that they did or did not have cancer within four weeks of an urgent referral, and the target is 75%. We had Cally Palmer and Professor Peter Johnson before us in one of our early topical sessions. I know they are working their socks off to make sure that we meet our cancer standards, but we cannot let anything slip. There is a serious situation with cancer services, and I think that people want to be assured by you that in your conditions strategy cancer will have its rightful place and will have focus from you as the Secretary of State.

Steve Barclay: I am very happy to give that assurance. Knowing your interest in this, you can imagine that when we were drawing up the major conditions approach we had that in mind as well. You mentioned Macmillan, which is an absolutely key stakeholder in this regard. Previously it said: "The presence of long-term conditions is associated with poorer cancer survival rates and a higher level of need. We need to care for the whole person with cancer, not just treat single diseases and their individual symptoms separately." Macmillan itself had previously called for national policies to consider the impacts of other conditions on cancer. That is what we are doing with the major conditions strategy.

There is one exception to that, and that is suicide. Mr Morris and some others in the Committee may have a particular interest in that, given their past work. We think a separate suicide strategy is warranted, because it does not fit in quite the same way within the approach we are

taking to major conditions, so that will be taken forward with a separate approach, but mental health as a whole fits within the major conditions paper.

Chair: We will come on to mental health in a bit. Dr Caroline Johnson.

Q7 **Dr Johnson:** Thank you, Chair, and Secretary of State. I have three questions on three quite different areas. The first leads on from cancer to something that we know is a preventable cause of cancer—tobacco smoking. The Government requested the Khan review, which was published last June. The then Secretary of State committed to using the information both to inform the health inequalities White Paper and to publishing a tobacco control plan. There is a difficult message to balance, to get people who smoke to stop, or to vape instead, while preventing children from taking up either. What response do you have to that? When will your tobacco control plan be published?

Steve Barclay: I am sure that Professor Chappell will talk about some of our prevention work on smoking cessation. Everyone recognises the centrality of our approach on smoking cessation in the context of lung cancer. There are a number of areas where we can be innovative as part of that. We may, later in the session, come to some of the regulatory flexibilities that we have as a result of leaving the European Union. One that I was looking at last week was in the context of vaping. The dosage level of vaping can be flexed, in terms of our regulatory freedom, to better shift people away from smoking to vaping.

In the context of our wider prevention work we are looking, first, at recognising that smoking cessation is absolutely core to our approach on tackling lung cancer, which is extremely difficult in terms of treatment; and we are looking at some of the regulatory freedoms. Lucy might want to add to that.

Q8 **Dr Johnson:** The question is, when will your plan be published? It was committed to for last year, but it has not been published yet.

Steve Barclay: We have not set out a firm date on that. The priority has been around the three recovery plans, in terms of cutting waiting times, so there has been a particular focus on that in recent weeks. What I am signalling, Dr Johnson, is the fact that we absolutely recognise the importance of smoking cessation, within the wider approach to cancer.

Professor Chappell: I very much agree. We need to see it in the framing of the benefits that come in terms of both cardiovascular disease and the excess deaths there, and cancer prevention. It goes back to the major conditions strategy, trying to see this from the perspective of a patient, which is that they want joined-up conversations. It is where we want to see a greater emphasis on secondary prevention. Secondary prevention is an opportunity for all healthcare professionals to ask what they can do, so that they take the opportunity to think about smoking cessation for the person in front of them, and about the range of options

we have, such as using vaping as a bridge to quitting, as well as other methods. We have seen that particularly in pregnancy, for example, where there are inequalities across the country and we may need a range of approaches for working with pregnant women. Then we can really see a focus on what is such an important area, as you know from your work.

Q9 **Dr Johnson:** My second question is on a slightly different topic. We know that an increasing number of children experience gender dysphoria and there are spiralling waiting lists. These children are waiting an unacceptably long time for a professional medical assessment from the expert clinics. Last summer, Dr Hilary Cass essentially said that the Tavistock Clinic, the only one for this specific specialism, was not fit for purpose, and recommended it be closed.

There has been a consultation on an interim service guideline, but at the moment, while two new clinics are supposed to open in spring, the consultation is finished and we have not heard much from Government. What is being done to ensure that children get better care and that waiting lists come down? To follow up on that, how are you making sure that the people who ran the clinic so badly before are not put in charge of running the new ones as well?

Steve Barclay: Taking the latter point first, one of the best ways of addressing that is far greater transparency. One of the concerns with what happened previously—my colleague the Minister for Equalities has spoken out about the concerns—was the lack of transparency about what was happening. There were concerns about the advice, and about the decisions that children were taking, often at a very young age. In terms of the concerns about those involved previously, part of that is being much more transparent about what actions were taken and how people are held to account.

More generally, we need to be cautious about decisions that very young children take, and at what stage of life that is, ensuring that we empower the patient but reflect the stage of life they are in before decisions are taken from which it is hard to return.

Q10 **Dr Johnson:** In the interest of transparency, there was a consultation, which was completed on 4 December. The clinics are due to open in April 2023, so that is not very long from now. Are you confident that the new clinics will be open by then?

Steve Barclay: I will have to write back to you about the timing of the clinic openings.

Sir Chris Wormald: To be clear, this is an NHS programme of reform; it is implementing the Cass review, so we will get you an update from the NHS on what their current timelines and plans are. Lucy, do you want to add anything?

Professor Chappell: This is an area where it is clear that the evidence base for prescribing treatments has been uncertain, so we are actively working from the research side with NHS England to look at how we offer

evidence-based care. We typically use a range of clinical research options, including randomised controlled trials. We have seen how they worked in covid, when we had uncertainty over the best treatments. We will be clear about the collection of outcomes and not just understanding the short-term outcomes, but investing in collecting the longer-term outcomes. This is not just in the UK. It is an area of uncertainty on an international basis. I think we are going to be leaders in how we approach this, going forward.

Dr Johnson: My final question is about dentistry.

Chair: Shall we come back to dentistry? I want to get the mental health piece in before the half-time, or quarter-time, oranges—imagine if we had them. Then we will come back to dentistry, because it is a really important point. I will let you sharpen those questions.

Q11 **James Morris:** Coming back to the mental health plan that you mentioned, Secretary of State, midway through last year the Government announced a consultation on a 10-year mental health plan. Why did you abandon that?

Steve Barclay: We are putting significantly more funding into mental health—£2.3 billion more a year by ’24-’25. We have been doing a lot of work to evaluate the measures that have been taken to date. You may have seen that there was some very positive evaluation of the interventions we have been making through the schools programme. The data on its effectiveness looks positive. More than a quarter of schools are now in that programme and I think there has been recognition, as the Committee as a whole has recognised in the past, that mental health pressures often accumulate at a very young age. That is why prevention before the age of 15 is important.

Q12 **James Morris:** But why no distinctive mental health plan? Why have you made the decision to fold it into the major conditions strategy, notwithstanding your comments about suicide prevention? During the coalition Government, the Government for the first time brought in a five-year plan for mental health, which sent a strong signal not only to patients but to the mental health community, that for the first time mental health was being taken seriously in terms of moving towards parity of esteem between physical and mental health. It acted as a way of galvanising action in relation to the focus on mental health. One of the concerns is that abandoning a 10-year plan for mental health sends quite a bad signal that the aspiration to achieve parity has been abandoned or downgraded.

Steve Barclay: First, the financial commitment is there. Secondly, obviously I cannot pre-empt fourth Session legislation, but the Committee will be familiar with the fact that the House of Lords has been looking at pre-legislative scrutiny of the mental health Bill. Perhaps as a signal to the Committee, the fact that I was discussing that with Baroness

Buscombe last week perhaps indicates the direction of travel. I go no further than that in pre-empting whether there will be legislation or not.

I think there is a danger, if I can be so bold. When I was in the Cabinet Office I had at one stage responsibility for science, and I discovered that we had over 60 strategies for science and technology across Government. There is sometimes a danger that people confuse a strategy with delivery on the ground. With the major conditions, we have the funding commitment and more evaluation to assess what works, and we are testing where we can use innovation more. I flagged this in the House. One of the areas on which I was rightly challenged from the Opposition Benches was how we support people before they go into a mental health crisis. I gave an example of how we can use digital much more to empower the patient. We should be looking at conditions much more in the round, and that is in the major conditions paper. It would be a mistake to think that a plethora of strategies is necessarily the best way to deliver.

Q13 **James Morris:** On that, there was a consultation last year which raised a lot of expectation that the Government were taking mental health seriously. A lot of people put in quite good submissions. What are you going to do to make sure that those submissions get taken into account in the major conditions strategy, and that mental health does not just become some kind of subset, given the other priorities that you currently have?

Sir Chris Wormald: You are spot on. We have to avoid exactly what you say. All that information is with the Department and with the NHS and will be built into policymaking, but what we are really describing, to come back to something the Secretary of State said earlier, is having a tension in health policy between treating conditions and treating the person. Really great health policy does both, and it has come out in the debate that we have had: do you have a condition-specific strategy or a person-specific strategy? As I say, clearly you want both and—

Q14 **James Morris:** Sorry to interrupt. I understand that. I will give you an example of the issue for mental health. Stephen Powis did a clinically-led review two years ago, and made some recommendations about waiting times and access standards for access to mental health services. Since he did that review, it is fair to say that nothing he was recommending has been done in relation to waiting times and access standards. Previous to that, there was a big battle to get any agreement on waiting times and access standards; my concern is that with the downgrading—we can argue about whether it is a downgrading—those battles become even more difficult when we are talking about mental health, because of the prioritisation of cancer and other prioritised physical health issues. Then it becomes even more important that mental health gets its own space.

Sir Chris Wormald: I agree completely, except for the word "downgrading". I do not accept that either we or the NHS have done any downgrading. We have, post the last piece of legislation, a new vehicle

for integration, the heart of which is "Let's look at the person as well as the condition." The test of your description of what needs to happen will be whether the ICS and ICB process properly prioritises mental health in exactly that way. The reason you have to do it that way is, obviously, the overlap—just as there is a big overlap where people have different major conditions—when people have mental health conditions and physical health conditions, and the self-reinforcing nature of those. If you have a musculoskeletal problem and you cannot work and are in serious pain, it makes your mental health worse. We have all seen those examples. That is one of the integration issues that the ICS-ICB system is designed for.

