HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Work of the Department, HC 1093

Tuesday 20 June 2023

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Watch the meeting

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

Questions 80 - 141

Witnesses

I: Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care; and Shona Dunn, Second Permanent Secretary, Department of Health and Social Care.

Examination of witnesses

Witnesses: Rt Hon Steve Barclay MP and Shona Dunn.

Q80 **Chair:** Good afternoon. This is the Health and Social Care Committee, from a warm Westminster. We are very pleased to have the Secretary of State for Health and Social Care, Steve Barclay, with us. He is joined by the deputy permanent secretary at the Department, Shona Dunn. Thank you so much for joining us. It is nice to see you, Secretary of State. Thank you for coming in.

Can we start with industrial action? There are various reports around, about the nurses' strikes. Someone from the RCN was quoted as saying that they may "hit the end of the road" this week. Some of the official figures from NHS England—the statistics about the junior doctors' recent walk-outs—show that quite a few thousand fewer junior doctors took part in the most recent strikes. Of course, not surprisingly, the number of appointments and operations that were axed as a result was also down. Where are we on industrial action, and is it hitting the end of the road?

Steve Barclay: The first point to make, Chair, is that it is important to recognise the huge pressure that the NHS workforce has been under. I know from previous evidence sessions that the Committee massively values the work and contribution of NHS staff. I absolutely share that view. Clearly, the pressure has come from a number of quarters. Obviously, it has come from the pandemic, but not just from there. I know that the Committee has looked at the growth of the older population and the fact that one in four adults now has two or more conditions. The number of long covid cases, for example, coupled with the flu or strep A during the December to January period, provided a good illustration of the sheer pressure that the system has been under. The industrial action must first be seen in the context of the fact that we massively value the work. At the same time, the Government have to look at the balance in terms of bringing inflation down, which is also in the interests of the NHS itself, given the cost pressures on it.

As to where we are, I would think about the different workforces separately. We had constructive discussions with the NHS Staff Council and I am happy to recognise the work that Sara Gorton did as its chair. We had intensive daily discussions and both sides moved. The Government were initially reluctant to open 2022-23, which was a key demand of trade union colleagues. We moved on that with the non-consolidated lump sum, which comes in two parts; I think you are familiar with that. We also moved from where we had been in our evidence to the pay review body—3.5%—to 5%. To be fair, trade union colleagues also moved. That is how we came to the 5% plus the lump sum—6% on average but for a newly qualified nurse 7%. As you know, the majority of the Staff Council accepted that, which is extremely good news for over 1 million NHS staff. That will be put into pay packets this month.

That is not the end of the process, because within the negotiations we also agreed a series of non-pay measures. Again, I think that everyone on the Committee shares concern about violence against staff in the NHS. We agreed to do some further work on that. Indeed, I chaired a roundtable with frontline nurses yesterday as part of our ongoing work, and we are looking at other things such as the nurses' spine, safe staffing, and continuation of the pension abatement. So the process covered the pay amount, the lump sum in addition, and a series of further work that we agreed to take forward with trade union colleagues. That was extremely constructive, on all sides. There was movement on all sides and we reached a deal that was recommended by the majority.

Q81 **Chair:** Before we move on to the other side, which is the doctors—

Steve Barclay: Absolutely. Within that, despite recommending the deal, the RCN has gone to a subsequent ballot. We will get the result, I think, on Friday this weekend. Obviously, as with the Committee, we need to await the outcome of that. I simply point out that Pat Cullen not only recommended the deal to her members but also said it was the final offer from the Government. That is where we are.

Q82 **Chair:** Do you think that some of the briefing that has gone out, such as that nurses' strikes may hit the end of the road this week, is management of expectations in relation to the ballot result?

Steve Barclay: I think that would be a question for Pat and RCN colleagues; it is not for me to answer on their behalf. From a Department point of view we are extremely keen to take forward the other elements of the deal that we agreed with Pat and RCN colleagues. Again, the RCN was at the table as part of Staff Council throughout the negotiations, and raised specific issues that we took on board. She then recommended the deal to her members. We are keen to get on with the other elements of the agreement in an extremely constructive spirit. I have met Pat since the decision and, indeed, she has written to me signalling her desire for us to work constructively together.