I completely agree with you that in the approach that the Government and the NHS are taking, it is very important that mental health does not get lost, and that it is hardwired into general thinking about health, as opposed to "We've done all these things and, oh yes, now we need to do some mental health on the side." Your test is exactly right.

Q15 **James Morris:** The bell is about to go and I have just one question. Secretary of State, you said that you had been discussing the Mental Health Act reform following the Committee's report, so is it your expectation that legislation will be brought forward for the reform of the Mental Health Act in the next Session of Parliament?

Steve Barclay: As I just alluded to, answering the Chair, it is a cross-government decision on legislation for the fourth Session; but we welcome the report of the Joint Committee and are considering that. Partly why I met the Baroness was to discuss that.

Further to that and the permanent secretary's points, you ask whether we are showing commitment to mental health, and I will give two examples. One is from this week. You can see that the commitment to mental health ambulances was a key priority and I think it will make a material difference. Secondly, there is the roll-out, three years ahead of schedule, of 24/7 helplines for mental health by all providers.

You are right; if one goes back to a previous Prime Minister, Prime Minister May, she had a big commitment to mental health. That was reflected in the long-term plan. The Chair is familiar with the discussions held at that time. You can see just from the announcement this week that there is a commitment to mental health. Obviously, discussion on legislation and the Mental Health Act and making sure that we have legislation fit for the 21st century is part of that, but you can also see the funding commitment that has been made. The context for the last couple of years was the pandemic, which had a short-term impact on some of the longer-term plan objectives.

Chair: Thank you very much. We cannot pre-empt fourth Session Bills. Spoken like a former Whip, Secretary of State, if I may say, and I was there with you.

Q16 **Lucy Allan:** Secretary of State, I represent a constituency that has one

of the poorest performance metrics across every single measure, and I am very grateful indeed for the urgent and emergency care plan that you have announced because it will make a massive difference to my constituents. What is your Department doing to tackle the huge disparities? If you live in London, you will have been getting orthopaedic care throughout covid, but if you live in Shropshire it has not restarted at the Princess Royal in Telford. There has been no orthopaedic surgery since before covid. We have huge disparities right across the patch, whether it is access to GPs or maternity care in a particular area.

Does your Department look at poorly performing trusts, areas that are not delivering care to patients, and work with them? It is beyond special measures; it is identifying and tackling that massive disparity, because it cannot be right that how you are able to access care depends on where you live.

Steve Barclay: There are a number of things in that question. There are programmes like Getting It Right First Time, which looks at how we redesign pathways to enable patients to get the right care; how we empower patient choice, which is something that we are looking at within the electives.

Q17 **Lucy Allan:** How do you target the bad performance?

Steve Barclay: Your trust, I think, is in operating framework 4, which means that it gets national support for reasons that you and I have talked about offline in the past in terms of the challenges that Shrewsbury and Telford has faced.

I would slightly widen it from just the trust. We need to be looking much more at the system-wide response. The integrated care boards became operational in July. I do not think it is right that every trade-off on risk should be taken by me or by the permanent secretary or the Department centrally. We should be devolving more, but the flip side to that is that we should have greater transparency on the data so that we can particularly target variation in performance.

We should not be second-guessing all the decisions; we should devolve. The Hewitt review is tasked with looking at how we best do that, and then within that what is best done at regional level and what is best done at national level. Within that, there will always be a place for some national support programmes for areas that are under particular challenge. That is the nature of the support that Shrewsbury and Telford has been receiving.

Sir Chris Wormald: If he was here, this is what Sir Jim Mackey, who runs that programme for NHSE, talks about. If you look at the elective care plan, I do not think there is any dispute that those are the right actions. They have wide support across the NHS, clinicians, and so on. We are very confident that we in the NHS have a clear plan. He talks about how you drive that in local circumstances in a difficult place that is

not performing, and that is his laser-like focus in exactly the way the Secretary of State said.

That is not to say that it is easy. As we discussed before, the difference between having a great plan and one more elective surgery that was not happening before happening in a hospital in a constituency is the tough bit. If you look at what Jim and his colleagues do every day, it is exactly what the Secretary of State described.

Q18 **Lucy Allan:** It is about making sure that the worrisome trusts are on your radar. I will move on to maternity care and back to my local experience—

Steve Barclay: Just on that, 15 trusts were responsible for more than half of ambulance delays in the summer. We have massive variation in theatre utilisation. We should be aiming for 85%. We do not have that. Quite often, theatres take too long to get going or finish too early.

Q19 **Lucy Allan:** You very kindly agreed to meet me and my Shropshire colleagues.

Steve Barclay: Exactly. Those are the sorts of things we will be looking to push on.

Chair: Hold that thought on maternity. The sitting is suspended while we vote, and then we will resume.

The Committee suspended for a Division in the House—

On resuming—

Chair: The Health and Social Care Select Committee is resuming its session with the Secretary of State. Lucy Allan was about to ask about maternity services.

Q20 **Lucy Allan:** We were talking about regional disparities in performance. I wonder if I can open that up to look at maternity care, because this year we had the publication of the Ockenden report, which was unfortunately very many years in coming to light. What is your Department doing to ensure that where we have failing services they are identified quickly and that the disparities are evened out so that we can have a national health service right across the country where quality of care is equivalent?

Steve Barclay: You raise an extremely important point. All of us are very conscious that there has been a series of incidents. I was in the Department with the Chair when there were the issues with Morecambe Bay. I remember the very concerning evidence of James Titcombe about Joshua. That was something I particularly remembered coming back into the Department when I saw the work of the Ockenden review.

As you will be aware, we have accepted all of the recommendations in full. That included the 15 immediate and essential actions to improve care. I am sure Professor Chappell will come in, but I would frame them

in three ways: first was looking at establishing the independent working group led by the Royal College of Midwives; second was the endorsement of the plan to establish a special health authority; and third was the endorsement of the Committee's recommendations in terms of additional funding.

The additional funding has gone into prevention of harm; that is £200 million to £350 million into maternity services to prevent harm. There has been that investment as well, recognising, quite rightly, the points that the Committee has previously made when looking at that. There has been a serious issue. There is recognition that improvements need to be made. The Ockenden report is extremely important, and it is one where the Department has accepted the recommendations fully.

Q21 **Lucy Allan:** If I could interject , one big takeaway for me was the difficulty in getting people to take seriously the concerns of families. I was a new MP in 2015. I would raise this with management, and there was a culture of, "No, this is perfectly normal; this is what happens. Nothing to see here." It was an accountability issue. A culture of accountability was really lacking: "Why are these MPs asking questions?"

I think we have moved forward, and we now have a fantastic ICB chair, Simon Whitehouse, and a great chief executive of the hospital trust, but there will be management in place today elsewhere who are not looking for signs that things are going wrong. What is your Department doing to make sure that when it comes across your desk warning signals flash straight up?

Steve Barclay: Again, part of it comes to the work we are doing on data transparency. One of the things I am very interested in is looking at variation in performance, looking at where similar trusts are producing different results, and thinking about how we use technology to better assess large volumes of data, for example the way artificial intelligence can identify patterns within data, which then allows for more targeted investigation. There are important lessons.

Certainly, I was very struck by the response to the women's health strategy where one of the key themes that came through was a feeling of women's voices not being heard in a system where, despite the workforce being predominantly women, the feedback was very clear that it was felt it was designed by men for men. That was reflected in the women's health strategy around, for example, the one-stop shops and redesigning services in a more holistic way.

The same goes for maternity in looking at where there are patient safety incidents, how those have been reported, and how whistleblower concerns are addressed. Anyone who recalls my role on the Public Accounts Committee will know that I particularly championed the roles of whistleblowers in health, and stopping gagging clauses because transparency is important in picking up on where there are issues.

Q22 **Lucy Allan:** Do you think there is a culture in the NHS that needs to change?

Steve Barclay: I think there is variation in the NHS. You see some areas that are extremely good and others where there have been persistent concerns. The question is the speed at which those are identified and how quickly measures are taken to intervene.

Sir Chris Wormald: You put your finger on a very important set of points, like triangulation. For any safety system in any environment, but particularly in health, it is no one thing. It is duties of candour. It is inspection. It is in-trust systems. It is patient voice. It is whistleblowing. It is patient safety commission. You have to have a multiple system so that if one bits fails—in your example, the in-trust governance had not worked—there are multiple other ways of identifying the same thing. If you look at the development of this, particularly under the current Chancellor who made it a big issue, that is what he put in place and what we have built on. Hopefully, we are not reliant on any one thing to spot a potential problem. We ought to let Lucy speak, given that it is her field of expertise.

Chair: With respect, Permanent Secretary, we will decide who answers which question. I feel you have had enough answers, Lucy.

Q23 **Lucy Allan:** Do you have something you would like to say quickly, Professor Chappell?

Chair: Briefly, Professor.

Professor Chappell: I speak as a practising consultant obstetrician. You are right. When I talk to women every week in clinic, they want to have a safe mum at the end of pregnancy, a healthy baby, and a positive experience, with respectful care. Our colleagues as healthcare professionals—doctors, midwives, ambulance colleagues—all want to be part of that, and we want a real impetus towards a culture where we go to work to do an amazing job to make a difference, and we want the environment in which that can thrive. We have seen the reports. We are also seeing real motivation through a whole range of moves, not just the numbers but, as you say, variation and how we work to get that culture right.

Chair: That was a very interesting exchange. Thank you. Chris Green will ask about ICSs, which, Secretary of State, you will know, we are holding an inquiry into—the original inquiry into ICSs. We very much welcome Patricia Hewitt's help.

Q24 **Chris Green:** Secretary of State, the integrated care system/boards/partnerships are key to driving the improvements in the national health service across England. Health and social care devolution like this first came to Greater Manchester in 2016 as a mayoral responsibility. Was it a success?