Nurses are an absolutely core part of the NHS. It is important that we take forward the package as a whole, because it is part of our valuing that, which is what the roundtable yesterday was about: hearing about the frontline experience, including the excitement among some nurses I spoke to about the development of virtual wards, the use of innovation and how the ICSs are starting to integrate more between health and social care. It was quite heartening to hear from nurses on the frontline about innovations that they think we can scale more widely.

There is a separate discussion about junior doctors and consultants, which I am happy to come to if Members would like.

Q83 **Chair:** I think the figures are that we are on 651,000 appointments and operations cancelled because of the strike action in this period. That obviously does not help with your pledge to cut waiting lists. Talk to us,

then, about junior doctors. They have very high pay demands. You were in Manchester last week and they were protesting there, as well. What hope do we have for a resolution to that, and a conversation about it, the next time I see you, as positive as what you have just said about the Agenda for Change cohort?

Steve Barclay: That is very much where we would like to be. We had around three weeks of talks with the junior doctors committee. The Department was keen to show flexibility. Early on, the BMA chair raised the question of bringing in an intermediary as a way to build more trust between the sides. It recommended a figure for that. It was not someone chosen by the Department. It was a name suggested by the BMA, a very senior and respected NHS leader, Kathy McLean. Kathy McLean played a leading part in a previous dispute between the Department and SAS doctors, which some on the Committee may be familiar with, so she had been constructively involved in the past and we agreed with the BMA recommendation.

Notwithstanding that, and the fact that we moved our position, to date the junior doctors committee has refused to move at all from the demand for 35%. I have to be clear, in the context of the inflation and other pressures that the Government face, that that is not an affordable demand. They have floated, in the media, the idea that they might perhaps look at a multi-year agreement. However, to put that in context, they said that if we included 2024-25 they would want 49%, not 35%. So there needs to be movement on both sides.

Notwithstanding all of the above, it was the junior doctors committee that collapsed the talks, because we felt there was still merit in exploring issues such as health and wellbeing, rotas and medical fees. I do not particularly like the term "junior doctor".

Chair: No—nor do they.

Steve Barclay: Often they are very experienced clinicians. Putting that to one side, as it is the term that tends to be used, when I talk to them—and I am sure when members of the Committee talk to them—quite often, although pay is a factor, they raise many other issues as well. I thought that there was merit in both sides, under Kathy's co-ordination, in exploring some of the other elements to do with health and wellbeing that impact on junior doctors, but they decided to break the talks and have a further strike. As you alluded to, that is having an impact on patients. It is of course in the Department's interest to resolve it, because we have plans for elective recovery—which the Committee might want to come on to—making progress on the two-year and 18-month parts of that. The plan is working, but, clearly, industrial action is a headwind in our delivery of those plans.

Q84 **Chair:** There is obviously an impact on trusts because they are the employer, in the direct sense, anyway. There are stories about the junior doctor strikes—that consultants are earning up to £2,000 a day covering them. Do you recognise those figures? Is that acceptable?

Steve Barclay: I recognise that often there are high costs to covering. I would first thank the many consultants who are covering. At Easter in particular we had a period where many people had booked holiday. The Easter break coincided with Ramadan and school holidays. Many consultants changed their personal plans to come in and cover it. They should be hugely commended. Many consultants really stepped up and ensured that the focus on patients, maintaining emergency cover in A&E and so forth was maintained, notwithstanding the junior doctor strikes.

Q85 **Chair:** They stepped up, yes, and everyone would agree on that; but it is a consultants' market—right? If they are able to charge £250 an hour and earn £2,000 a day, should they show a little more restraint, if that is true?

Steve Barclay: Again, I think that is probably a question more for the BMA and the consultants. Clearly, I would want the additional costs of the industrial action to be mitigated. Many consultants changed their plans at great personal inconvenience and came in and worked. Some of those figures may have a very narrow, localised basis, while many other consultants who provided cover did not seek higher fees. It is the sort of thing that the Committee may want to explore, but I would not want the issue to detract from the fact that many consultants provided much valued cover at times when it was really important for the NHS.

Q86 **Chair:** Without them we would not be safe, would we? They are providing that safety that I know is your primary concern—and rightly so.

I have a final question on pay. Obviously, the pay review body process is always ongoing. There was obviously a bit of flux in the Government early last autumn. The remit letter traditionally would go in September or October and come back in January. There would be a report to the Government, who would consider it, and there would be an announcement in the Budget. That is where we should be. Is that what you want us to get back to—to get into that proper cycle again? You do not want to have on-the-hoof discussions about pay, do you?