Steve Barclay: I don't think the Mayor of Manchester has been as successful as one would have hoped in what has been devolved. Clearly, there is a role for combined authorities in what the wider direction of travel is around integration. I think there is a role for elected mayors, particularly in the public health space, to play a role in that integration.

I come back to the point about variation in performance. If one looks commercially, I do not think most businesses would accept the level of variation that we tolerate, or is tolerated, in the NHS. Accepting that the 42 ICBs are different demographics and different sizes, and at different levels of maturity, the opportunity moving forward is to compare and contrast their performance, which is not to say that each one should be similar to others, but to look at cohorts within those 42 ICBs where there are comparisons that can be drawn and look at how they are managing the devolved powers and how we compare and contrast that between them.

There is a role for the mayor. I do not think the pilots that went to the Mayor of Manchester have been as successful as they should have been, but I am very keen that we have greater transparency so that we can empower people to reach their own judgment.

Q25 **Chris Green:** That must be quite frustrating because not only was £450 million transformation money put into Greater Manchester but it was supposed to a certain extent to show leadership to the rest of the country as a role model to follow. This is where health and social care should have been brought together more effectively. It should have been role modelling that in Greater Manchester so that other parts of the country could now be following.

Steve Barclay: Yes. There are other authorities, like my own in Cambridgeshire and Peterborough—albeit that, as Mr Bristow will know, that authority has just had a letter from Government because it is failing, so it is probably not the best model on which to draw—where they also had some opportunity in the health space. The wider direction is that there is a role for greater integration, and, clearly, mayors, in their interaction with local authorities have a part to play, particularly around public health, and more generally. In a system where in the past there have been too many silos, how do we take a more integrated approach? The right prism through which to do that is the ICBs. That then allows the Committee, Parliament and colleagues to have much more transparency, and particularly the public to have more transparency, around the relative performance. That in turn will allow the public in Manchester to reach a better decision on the effectiveness of the powers that the Mayor has had.

Q26 **Chris Green:** We have, I think, 39 police authorities across England. Last June, six of those were in special measures of one form or another. There are 42 integrated care boards and integrated care systems. If we anticipate a similar rate of failure or significant problems in that system, what mechanisms and what levers do you have to take action equivalent

to that taken against those police forces?

Steve Barclay: The lead on this from an operational performance point of view legally is NHS England, so that is why—we touched on it in the context of Shrewsbury and Telford—through the operating framework you have the different levels: level 3, OF 3, which is the regional level of intervention, and level 4, which is a national level of intervention. Both Ministers and Members of Parliament have a role to play. One of the things I am very keen to do is empower parliamentary colleagues more through giving transparency on the data on their ICBs so that Members of Parliament can be more engaged in those conversations, rather than being on receive mode from health leaders, and being a bit more able to look at variation in performance and ask why their trust is in a different place from others.

Of course, in terms of leadership more widely, Mr Green, the Messenger review had seven recommendations for how we improve leadership across the NHS. Again, I think most people recognise that there are some areas of outstanding leadership in the NHS, but there are others where there are trusts that are troubled. What I am very keen to do, in those troubled areas, is to set realistic objectives, because sometimes in the past—I remember United Lincolnshire a few years ago being an example of this—the chief exec kept being changed, but actually there were underlying difficulties of geography, recruitment and various things, which, whoever the chief exec of the day was, were going to be very difficult in terms of managing. We have to have greater transparency, set realistic objectives for the leadership team and then look at how we address variation in performance.

Q27 **Chris Green:** I appreciate the point about democracy and accountability locally. Just as a closing point on this, I don't know whether the devolution to mayors is an experiment that you are going to be pursuing in the future with the devolution agenda being pursued more widely. Are you anticipating health devolution, and mayoral responsibility over it in that sense, to be carried on, or is that drawing to an end now?

Steve Barclay: DLUHC has proposed some further round 3 devolution. That is more in the public health space. The direction of travel is to devolve more. As I said earlier, instinctively, I want to devolve more because risks should be best assessed closer to the ground. The counter to that is you have to have much more transparency in real-time data. You are starting to see that through the *Daily Telegraph* tracker and *The Spectator* data tracker. There are a number of tools that are now open source, which were not there two or three years ago.

The more we can have transparency on data, the better, but it is not simply the quantity of data; it is the quality of data. To what extent does it allow people to really understand what is happening with their health system? That is the area where, using technology, we can start to probe the variation in performance. If we can have a serious push at getting

different areas to the upper quartile, it can be very significant in terms of the transformation.

Chair: Thank you. A different subject now, Secretary of State. We are going to talk about pensions and visas with Martyn Day.

Q28 **Martyn Day:** Thank you. I am always going on about pensions, Secretary of State. I raised them with you last week at questions. At that stage, you said discussions were ongoing, and that follows up what you said in November. To be fair, the villain is the Treasury in this one, not you, so, hopefully, we are on the same side. What more are you planning to do to tackle the problem?

Steve Barclay: First, Mr Day, is to recognise pensions as an important part of the debate. You are quite right; the Treasury has a material interest in this. There has been progress. You will have seen the flexibility, which is something that was started in covid, and the ability of people to return to the workforce while continuing to top up their pension. That flexibility was there. The rule that staff could only work 16 hours a week in the first month after retirement has been flexed. There is a direction of travel in recognising that we need to be more flexible on pensions. It is something that I know my right honourable friend the Chancellor is also looking at in the wider context of consultants and the difficulty there. The debates are well voiced in that regard. Those discussions are ongoing, but you can see that there is a direction of travel, and a number of flexibilities have already been put in place.

Q29 **Martyn Day:** I am very grateful to hear that. When do you think I will be able to tell the doctors who keep raising this with me what the answer is going to be?

Steve Barclay: I cannot commit, Mr Day, to a date, for reasons that you would understand, but these are areas that are discussed within Government and discussed with Treasury colleagues.

Q30 **Martyn Day:** Can I go on to the impact that Brexit has had on the workforce? The Royal College of GPs has highlighted that 40% of GP trainees are international graduates, but that 49% have reported issues with the visa process, and as a consequence perhaps as many as 17% are thinking about leaving the UK altogether. Surely, there must be something that can be done to streamline the process for the key workers we need.

Steve Barclay: There are two points within that. First, there is a recognition across the Committee of the importance of recruitment, and that is partly why the Government have committed to the workforce plan. We have committed to its being independently verified, and, clearly, more will be said on that. That is within the context of already recruiting more. We have 4,700 more doctors. We are on track with our manifesto commitment for 50,000 nurses. Over 30,000 have been recruited, 10,500 more than last year. We are recruiting more.

You raise, Mr Day, a perfectly valid point about visas. That is something I have discussed with my colleague the Home Secretary. It is part of a wider discussion. I am very keen, with Home Office colleagues, that the Department of Health and Social Care is constructive around how we work with the police on mental health. There is a very interesting pilot on mental health in Hartlepool where we have seen significant reductions in police time through working differently with healthcare. My understanding is that it is largely a historic reason as to why that sits more with the police—from when suicide was a criminal offence.

I am very keen that the Department of Health and Social Care assists colleagues in the Home Office in how we tackle some of the pressure on police time on mental health. Equally, I am very keen that the Home Office works with us on some of the visa challenges, and those are discussions that we are having.

Q31 **Martyn Day:** That is good to hear. I have quoted the Nuffield Trust a few times when I have questioned you before. I have a different bit from it today. It found that the recruitment of dentists and social care workers from the EU has been left "uncompensated" by the increased recruitment drives from the rest of the world. Clearly, we have, in my opinion, a legacy from Brexit that is not filling the gaps that we need filled. How do we address that?

Steve Barclay: There are two things within that. Dentistry is something that is raised a lot by colleagues across the House. We have 6.5% more dentists now than we did in 2010. The issue is more the proportion of their time that is spent on NHS work rather than the overall number of dentists. Obviously, there is always a desire to recruit more. There is an increase in dentists. The issue is around how we incentivise the NHS work.

On EU recruitment, we have levelled the playing field in terms of having the approach to recruitment across the world. We have seen an increase in EU staff in the NHS, so those numbers are up. In fact, I was just looking at our evidence to the pay review body, and as part of that evidence we have the increase in EU recruitment. What we have seen is a much higher increase across the board in international recruitment. The proportion rise is much higher internationally than it is from the EU. The number of staff in the NHS from the EU has also increased.

Q32 **Martyn Day:** I have one final question on a slightly different topic. Yesterday, you made the announcement about the additional £1 billion in England. Is that new money or is it part of the £14 billion that was announced in the autumn statement.

Steve Barclay: The £14 billion is new money because it starts from April. The £14.1 billion is made up of the £6.6 billion over two years to the NHS and the £7.5 billion for social care, which is the biggest ever increase in funding for social care. That is a tribute to the work the Committee has done, because from looking at evidence in the past, one

of the very strong flavours that comes through is the importance of integration between social care and health. The Chancellor recognised in the autumn statement that it was not simply about funding the NHS with the £6.6 billion; it was also about the social care funding. We may come on to discharge and the interaction with some of the pressures on A&E and ambulance handover times, but a lot of that relates to the social care side. That £1 billion is from the £14.1 billion. That will kick in from April this year.

Q33 **Chair:** In a Westminster Hall debate on the subject of visas for doctors, a previous Health Minister committed to look at integrated care systems or primary care networks acting as umbrella sponsors for visas. I wondered if you had anything to add on that or whether you could take it away and have a look at it for us.

Steve Barclay: I am very happy to take that away.

Q34 **Chair:** In principle, it is about the reason why not.

Steve Barclay: Not only that. In principle, subject to Home Office colleagues and discussing it with them, as a direction of travel in the social care sector, one of the things I am very keen we explore is clearing houses. In the social care market, a number of big players cover about half of the market, but there is quite a long tail of very small providers that realistically will find it much more difficult to recruit internationally. Also, you want to ensure the right safeguards are in place on things like modern slavery in terms of recruitment of people as they come into the UK.

One of the things, certainly on the social care side, is thinking about how we approach immigration in different ways and use clearing houses to better triage that, and put some wraparound safety features into it. If there is an opportunity to do similar on the NHS side, I am very open to looking at it. The chief nurse, Ruth May, more generally has been looking at how we accelerate international recruitment because we recognise the pressures the system is under now, and that is why we are ramping that up alongside the work that is going into the medium and longer term with the workforce plan.

Q35 **Paul Blomfield:** I was going follow up on social care and will do so, but I wonder if I could first ask a question that relates to one of the crises in the service at the moment, and that is in relation to staff across the board. I talked earlier to some of our colleagues from the ambulance service, and one of the things we talked about was the problem with staff retention. They told me about younger members of the service in particular who were thinking of not sticking with the job because they could not afford to. We know that retention is a problem with young doctors.

There was a report a couple of weeks ago that suggested that 42,000 nurses had voluntarily left in quarter 2 of last year. How far does the challenge of retention figure in your thinking when you approach the pay

disputes, and how far do you think a settlement could play a big role in boosting morale and keeping people in those jobs?

Steve Barclay: Mr Blomfield, you raise a very important point; retention is extremely important for several reasons. First, given the length of time it takes to train a clinician and given the immediate pressures that we face, you can understand why it is far better to be able to retain that clinical support rather than incur a time delay in training others and the cost of doing so. Indeed, part of the discussion with Treasury colleagues in the pensions debate is looking at some of the trade-offs there. Retention is extremely important. When looking at that, one needs to look at the total remuneration.

On average across the NHS, alongside basic pay, the average additional income is 29% from overtime, clinical excellence awards, antisocial working hours and some of the other additional elements. That is the average across the piece. If one looks at the pension compared with the private sector, for a nurse an extra 20% goes into their pension. That is obviously much higher than would be the case for many constituents. In considering retention, one of the issues in the context of the pay dispute is looking at the remuneration in total, not simply what the baseline pay is.

Q36 **Paul Blomfield:** Can I push you on that, Secretary of State? That does not seem to be working at the moment, does it? That overall remuneration package is not convincing people that they should stay. Do you not think that a pay settlement closer to the ambitions of the staff across the sector might be a factor in persuading more people to stay?

Steve Barclay: There are pressures on the workforce—I will let the permanent secretary come in—because of pressures of the pandemic, which everyone recognises has created huge pressures on the system. There are wider pressures on the economy as a whole, which is why the Chancellor set out other fiscal support that applies to NHS staff, as it does to other staff, such as with heating costs. There are pressures from inflation, which play into people's food bills and other costs.

In terms of the wider Government approach, getting inflation down is hugely beneficial to the cost of living pressures of NHS staff, as for other staff. Of course, we are recruiting more than are leaving, so there is recruitment. Clearly, the more staff we retain, given the time it takes to train people, the better, and that is an area we are looking at. Obviously, these are issues that the pay review body weighs up when looking in the round.

Sir Chris Wormald: That is exactly what I was going to add. Key data for the independent pay review body system is both recruitment and retention rates. That is one of the key things that they look at when they come to us with their recommendations. The word to add to the list, which flows from what the Secretary of State said, is "return". There is a general change in the labour market. Because of lengthening careers,

people do not stay in the same career for their entire time. When I used to do education, there were lots more leavers from the teaching profession. There were also lots more returners. You were just seeing a change in the labour market. Because of the training in health, that is much more difficult, and it is one of the things that we and the professions need to think about.

If you are not going to be in the same profession for your whole career, how do we get the GP who wants to come back and be a GP into the labour force quickly without going back to the beginning of training? It is likewise for all the other professions. It is a particular challenge, which we are talking with the royal colleges and others about. If that is the way the world is going—

Q37 **Paul Blomfield:** I was specifically trying to explore the relationship between pay and retention.

Sir Chris Wormald: The key bit of that is the pay review bodies. That is an absolutely crucial starting piece of data that the pay review bodies use and feed into their conclusions.

Steve Barclay: Could I add one that is non-pay but I think is valid? It was one area of common ground with trade union colleagues when I discussed it with them. If you take nurses, the leaving rate was 11.5%, but the number actually leaving the NMC register was 3.5%. What is interesting about that discrepancy is what we can do around more flexibility for staff, particularly when people are going through different stages. They may have caring responsibilities at one stage or at a later stage of their career. How can we offer more flexibility in roles? That is something that trade union colleagues certainly said to me was of interest.

Pay is a factor. One looks not just at the baseline but at the additional pay and the wider remuneration on things like pensions. It is also looking at the estate, the tech, the non-pay benefits, the flexibility, the e-rostering and things like that, because all of them are factors. For paramedics, interestingly—it is only an anecdote so I will not say that it applies to all areas—when I visited one station recently, their frustration with the length of handover delays, they said, was a greater issue for them than pay. That was not to say that pay was not a factor, but in terms of morale they were hugely frustrated with the handover delays.

Q38 **Paul Blomfield:** We could pursue that a lot further, but I want to return to my original questions on social care. Our politics generally has failed to grapple with the issue, but we had a Government come in 2019 who made a big commitment and said there was a plan to deal with the crisis in social care. It turned out it was not; it was a plan to deal with a niche issue within that, the payment regime, and even that has fallen apart.

I accept that more money—you talked about it earlier—has been put in to patch up and deal with the crisis interaction with hospitals, but is any

work going on in the Department to develop a plan, the sort of paradigm shift that might enable us to have the sort of care system that could meet the changing needs of the country, and the current needs of the country?

Steve Barclay: Yes, there is a huge amount of work going on in the Department. There has been a step change in focus on social care in recent years, certainly compared with previously. When I was first in the Department, we did not have social care as part of the Department, and that was something that the now Chancellor, then Health Secretary, pushed very hard to have included in the Department, in conjunction with the permanent secretary. Since then, there has been an increased trajectory of focus on social care.

Q39 **Paul Blomfield:** When might we see the plan?

Steve Barclay: There is a huge amount. There is £7.5 billion, building on the money that has gone in. The sort of area where we are seeing significant improvements is around the reporting of data. There are areas that need to improve on that. We need much better data on social care in order to see which interventions are having the best impact on discharge.

Q40 **Paul Blomfield:** Are we going to see a plan for social care before the general election?

Steve Barclay: It depends on what you mean by a plan. We have a long-term plan—

Q41 **Paul Blomfield:** I guess I mean an attempt to fix a broken system, to ensure that we are able to recruit, train and support care workers properly, and that we are able to meet domiciliary and residential care needs.

Steve Barclay: Literally yesterday, I set out a plan on urgent emergency care; indeed, the Minister for Social Care did the media round on the plan, which indicates how involved she was in our work on the UEC. If you want to tackle pressures in the emergency department and ambulances, tackling discharge and looking at how we better integrate the social care element into the pressures in the NHS is central to that.

The deferment that you mentioned, Mr Blomfield, relating to the charging reform is a separate issue from how we get the right support for the workforce, how we get the right data and how we get integration between social care and the NHS. There is already a huge amount of work. In the summer, I looked at the Jean Bishop Integrated Care Centre which is bringing social care and health together. I was up in Blackpool a week or so ago looking at how they are doing that. There is a huge amount of work going on with that.

Q42 **Paul Blomfield:** I accept there is a lot of work going on—we talk about it regularly in my area—in terms of integration, but you are integrating with a basically inadequate social care system. I wondered where the vision

was in taking that forward. Am I running out of time?

Chair: Good anticipation.

Sir Chris Wormald: Obviously, there is the big question that political parties debate the entire time about the division between what has been there since the beginning of the NHS—a national, free service—versus a local means-tested service. I will leave that debate to you. Because of that debate, it is very easy to underplay the amount of reform that is going on in social care. The last legislation that we passed created a much clearer accountability system for social care and the provision of data and, during covid, for the first time, the inspection of commissioning.

As you know, we took a much more proactive approach to the management of social care and the leadership of it, and that continues post covid. We are very active on the recruitment questions that we were discussing earlier. We are doing quite a lot around the careers structure of social care and trying to give social care workers a career ladder, which is part of the recruitment things that you have raised.

Then there are the additional investments that the Chancellor has made in the social care system. That adds up to a comprehensive set of reforms to social care to tackle the issues that you have been describing. Does it affect the basic dynamic that you described at the beginning? No, that is clearly a big legislative societal question about how we run the two services. What we have been focused on—it comes back to Mr Green's questions on ICSs and ICBs—is how we pragmatically drive integration within the current legislative framework, and that is all about the ICB/ICS system.

Q43 **Chair:** To back up my colleague, it is also about the long-term funding for it. Let's remember that the Theresa May Government, admittedly during a general election campaign, which was not the brightest idea, launched the policy of people's homes being brought into that, and then the Johnson Government put the 1% on national insurance, which the Truss Government took away. The answer was that it would be funded by general taxation.

Sir Chris Wormald: And it is being, in the numbers that the Chancellor announced. It is very important, and you were drawing this distinction, that the reforms that you are describing in the general election and the Dilnot reforms are about what the right distribution is between the state and the individual of the same-sized allocation. That is a very important question, but a lot of the issues about the day-to-day service are about how much is part—

Q44 **Chair:** It is a very important question, but it is a bit like the West Lothian question of our times, isn't it, because nobody seems to be able to answer it? The public did not want the "dementia tax". Many people in Parliament and many people outside did not want a 1% increase in

national insurance to pay for it. I do not see huge polls suggesting that the public want great income tax rises right now to pay for the general taxation change to it. It is a big societal question, but, as Tam Dalyell found with his question, it was not answered.

Sir Chris Wormald: That goes exactly with what I am saying to you. There is that big question, which is a matter of politics and finance and taxation, and there are a set of reforms that we can get on with right now, which I have just described, that are about making it better. We are focused on the second question. Of course, that first question sits on the table, but in answer to your question about what is going on, the Department and our local government colleagues are focused on—

Q45 **Paul Blomfield:** You are doing what you can, but you cannot fix the scale of the crisis.