Steve Barclay: Very much so. In my discussions with Sara Gorton and others that was a fair point that trade union colleagues raised, and we are very alive to it in the Department. I think there were some unique circumstances this time, given the inflation pressures and the expectation of inflation coming down, where the SR had been, at 2%, and our affordability at 3.5%. So it was right that we took a bit more time to get cross-government agreement on these things. As you will know, Chair, having been in government, a response needs a cross-government view with Treasury and other colleagues. It was right that we got that movement in our reply.

The NHS Staff Council raised the question of how we get the pay from the decision of the pay review body into pay packets sooner, and we are keen to do that. One thing that we are working on as part of the wider package is what changes will give more confidence in the pay review body

process. I am aware that HM Opposition's position is to support the pay review body process, so both major parties fully sign up to the PRB. If the trade unions say that they have lost confidence in aspects of the PBR, it is in all our interests to look at what we can do to address that constructively. Part of that is an issue of timing. This time there were some particularly unique circumstances.

Q87 **Chair:** Finally, we were both in Manchester last week at NHS Confed. I was there and saw your speech. You were asked by Matthew Taylor afterwards how hopeful, on a one to 10 scale, we might be that the NHS workforce plan will come out by the time there is some NHS birthday cake around. You said eight or nine.

Steve Barclay: I think I said eight or nine.

Q88 **Chair:** Could you update us on that? If you would like to give us an exclusive published date, we would be very grateful.

Steve Barclay: You tempt me. A huge amount of work has gone into the long-term workforce plan. It is an extremely important document. It is not simply a question of numbers, and it would be a mistake to see it as that. Again, there is a consensus that we need to grow our domestic supply. International recruitment has always been a part of the NHS, throughout its history. It always has—and particularly in the short term it will continue to have—a role to play, but in the longer term that will become more competitive to sustain, as other countries increasingly compete for the same workforce. So there is a consensus that we need to grow our workforce in terms of our domestic numbers.

Alongside that, we need to think about the wider skills mix. How do we have more career progression between roles? With the pharmacy first strategy, we were saying that we had huge skills in our pharmacists and that we could utilise that expertise more. How do we use our skills mix more?

Secondly, we can do a lot more with vocational training. There are trusts that find it difficult to recruit in certain parts of the country, and the more apprenticeships we have the more we can grow our own. That is hugely desirable and should be a key part of the long-term workforce plan.

There are questions of technology. How do we ensure that technology enables people to operate at the top of their licence—again, that is perhaps not the best of phrases but the one that people tend to use—when on the one hand dealing with some of the bugbears of frontline technology, such as things taking time to load, and on the other taking the big opportunities around demand management and redesigning pathways? Imaging is the area that is most quoted in terms of the potential for technology like AI.

Then there are questions of wider reform and looking at international best practice. There are a lot of opportunities within the plan, above a simple numbers game.

Q89 **Chair:** You are not going to give us a date. Does the consensus around growing the domestic workforce, for instance, mean dramatically increasing the number of medical school places? Could it mean that?

Steve Barclay: You will recall that places were increased 25% in 2018-19 as part of that expansion, when the current Chancellor was Health Secretary. As to the funding, that will be part of the announcement and there are multiple layers to that. There is the issue around funding the training places themselves and what capital needs to go alongside from the perspective of the training institutions as well as, for example, GPs. If the number of GPs is increased, we will need to look at the capital that sits alongside that. There is the additional pay as we boost numbers, and the interaction with the reforms and so forth. These things have a number of components, which is why it is a bit complex.

Q90 **Chair:** You have No. 10, No. 11, your Department and NHS England, and there are four people in that marriage. Therefore, I can appreciate that getting this out of the door is incredibly difficult; but I am sure your eight or nine presumably puts you in the ballpark of getting this out before summer recess—because things change. Yes, it may evolve, but there is going to come a point when you have got to get this out—right?

Steve Barclay: There is a strong desire to get the document published and a recognition—the NHS family as a whole is extremely keen for us to publish. The Chancellor committed in the autumn statement that we would do so this year, and, as I alluded to the NHS Confederation, a lot of work has already gone in; but it is also right that with something so important we take our time on the document as part of that publication.

Chair: We understand. We are going to talk about mental health next, and James Morris is going to lead on that.