Sir Chris Wormald: It depends on what you mean by fix. If we are asking whether we can improve the current system so that care workers get a better deal and the people they serve get a better deal, that is, of course, a matter, as you say, of recruitment, investment, and the reforms we are doing. That does not necessarily help answer your bigger question, but nevertheless, as I say, we are frequently in danger of underplaying the amount of work being done in the social care sector because that big question, as you say, has dominated the debate.

Chair: We are full of big questions here. That is one of the things we do. In this sequence, Paulette Hamilton will continue the care questions, and then I might ask Rachael Maskell to ask about retention, and then there are some other bits that we might come back to later. Paulette, do you want to continue the care questions from Paul?

Q46 **Mrs Hamilton:** I would like to start by thanking you, Secretary of State, because the extra money given to areas like Birmingham increased our bed capacity. For Birmingham and Solihull that system increased bed capacity. Saying all of that—

Steve Barclay: I feel we should stop there.

Chair: Paulette has a but, I'm afraid.

Q47 **Mrs Hamilton:** Let me keep it simple. You also promised quite a lot of money for next year, but it still does not meet the gap. You have asked local authorities to top up. What if they are not able to do so? What then happens going forward?

Steve Barclay: In terms of the contribution from local authorities?

Mrs Hamilton: Yes.

Steve Barclay: First, we have the £2.8 billion next year, and there are conversations with local authorities on how that is allocated, and ensuring that we make the case with DLUHC colleagues, which we obviously have already been doing, in terms of the prioritisation for tackling discharge

and having the right domiciliary care packages in place, with local authorities looking at what additional revenue they raise and what they spend on the other competing priorities that they have.

In terms of the funding, people can see the interaction between what is happening in domiciliary care and what is happening in the hospitals, and that is why there is a very strong case to target £2.8 billion on the discharge side, because that in turn relieves the pressure on hospitals. Those are conversations we have with DLUHC colleagues in terms of the allocation of that funding, and part of the conversation on data is to give more visibility to that as well.

Q48 **Mrs Hamilton:** My second point is that even with the extra funding we do not have the additional staff we actually need at this moment in time. We do not have an urgent workforce plan in place at the moment. You talked about it earlier, so I will not go over what you have already said. The dates keep slipping. Will part of the solution be that the national staff plan will be run by ICBs, or will it remain a national thing?

Steve Barclay: The workforce plan document that we are bringing forward is a document from NHS England. It is being led by them, not by individual ICBs. On the wider point on the workforce and how we have the workforce to deliver what was set out to the House yesterday, the key point is that we need to look differently, rather than simply having hospitals as magnets for more and more activity.

We have to do more work upstream on demand management, particularly around the frail elderly, rather than them having to come to the emergency department, and we need to do more work at the other end in terms of patients being able to go home sooner, which is what most patients want. On the whole, they prefer to recover at home, but they want the clinical safety net of knowing that there is ongoing supervision and ongoing clinical support. That is what the work on virtual wards, of the sort that Watford and others have been trialling, has shown. It is about working in a smarter way, thinking about where is the best place for the patient to be treated.

Let me give you an example. At the moment, quite often you find a patient who is solely on a ward because they need three antibiotics a day. They need to be on a ward to receive those three antibiotics. We know that there is equipment now that will enable someone with one home visit to give them a more continual dose of those antibiotics, so they can recover at home and have their antibiotics without having to be on the ward simply to wait for their three doses of antibiotics. It is thinking innovatively about how we use our workforce in a smarter way. It is thinking about which roles that nurses are currently doing can sometimes be freed up, such as some of the administrative burden.

When I went to Maidstone, nurses had previously spent a lot of time phoning around looking for where there were beds. They have now brought in an e-bed management system with barcodes. As soon as the

bed is ready to be cleaned, the barcode is scanned, and the porters and cleaners are notified. As soon as they are finished, it is scanned, and the control centre knows that the bed is available. What that has done is to shift that work away from the nurse and allow the nurse to focus on what they are trained to do, which is the clinical side, and not be distracted as much on the administrative side.

It is thinking about how we work in different ways. The control centres, the virtual wards, more work upstream and more work downstream are all examples of how we can deliver those services in the right place.

Q49 **Mrs Hamilton:** I have a final point and then I will pass on because somebody else is going to cover what you have just talked about. I absolutely agree with you about the fact that we need to work smarter. The problem is, Steve, we do not have the numbers in the system to work smarter. Social care is buckling. Whether we do social care in care homes or we do social care in people's homes, or we just get friends and relatives to do the caring role, it is buckling at the moment. My point is that the ambulance staff who are sitting behind you are feeling the pressure from the backlog. You have nurses who are feeling the pressure on the wards, as you have just talked about. You have doctors and all the health professionals feeling the pressure.

Going back to the plan, it is okay to say we have to work smarter, but how are we going to bring those people in? If we are going to work smarter, no matter how we try, we are going to have to increase the numbers of bodies who are on the ground helping us at different levels to get the job done.

Steve Barclay: I agree. We need additional workforce, and that is what we are putting in place. We have 4,700 more doctors than last year. We are on track with nursing to hit the 50,000 target that we set out in the manifesto, with over 30,000 recruited. We are having more. There are more people working in the NHS than ever before.

It is also about how we then think about people operating in the way that best fits their clinical skills. What are the administrative roles that we can take off people so that they can focus on things? How do we get people, as the saying goes, operating at the top of their licence? It is thinking about how we maximise where people have had significant investment in their training and how we make the most of that and empower them to do more.

An area I know the Committee has looked at in the past is around pharmacy and how we do more with pharmacies, where we have people who are very well trained and can do a wider range of roles, so there are opportunities there. It is thinking about the workforce. I am very keen—the permanent secretary touched on this earlier—on having a clearer ladder between roles, from social care into the NHS. Of course, there is a place for international recruitment as well, and we are increasing

international recruitment to bring more people in as well, particularly on the social care side.

We are increasing the numbers through different channels. We have 3,000 paramedics being trained a year. There are 40% more paramedics now than in 2010. We are increasing the numbers, but we can all accept that the demand is also increasing, and that is why we have to look at the major conditions paper and treating people who have multiple conditions. It is why we have to look at the technology side. We have to look at how we get people operating at the top of their licence as well.

Mrs Hamilton: I will stop you at that stage.

Chair: Thank you, Paulette. I enjoyed your disarming start. It is something we could all learn from, and Rachael is now going to show a brilliant example of it in a brief exchange about retention, which is one of the points she wants to raise—we will come back to some others later—following on from what Paul discussed.

Q50 **Rachael Maskell:** Thank you. It feeds into pay as well. There are 133,500 NHS staff who should be in their uniform doing their job, and they are not there. How are you going to retain the people at the moment who are really broken, who are clearly facing the retention crisis, and who are not motivated by what you are saying because they have to deal with the day-by-day crisis that is crushing them? How are you going to address that issue right now? We seem to be in a spiral. Unless an injection is put in, that spiral will continue to escalate.

Steve Barclay: There are a number of things. First, in terms of pay, it is through the evidence to the pay review body, and the point that the permanent secretary raised earlier about how there are pressures on recruitment and retention and pressure from inflation. Those issues are balanced by the pay review body because pay is obviously a central part of the debate. That is part of it.

As Mrs Hamilton has just set out, it is looking at some of the wider pressures and how we address those system-wide. It is about how we tackle the frustration in the ambulance service that I hear very clearly around handover delays, and that is why we set out a comprehensive plan, putting in the extra capacity that we just talked about in the context of Birmingham, which has helped immediately in terms of the pressures this winter, and looking at the plan that I set out yesterday in putting more resilience into the system for next year through the urgent and emergency care plan.

It is looking across the piece at the pressures on electives. That is why we have the elective recovery plan. We hit the first key milestone of that in the summer. It is looking at primary care, where there are significant waits, and we have a primary care plan that we are coming on to. There is an element for pay, but there is also an element in terms of the non-

pay pressures within the system, and that is looking at a whole range of interventions, and the recovery plans give a good flavour of that.

Q51 **Rachael Maskell:** But the pay element is not working because we have staff out on strike right now. They are saying that they cannot survive on the pay they are on, and at the same time they are working extraordinary additional hours on top of their paid hours and have been giving everything they have to the NHS over the last few years. While addressing the issue of pay, when it is meant to balance recruitment, retention and motivation, is the practice in theory, the reality is very different. What else can you do? I recognise that circumstances have changed over the last year, which means, surely, that the approach needs to change. What are you going to do about that?

Steve Barclay: Part of the evidence to the pay review body is that they weigh in the round the changes to which you alluded, but these are not simply challenges that we face with the workforce in England. We see very similar challenges with strikes in Wales. We have seen similar challenges in Scotland. The French healthcare system is experiencing strikes. Around the globe, the Canadian system has been under huge pressure.

The pandemic has had massive pressure on healthcare systems, and these are manifesting themselves through difficulties across the piece, particularly across the United Kingdom. This is not simply an England-only phenomenon. That also sits in the wider reality that the cost of living pressures are not confined to the health sector. That is why there are strikes in the education sector and there are strikes in other sectors as well. These issues need to be looked at in the round. As a result of the war in Ukraine and the pandemic costs, there are wider cost of living pressures that are felt by health staff, but they are also felt by staff in other areas, and that is part of the cross-government decision.

I obviously make the case for health because my job within Government is to make that case on behalf of the NHS, but other Departments are also saying that it is not simply a health pressure; their staff are also facing cost of living pressures.

Q52 **Rachael Maskell:** We have 165,000 vacancies in social care as well. I am sure if we sat down we would have the same analysis. The question is what you are going to do about it. Are you saying that it is above your pay grade, and that it is now a matter for the Treasury to resolve? Until we get a resolution, we are just going to see that spiral ever increase.

Steve Barclay: There are a number of things. First, we are putting evidence to the pay review body as part of that process.

Q53 **Rachael Maskell:** But that has not worked, has it?

Steve Barclay: The Government think the pay review body is the best way to look at these issues in the round. The Opposition do as well, or at least Opposition Front Bench Members have said the same. It is not

simply that that we are doing. We will also bring forward our recovery plans, recognising that the system has been under very significant pressure. That is what I set out to the House on the first day back after Christmas, the £250 million responding to the immediate pressures we had seen with the spike in flu and covid over Christmas.

We are recruiting more staff. That is why we have the extra recruitment of nurses and paramedics, and training the extra doctors who are being recruited. We are looking at some of the non-pay issues like pensions, which Mr Day surfaced, and looking at what flexibilities we can have there. There is a range of issues. The honest position is to recognise that it is not simply a pressure on the English NHS; it is something the Welsh, the Scots and others are also facing, as are health systems across the globe.

Q54 **Rachael Maskell:** With respect, that is not resolving the dispute. At the moment, staff need a resolution, and I am searching to hear how you are going to achieve that.

Steve Barclay: We are discussing with them. There is the pay element, and the Government's position is that the best way to deal with that is through the pay review body process.

Q55 **Rachael Maskell:** But that hasn't worked.

Steve Barclay: There are also a number of things we can do on the non-pay side, and, indeed, the Committee has touched on a number of areas around some of the flexibilities. We can explore some of the workforce pressures that have been experienced and how we maximise the opportunities there.

Sir Chris Wormald: You raised the question of social care and so did Mrs Hamilton, so I will cover that bit. I think everyone agrees that social care vacancies are too high. They are a bit over 10% at the moment. We have early indications that we think we might have turned the corner and that those numbers are getting better, but we need to see that reflected in the actual national figures.

We are doing six things. There is overseas recruitment, which we have already mentioned and is going rather well. There is obviously the new investment. The vast majority of that money in social care gets spent on staff, its being a person business. We are working with both DWP and DFE on recruiting to social care. We run our own recruitment campaigns. I think the last one started on Boxing day. I am sure you have seen the adverts. The career progression and skills piece is very important, as you have raised, and we have mentioned that before. We have digitisation to reduce the strains on the workforce. We have a very comprehensive package. We need to see—of course, this is not an area where there is an industrial dispute—that activity turn into the hard numbers and the vacancy rate coming down.

Q56 **Rachael Maskell:** Why not have a job evaluation scheme? Agenda for

Change works for staff in the NHS. Why not extend that to social care and ensure that they can get the reward rather than searching the world over to find social care staff?

Sir Chris Wormald: Obviously, social care is a private market, and employers are—

Q57 **Rachael Maskell:** So is some of the NHS.

Sir Chris Wormald: Yes, but social care is a completely different style of service with private employers.

Q58 **Rachael Maskell:** Do you want integration?

Sir Chris Wormald: Yes, we do, but the way it is set up at the moment is that they are private employers. At the moment, the vacancy rates in the NHS and social care are quite similar, including for nurses, so perhaps other factors than that are driving it.

We want to see, as I said, much more focus on career progression and ladders in social care and skills in social care, because when you look at the turnover in social care a majority of it is turnover within the social care sector. It is people jumping around different jobs as opposed to leaving. There are people who leave and people who join. We want to look at whether there is a better way of doing career progression. Obviously, turning it into a kind of public service with an AFC solution is a much bigger thing. I am describing what we are doing right now. We have early indications that it is working. We need to see that in hard numbers, so that I can prove to you that it is working.

Chair: Okay, enough ladders. For 10 minutes or so Taiwo will approach the very important subject of the women's health strategy. Over to you, Taiwo.

Q59 **Taiwo Owatemi:** Thank you, Chair. Actually, I want quickly to go back to retention. Secretary of State, let's quickly imagine that you are a band 5 newly qualified nurse on pay of £27,055. Monthly, that is £2,254.38. For NI and taxes deducted, you pay £386.27. Rent is £795. The energy bill is £175. The water bill is £34. The internet is £30.30. Transport is £119.58 if you look at petrol. Council tax is £124.42. Road tax is £13.75. The phone bill is £38.22. The TV licence is £13.25. The food bill is about £318. Car insurance is £47.50. Student finance is £15. That all adds up to £1,724.02 at the end of the month just for your basic monthly expenses. When you take that away from your monthly earnings, you are left with £144.29.

NHS staff who have to drive to work, which most of us do, and have to pay to park, will in many cases pay up to £200 per month to park. When you take that away from how much money you have left, you have minus £55.71. That is the reality for many NHS staff. Last week, I was at my local hospital doing my pharmacy shift and one of the pharmacy staff asked me to ask you two questions. Charlotte said, "When will NHS staff

stop having to pay to park at work?" The second question was, "When will all NHS staff start to benefit from basic perks such as having milk provided to make a cup of tea?" What shall I say to Charlotte when I see her next week?

Steve Barclay: There is always a danger that things look tokenistic as a Secretary of State once you start straying into decisions on what an individual hospital does around milk and items like that. That is the sort of thing where a chief exec of a hospital and the senior management team, recognising the importance of workforce and the importance of retention, which we have just been discussing, will want to talk to their staff council and talk to their teams about how they best support them. Where there are cost-effective things that can done very constructively for staff, those are the sorts of things I would have thought an executive team would be looking at rather than me nationally dictating.

Q60 **Taiwo Owatemi:** On the issue of parking.

Steve Barclay: On parking, you raise a very important point. Certainly, on staff surveys, quite often the issue of car parking comes up. It is particularly acute when a shift overruns, and sometimes that can have an impact on car parking. With all these things, there are cost trade-offs around doing these things. We have been hearing about the importance of prioritising pay, and that it is about pay and not non-pay benefits. What your question very helpfully highlights is that we should look at these issues in the round, and that sometimes non-pay benefits are also important alongside what is done on pay.

In terms of your wider example around the fiscal pressure—

Q61 **Taiwo Owatemi:** That's fine, Secretary of State. I am aware of time and I know that the Committee Chair will have to move on to other people. I will move on to issues in community pharmacy.

You as the Secretary of State have statutory responsibility to ensure that patients have access to medicine. We are currently in a situation in this country where 670 pharmacies have shut in the past five years, with 40% of them being in the most deprived areas in the country. Do you think that currently you are meeting the statutory responsibility to ensure that patients across the country have access to medicines fairly?

Steve Barclay: We are investing more. We put an extra £100 million on top of the £2.6 billion a year we commit to community pharmacy to expand the range of clinical services. We have over 2 million patients who have been referred to community pharmacy from NHS 111 as well. One of the issues I am very keen on is to explore what more we can do in pharmacy, not least given the pressures on GPs and the opportunity to look at what people currently go to GPs for where potentially there is scope to do more at the pharmacy. We are already doing that if you look at things like—

Q62 **Taiwo Owatemi:** That is good to hear. I will be coming on to that.

Lloyds Pharmacy announced a couple of days ago that it is going to shut 200 pharmacies in this country. Looking at the pattern of pharmacies shutting, many pharmacists are starting to get the feeling that the Government's policy seems to be driving community pharmacies to collapse. Is it the Government's notion that there are too many pharmacies in the country and they need to shut, or is the problem that there might be professional snobbery within the NHS which means that pharmacy might not be able to provide services? Essentially, can the Secretary of State explain to me the blocks that are preventing the Department from giving pharmacies a greater role that is going to benefit patients?

Steve Barclay: You asked whether it is snobbery within the NHS. Sometimes change is difficult. What I share your desire to do is to deliver change so that pharmacies do more. Looking at blood pressure, the direction of travel is that we have over 8,000 pharmacies now providing blood pressure checks. Oral contraception is a service that we are going to—

Q63 **Taiwo Owatemi:** That is so good to hear. I am glad you mentioned all those services that are part of the PGD. Currently in the country, we have a situation where in Wales and Scotland "pharmacy first" exists. The PSNC, which is the Pharmaceutical Services Negotiating Committee, submitted to you last year a "pharmacy first" model for this country to make it more beneficial for patients and more cost-effective for patients. We still have not heard anything, and it has been a year since then. If you really are trying to utilise community pharmacy, why has it taken you a year for a decision to be made?

Steve Barclay: I was only appointed less than 12 weeks ago.

Taiwo Owatemi: That's true.

Steve Barclay: Perhaps you will forgive me when we talk about what happened a year ago. There is strong agreement between us, which is that there is a significant role for pharmacies to do more. We need to look at the financing of that. There is a clear trajectory of additional services that can be delivered by pharmacy. Pharmacy offers opportunity in terms of ease of access and therefore different routes for patients. One of the workstreams we already have under way in the Department is to look at how we repurpose the NHS app, which 31 million people downloaded. It was largely downloaded so that people could get their covid pass, and it is now often underused on phones. There is a huge opportunity to use the NHS app for people who might originally have been planning to book a GP visit but, if they find they can get the service they need from a pharmacist much quicker through their app, they will see an opportunity.

Q64 **Taiwo Owatemi:** Absolutely. Sorry, I am trying to be very conscious of time. The reality is that community pharmacies are concerned. Industry is not particularly happy. I know that you know the ongoing situation with

the VPAS. All this is impacting patient access to medicine in this country, and it is going to have a long-term impact. I need to ask the question again. Do you think you are doing all that you can to ensure that patients in this country have access to medicine like those in other developed countries?

Steve Barclay: Yes, in that there is a huge focus through our Office for Life Sciences. Professor Chappell is very closely engaged and leads the Department in our work on this, around the £2.5 billion. Notwithstanding all the other economic pressures we face, there is £2.5 billion going in, £1.5 billion through UKRI and £1.2 billion through NIHR. There is a huge amount on how we bring forward that life science work in delivery of medicines and other innovation into the NHS more swiftly. We have the opportunity through the scale of the NHS to negotiate effectively on price.

There is a separate debate we can get into on VPAS around the life sciences industry, but there is no question around our intent within Government in terms of the prioritisation of the life science industry. Just last week, I was at a breakfast with the Chancellor and leaders of the life sciences industry. The Minister for State has regular engagement. Professor Chappell gives a huge amount of her time on these sorts of medicines.

Q65 **Taiwo Owatemi:** Thank you, Secretary of State. That is really good to hear. The last thing I would say about that issue is the fact that you are aware that two major pharmaceutical companies have left VPAS, and that is something that has never happened before. There are genuine concerns about what that would mean in the future. I want to ask one last question—because I can see the Chair looking at me—about the women's health strategy.