Q91 **James Morris:** Secretary of State, you have quite rightly been relentlessly focused on elective backlogs and waiting times, but there is lots of evidence that people are waiting longer for access to mental health services in the community and children are waiting for access to mental health services. The anecdotal evidence is that waiting times in mental health are also getting worse. You talked about the primary care recovery plan and other recovery plans, but, unless I missed it, I have not seen a mental health recovery plan. Do you think we need one?

Steve Barclay: Obviously we are extremely seized of the pressures on mental health. Far from having shied away from a mental health plan, we are bringing much more transparency to this very issue. Let me give you an example. If I take long waits in A&E, often the cohort that waits the longest is the one with mental health needs. So we have done something that was in some ways quite challenging. That was to publish the 12-hour waits in A&E, from arrival. Previously that was not published, but now it is published from April. Of course, that leaves us open to criticism when too many people are waiting; but I am a great believer that transparency helps.

Q92 **James Morris:** Do you think we should have transparency like that in other areas too? Historically, when the five-year forward view for mental health was published, back in the coalition Government days, it was an aspiration to have waiting time targets across the spectrum in mental health. For perhaps good reasons that has not happened. Do you think we need that level of transparency for other things, like access to CAMHS or acute mental health?

Steve Barclay: As a general principle, I think we should have fewer targets, and should trust local commissioners and particularly the ICSs more. A more place-based approach allows people to tailor their services to the needs of the local community, which in some communities might be IVF treatment, in others mental health, and in others frail elderly patients. The needs in a city will be different from those in a coastal community. The danger of too many targets is that different places will often have very similar but not completely aligned priorities. So I think it is a combination.

Your initial question, Mr Morris, was about transparency and the recovery plan. First, mental health is part of the urgent and emergency care recovery plan. It is also part of our wider plans. The approach is a combination of factors, the first of which is more funding. We are putting in £2.3 billion a year compared with four years ago. That is an increase of almost a quarter over four years. More funding is going in. That in turn enables us to have more facilities, whether it is 100 new mental health ambulances, the money going into the mental health crisis cafés, the 500 dormitory beds or the three new mental health hospitals. That, in turn, is facilitating more treatments. That additional funding unlocks, this year, 2 million more treatments compared with four years ago—and, interestingly, more than a third of a million children's and young people's treatments compared with four years ago.

That is, again, not to suggest that it solves the problem. As I am sure the Committee is aware—and we may come on to this point—demand has also increased significantly. There is a time lag in the data, but to take one year for comparison there was a 41% increase in referrals for children and young people between 2020-21 and 2021-22. The increase in demand is incredibly stark. I hope that you can see we are prioritising funding, facilities and more treatments. We are also looking at how we make access much easier in mental health.

Q93 **James Morris:** Can I ask a specific question about what was historically called the IAPT programme—improving access to psychological therapies? IAPT has been running in the NHS since, I think, 2008. It was introduced by the previous Labour Government. Over time it has become the monopoly provider of psychological and talking therapies in the NHS. In that time, I do not think a review has been done of whether it has been effective. There have been a series of anecdotal studies about its effectiveness, but I do not think there has been a review of its effectiveness and whether it has crowded out access to other forms of

psychological therapy in the NHS. Is it time that we had a review of IAPT, given that it has been running for a number of years, and we need to understand whether or not it has been effective?

Steve Barclay: I am always very keen to be open-minded about how we evaluate things that are in place, and what new opportunities there are. Perhaps in that spirit a good example of "show not tell" in the mental health context would be 111. It started as an out-of-hours GP service, but it has now become quite different and is an essential front door to the NHS. We are looking at how we open up more mental health access through 111, which will come on stream from April next year so that people can get mental health support via 111. That links in to the 160 projects we have got in terms of crisis cafés and other support.

On your point about innovating, again, the Chancellor agreed £200 million for digital apps. We are thinking about how we use technology, including out of hours, in a scalable way. It is very exciting that the NHS will be a world leader in its use of mental health digital apps. We will be the first healthcare system to trial many of those. We have £200 million allocated for that and we are interested in how we link that in with the NHS app. Of course, we are hitting two targets in terms of the talking therapies national target and the psychosis national target.

Q94 **James Morris:** Would you want a review of the efficacy of that IAPT programme that has been running since 2008?