Chair: Yes, please do.

Taiwo Owatemi: As a woman, it is an area that I am passionate about. I looked at the major conditions strategy, and it was very obvious to me that gynaecological conditions were omitted from the Government's major conditions strategy. That is despite the fact that pretty much all women experience menopause and one in 10 women are living with endometriosis. I have a constituent, Rachel, who despite being only 33 years old needs to apply for a blue badge; she cannot walk from her car to the supermarket because she has endometriosis. I am just trying to understand why gynaecological conditions were not included in the Government's major conditions strategy.

Steve Barclay: I do not think it is simply women who are passionate about the women's health strategy. I, as a man, a father and a husband, am passionate about it. It is half of my constituents. I have a very strong interest in it. When I was in the Treasury, I led during my time there the first time round on the women in finance strategy. It is something that unites us. I do not think it is simply that part of the Committee is

passionate about it and the rest is not. All of us should be. That is why we set out the women's health strategy in the summer.

If I look at other key objectives for Government—for example, cutting the electives waiting time—the interaction with the women's health strategy is core to that because some of the concentrations in backlogs overlap with some of the priorities in the women's health strategy. When I went to Homerton, one of the things that was interesting was moving some of the procedures as part of the women's health strategy. Through their development of a one-stop shop, a one-hub approach, they could triple the productivity rate in terms of three times as many patients for the same procedure in their outpatients at Homerton compared with when it was a theatre procedure with anaesthetists and the full involvement of all that. There are opportunities to bring different strands of policy work within the Department much more closely together. It is an absolute priority for us to do so. It is something that the ministerial team is very focused on.

Taiwo Owatemi: That is good to hear.

Sir Chris Wormald: The one thing I would add is the work of Dame Lesley Reagan, whom we have appointed as ambassador in this area.

Chair: Very interesting, thank you.

Q66 **Paul Bristow:** Secretary of State, the budget for the NHS in 2022-23 was £180.2 billion. It was reported last year by the IFS that healthcare is forecast to account for 44% of budgeted departmental spending in 2024-25. What percentage of spend do you think is right to spend on healthcare?

Steve Barclay: As Secretary of State for Health and Social Care, part of my job is to make the case for increased health spending. One of my former roles was Chief Secretary where I would probably look more at this issue in the round. In terms of that figure, which I have used myself in the past, we need to disaggregate A&E spend from day-to-day Department spend—

Paul Bristow: Yes, I understand that.

Steve Barclay: —before people misguidedly think it is total Government spending, because obviously there is an important distinction to draw.

My answer as Secretary of State for Health and Social Care is that we need to spend the right amount to address the health needs of the country. We can all see as a consequence of the pandemic that demands have increased, and that combines with the fact that we have a more elderly population, and they are presenting with more complex needs. Where I suspect, Mr Bristow, that you and I would very much agree is that, regardless of where one settles on the quantum, we need to deliver value for money from that spend, and that is where I think the

transparency agenda that I am committed to will help people interrogate how the money is being spent.

Q67 **Paul Bristow:** That is exactly my point. The temptation if there is a problem in the system somewhere is always to call for more money to be spent on it. When we are dealing with such colossal amounts, it is absolutely crucial that that money is spent as effectively as possible. I completely agree that your transparency agenda is key to achieving that, but there are plenty of innovations—you and I have spoken about this in the past; I even asked a question in the Chamber the other day—that go on in our NHS that increase productivity and are making a difference, but how do we get that spread across the NHS at pace and scale? What drivers and levers are there to make sure that they are spread?

Steve Barclay: There are multiple ways of doing so. We touched earlier in the session on the work of Sir Jim Mackey and Professor Tim Briggs on Getting It Right First Time, which has been very much data driven in terms of how you get the right clinical pathways in place. There is work through the national clinical leadership in NHS England, whether that is on cancer or emergency care. Often, these messages are best put by clinicians to other clinicians rather than necessarily by Ministers to those clinicians. There is a big role for clinical leadership, not least from NHS England.

Thirdly, it is through greater transparency, informing parliamentary colleagues and "Show not tell" with ICBs so that they can see how their metrics sit against others. That transparency agenda, under the old adage of what gets measured gets done, can be very effective in highlighting best practice.

What is within your question is the speed of adoption. In the past, I have talked more about innovation. Actually, it is the adoption of innovation. There is lots of innovation already in the NHS; it is how we scale that. To coin a phrase, and to credit the permanent secretary, when I was last in the Department, he talked about industrialising innovation across the piece, and I think looking at variation is a key way of getting better value for money.

Q68 **Paul Bristow:** That is good to hear because we look at bodies like GIRFT. I completely agree that Getting It Right First Time has made a real difference. NICE technology appraisals and NICE guidance are compiled with all the evidence, but we still see, culturally in our NHS, uptake being far too slow. I completely agree that transparency is key. Can I press you slightly on the thing about parliamentary colleagues getting involved and seeing the data and the transparency? How do you envisage that working?

Steve Barclay: By giving clearer information on ICBs and what the data is, engagement with parliamentary colleagues and wider transparency. Certainly, as a constituency MP I have often felt frustrated in trying to obtain information relating to my constituency pertaining to health. I

don't think I am necessarily alone as a constituency MP in having that experience. Ultimately, when things go wrong, quite often they come back to the Secretary of State. If more MPs are empowered to ask well-informed questions of their system, that is a very helpful discussion to stimulate. On many of these issues, there isn't anyone in the House who does not want to improve the cancer times in their constituency. That is a common cause across the House. Let's be more transparent on the data around that, so that MPs feel better able to have some of those conversations with our ICBs and hold them to account.

Q69 **Paul Bristow:** In terms of ICBs, when we are looking at commissioning policies, I completely agree with you. Local commissioning policies are often hidden on page 94 of a 200-page document. They are very difficult to look at. It is about specialised commissioning as well. We need greater transparency on service specifications and commissioning policies, and I urge you not to forget that when you go to the ICBs. Make sure we get that transparency with NHS England and commissioning policies as well.

I have a slightly different question. Culturally, I feel that one of the ways we are going to deal with the covid backlog is greater use of the independent sector. We need to dispel the cultural problem of using the independent sector. We use it all the time. We need greater use of the independent sector. How are you going to achieve that? Do you feel there is a cultural barrier to more use of the independent sector in the NHS?

Steve Barclay: It is mixed. Some are more open to using the independent sector than others. You are right to identify it as an opportunity, and it is part of our elective recovery plan to do so. I want to champion the interests of patients and empower patient choice. There are ways of making that easier for the patient through the NHS app. We are not there yet, but moving forward we can do more through patient choice through the app. What the patient wants is to know where they can get treated as soon as possible. Give the patient more choice over that, provided we are guaranteeing, as we are, that it is free at the point of use. If there is capacity in the independent sector, we should maximise that, and I am very keen that we do.

Chair: Dr Johnson is going to come in with a return to dentistry.

Q70 **Dr Johnson:** Thank you, Secretary of State. I have raised this with you before in the House and privately as well, and with successive Secretaries of State. I am very concerned about the number of patients who cannot access NHS dentistry when they need to. You are absolutely right that we have trained more dentists and there are more dentists per population than there were 10 years ago, but there are contract issues and there are fewer dentists working in the NHS-private balance, and there are more dentists working part-time hours than there were before. What are you doing to address that, and what can I say to my constituents when they write to me saying, "I can't find a dentist"?

Steve Barclay: You and I have chatted about this on a number of occasions. There are some things that we have done already. We have more bands for units of dental activity. There is the introduction of minimum value for a unit of dental activity at £23, which was to help sustain practices where the 2006 reforms meant they were receiving very low payments for the same work. We are allowing dentists to operate at 110% of their contracted UDA so that those who are able to take on more activity can do so. We are supporting dental practitioners to operate at the top of their licence. We are requiring dentists to keep their availability for NHS patients up to date on the NHS website. I recognise, Dr Johnson—you and I have discussed this—that those are not the end; they are very much the start of proceedings, and there is much more that we need to do.

We have touched on some of that already in terms of the international recruitment side. We need to make it easier to have overseas dentists practise in the UK. We need to look at some of the innovations that are possible; things like the centre for dental development in Ipswich are opportunities for things we can support. There is a significant amount of work going on in the Department on dentistry. The permanent secretary would say it is an area that receives much more ministerial focus today than perhaps might have been the case in the past, and that reflects the fact that across the House there is much more parliamentary interest in dentistry than perhaps was the case in the past. It is something we are very actively working on. Some steps have been taken, but we recognise that there is a lot more to do.

Q71 **Dr Johnson:** Thank you. I would like a centre of dental development in Sleaford, as you are well aware. I am also curious about why you only let people work to 110% of their contract. If they can do more, why not let them get on with it? My other specific question about dentistry is about military personnel and their families. We have the armed forces covenant, which is our commitment to our service personnel and their families. We know that we should be ensuring that those who are in the military service and their families do not have detrimental access to public services as a result.

Having a number of RAF bases in my constituency means that I see populations moving around, and although the service personnel themselves are covered by the military dentists, their families are not, which means that, as those families move around, their children in particular and their spouses are not able to access NHS dental services because by the time they get to the end of a waiting list they are moved again. They get a dentist and then they are moved somewhere else around the country and they cannot travel so far to get to the dentist. What work are you doing with the MOD to ensure that we as a Government who are so committed to the armed forces covenant achieve it for those families and dentistry?

Steve Barclay: You raise a very good point. I am seeing the Veterans Minister, as it happens, tomorrow, so I will ensure that these points are

shared with him. The area I have been discussing more with him has been in the context of mental health and the significant work we have been doing around Op Courage, which I accept is not on the dentistry side. We have increased the funding from £17 million to £22.5 million from April. We have seen 26,000 referrals in total. That gives a direction of travel.

You raise an important point because we are, as a Government, hugely committed to veterans and to the covenant. That is a clear priority of the Prime Minister and the Government as a whole, and is a very clear message that he has given to me. There is work we have been doing with Op Courage and the Veterans Trauma Network raising the profile of veterans through the accreditation scheme with GPs. There is work we have been doing. Let me pick up tomorrow with the Veterans Minister the specific points around dentistry. I am very happy to write to you on that.

Dr Johnson: Thank you.

Q72 **Chair:** That is very kind, thank you very much. There are a couple of other things, Secretary of State: the new hospitals programme and delays to the business case approval. Obviously, cohorts 1 and 2 are either in flight or they have a programmed timescale, but there is uncertainty about the capital allocation. It is an established fact. Cohorts 3 and 4 trusts—I declare my interest—include Hampshire Hospitals, which I have in part of my constituency. They have pretty significant delays to their timelines, and they are spending money on make do and mend. I hear that from colleagues across the House who speak to me as Chair of this Committee. What is the situation with the new hospitals programme?

Steve Barclay: There is probably no issue that is raised more frequently with me by parliamentary colleagues. I am absolutely fully sighted on the importance of it, and it is one that I very much share. First, there is an interaction with the RAAC hospitals. Two of the seven are within the 40 hospitals programme, but five are not, and we need to look at how we address those within the wider estates plan. We are in the process of firming up the standardisation of the new hospitals, the hospital 2.0 that Lord Markham has been doing a huge amount of work on.

I am very struck by the fact that nine of the last 10 hospitals that have been built in England were over time and over budget. I believe we need a fundamental shift away from bespoke local designs by local chief execs to a more standardised modular modern method of construction approach, and that is what Lord Markham, on my behalf, has been tasked with delivering. He is working at pace on that. That will then allow us certainty in terms of cost in our discussions with Treasury to link it to the RAAC discussion, in order to be able to move the programme forward. I am acutely aware of the widespread interest from parliamentary colleagues. We are working intently in Government with Treasury colleagues to move that forward, and I hope to be able to update soon on that.

Q73 **Chair:** Would the budget be a reasonable timeframe?

Steve Barclay: I fear I would be remiss, with my permanent secretary here, in over-committing to a timescale on this. What I can assure you, Chair, is that I absolutely hear that it is an extremely important issue for parliamentary colleagues and for staff in those hospitals. On a show-not-tell basis, I have been to Whipps Cross, Hillingdon, Leeds, Watford and a number of those hospitals and seen at first hand the estate. They are all cohort 3 hospitals. I have been to RAACs like King's Lynn and so forth. I am very acutely aware of the issue and I am very actively discussing that with the Treasury.

Q74 **Chair:** Okay. The permanent secretary will remember from my time in the Department that over-promising on commitments is sometimes a hell of way to get things happening.

I am going to bring in Rachael Maskell in a minute on prevention. I just want to ask one other thing. On the workforce plan, this Committee successfully argued for there to be an independent assessment. Do you have an individual earmarked for that?

Steve Barclay: I do not have an individual to name today, but I recognise that there was an agreement. Your predecessor as Chair was keen on independent verification, and that is something the Government have accepted.

Q75 **Chair:** Okay. To introduce the subject of prevention, you will be aware that this Committee has launched a major inquiry on prevention. We have produced a request for ideas, which closes in a week's time. We have had a big response already. I know you are a big supporter of that work, as is the permanent secretary, who has spoken about it. Is it sustainable? I read an article on Bloomberg last week that was titled "Britain's NHS black hole is devouring the whole country". Is it sustainable to see health spending growing faster than our GDP? You talked about demand earlier. You talked about demand in the ambulance service and 100 times the number of people in the acute setting with flu. Demand keeps rising. Is that sustainable? Do you appreciate that prevention has to be something that we are serious about if the NHS is to be sustainable?

Steve Barclay: I am hugely focused on prevention. Notwithstanding the immediate challenges and other pressures that we have seen in our A&E departments and elsewhere in the healthcare system, it is something where we have taken a very conscious decision with Chris and Lucy and with the chief medical officer in the Department to ringfence time for.

Q76 **Chair:** Will you work with us? You mentioned the chief medical officer, who is talking about air quality and its impact on heart disease and cardiovascular disease. There is now some emerging evidence on air quality and cancer. We want to look at poor housing as a determinant of poor health. Will you work with us on this inquiry?

Steve Barclay: I am massively interested in it. Of course, I would be delighted to work constructively with the Committee. I am hugely interested in prevention. Sometimes, the political debate has gone into the wrong place around banning things and lots of debates on what is sold at the till. What I am very interested in is how we fast-track the adoption of innovation, how we work more closely with our life sciences, and how we do things at a much bigger scale. If you have an obesity drug that will have a significant impact—we have a significant societal challenge in terms of obesity and the interaction with diabetes and other conditions—how we look at that in a much more ambitious way is the sort of area that is interesting to explore.

We look at the pressures from mental health. We look at the pressures from MSK. We are committed to the various missions—the cancer mission, the dementia mission, the big plays that we have set out. Professor Chappell does a huge amount of work on this agenda in the Department. It is how we bring that innovation from being three, five or 10 years away and how we start to bring it more into the pressures that the NHS faces but deliver it in different ways.

One of the challenges with covid is that we use the innovation we did on covid and do not slip back into the old ways of doing things. How do we channel some of that covid innovation into prevention work and roll it out through different delivery models in a fundamentally different way?

Sir Chris Wormald: A big ICS role is the other thing. The ICS I happened to be talking to last week was looking at the question of how we basically eliminate child asthma deaths through early intervention. Spotting the people who might be in that category and intervening early was central to their mission.

Professor Chappell: I welcome the focus that you are putting on it. The other thing is that we have to shift people's mindset of thinking that prevention is something to do with outcomes in 10 years or 20 years and make it relevant to the now. We should show what you can do now that is going to have an impact in the next six to 12 months. Make it more real for them.

The other thing that I am sure you will see is a focus on health inequalities. If we put out our prevention agenda and we create it for those where the disparities are greatest and where variation is high, we will have a prevention service that works.

The third thing is what you said about other Government Departments. There is a lot that we can do in the Department of Health and Social Care, but we need to get other Government Departments on board with this and to think about co-benefits. Yes, you will have benefits in health, but there are also benefits in transport, education and so many Government Departments. This is the time to grasp it.

Q77 **Chair:** That is great. For our closer, I am going to return to Rachael

Maskell.

Steve Barclay: Am I allowed to ask a question because that is how I know these things work?

Chair: Of course.

Steve Barclay: On the prevention side, there is a huge amount more that could be done on social prescribing in working with other Select Committees and how we interact on that. It is a very underdeveloped area of policy.

Chair: That is great. We engage with the rather marvellous Helen Stokes-Lampard on the social prescribing issue.

Q78 **Rachael Maskell:** That is really encouraging. I wanted to make sure that prevention was part of our conversation towards the end. Does this mean that, with your commitment, you are going to see an increase in budget towards prevention so that we bring a refocus? Are we going to see the health disparities White Paper emerge, or has that been buried? Finally, on the budget, what is happening with the public health grant? The next year is about to start, and it seems that having all these one-year cycles of looking at public health somewhat defeats the object of the exercise when we should be thinking much longer term about how we are bringing in prevention.

Steve Barclay: Thinking with my former Treasury hat on, there is a long debate in Government around one-year budgets that are rolled over and how they operate, versus the ability to contract for longer. Perhaps an example of that is school sport where you often have a one-year roll-over and whether you could make that more effective if you were there. That is a longer-term thing.

In terms of prevention, I think there is scope to do things very differently. That is why I talked about channelling the covid innovation. I recently visited a really good innovation, one of the London hospitals where in the emergency department they are screening people, with their consent, for HIV, hep B and hep C. That picks up cases of people who did not realise they had those conditions. Because you can then treat them so much earlier, the patient outcomes are vastly superior. Secondly, inadvertently, they are not transmitting to other people through not knowing that they have the condition. Thirdly, it is obviously hugely cheaper because you are capturing it much earlier, rather than having the cost of treating them downstream.

All of that comes back to the data piece, because looking at what are, as Professor Chappell says, the health inequalities, how do we get upstream of those and how do we do them in different ways? It might be the case that you do not need all the screening to be done in the individual trusts. You can look at having a national centre and having a different delivery model. We have to be open to delivering in different ways. I want to reassure you about the commitment of the permanent secretary, the

CSA, the CMA and the senior team in the Department of Health and Social Care. We are hugely sighted on the importance of prevention, and that speaks to the longer-term sustainability in terms of health.

Q79 **Rachael Maskell:** When will we get the White Paper?

Steve Barclay: There is an obsession in politics with producing papers. What I am interested in is getting on and delivering things, and that is what I am particularly focused on.

Sir Chris Wormald: If the chief medical officer were here, he would talk about getting all the basic things right, particularly vaccination. If we are going to talk about prevention, that is where absolutely all those screening programmes and all those vaccine programmes are crucial. Because they were there, we do not tend to talk about them, but actually—Lucy will correct me—they are the absolute bedrocks of a prevention system.

Professor Chappell: We need to see prevention as everybody's business. We need to normalise it so that you might be going to your community pharmacist and we look at opportunities there, so that it is woven through what we do. Particularly with the issue of secondary prevention, we need to make sure that we see it as every healthcare professional's business, and normal for a patient or a member of the public to be asked about the wider things that they can do here and now, not something special that you go and do in a special place. We can deliver it in many different ways. That is why we have the lung cancer vans going to supermarket car parks and bringing it to where the people are.

Steve Barclay: To finish with a practical example, earlier this month I signed a deal with BioNTech, which, to the permanent secretary's point about vaccines, hopefully is about how we develop, working with the best of industry, innovative vaccines, in that case on the cancer side, to look at—Lucy's point on health inequalities—getting upstream, using vaccination and how we do that. As a show of the Government's commitment to prevention, whether the Moderna deal or the BioNTech deal, they are good examples of how committed we are to that.

Chair: Thank you very much. By my reckoning, we have been in session for two hours and eight minutes, and we have covered 21 different subjects, so that is not bad going. Thank you very much, Sir Chris Wormald, Steve Barclay, Secretary of State, and Professor Lucy Chappell. Thank you for coming in and giving evidence to us today.