Steve Barclay: I would be very keen, Mr Morris, to see any evidence or points that you or colleagues on the Committee would like to share, rather than just committing on the hoof, so to speak. One of the things I am extremely interested in, where things have been in place for a period of time, is how we are refreshing them, and what new opportunities there are in terms of those services.

Q95 **James Morris:** Can I just ask another quick couple of questions? You will have seen that the Metropolitan police said recently that they were not going to go out on mental health calls because of the level of demand that they were receiving. I raise that because it points to a rising demand out there, which has often been soaked up by the police, but also because it raises issues around the operation of the Mental Health Act. As you know, it was a manifesto commitment in 2017 and 2019 to introduce reform of the Mental Health Act. I raised that in a previous Committee. Do you think we will get reform of the Act in the next Session of Parliament?

Steve Barclay: The underlying issue that the Met raised with respect to the amount of police time often taken by mental health incidents is a valid concern. We were already working with Home Office colleagues on that. The example that most people are most familiar with is the Humberside pilot, which has had a significant benefit in freeing up police time. As always, there are things within the detail. Police access to the home is different from that of health workers and paramedics. There are

certain circumstances, particularly to do with the safety of staff, where we need to think correctly about the interaction with the police. One of the reasons for the £143 million investment in A&E crisis cafés and other facilities is to start thinking much more around those points of particular pressure—the amount of time the police spend on mental health cases and what more we can do from the Department of Health and Social Care, and NHS England. I know that Maria Caulfield was having meetings with the Policing Minister again this week about this. I spoke to the Home Secretary again about it at Cabinet, in the margins, this morning. A lot of work is going on. There is a shared desire in government to reduce the police time.

Q96 **James Morris:** And the Act?

Steve Barclay: A number of colleagues are very familiar with that, as I know you are, from being in the Whips Office. Legislation is always a matter for the Chief Whip, and of course legislation can either be done through the Government or, sometimes, through private Members' Bills. It is an issue that will be dealt with through the usual channels.

James Morris: I should just note for the record that I was a Minister in the Department relatively recently.

Chair: Thanks, James. I think, by the looks of it, that we are going to vote shortly, but Paul Blomfield just wants to come in on the back of that.

Q97 **Paul Blomfield:** I have one very brief question off the back of those asked by James. You talked about transparency. When we see the published waiting list figures—currently they are about 7.2 million—they do not include waiting lists for mental health treatment, which are separate and probably now run at about 1.6 million. Do you not think that in the interests of transparency, parity of esteem and focus it would make sense to publish together all treatment waiting lists for both mental and physical health?

Steve Barclay: It is a very fair challenge and I think it is one we can look at. Going back to the New Labour period, one of the challenges was always to think about the risks around targets and the extent to which they drive the right behaviours or, to coin a phrase from that time, people hit a target and miss the point, and sometimes how we ensure there is not gaming of targets as well. One of the challenges for all of us as politicians is consistency. I have been very clear that I want fewer targets and more discretion for ICSs. As to how we empower ICSs, rather than lots of central targets, I want to empower them much more, so I am naturally cautious about new targets. How we bring transparency to the mental health waits is a fair issue on which we are doing some work.

Q98 **Paul Blomfield:** With respect, I was not arguing for targets; I was simply arguing about focus. Inevitably, if the waiting list numbers published are simply about physical health, inevitably actions flow out of those and focus is driven by that. I am not arguing about targets, but you

do accept—and that is helpful—that we should be looking at publishing the mental health waiting lists alongside and as part of the general treatment waiting lists.

Steve Barclay: I am very happy to take it away and look at what is the right level of transparency in what areas. It is not simply that question; it is looking at what additional funding is going in; how we make it easier for people to access treatment; what the additional facilities are that we are providing for mental health; and in particular what more we can do on the prevention side before they get into the point of waiting. That is where, for example, things like the schools programme are making progress in ensuring that schools have a mental health lead. There is now support in more than a third of schools in terms of mental health support teams as a specific programme. There is a range of things within the mental health space.

Shona Dunn: To go back to the point about what behaviours can be driven, unfortunately, in applying more and more differentiation within the targets, exactly, as you say, we have to be quite thoughtful, particularly in the context of the Hewitt review and the decisions that have been made. The Secretary of State has been very clear about being really focused on what people are delivering. It is really important that we think through those sorts of things and we are very happy to take it away.

Q99 **Martyn Day:** I have a couple of questions about international medical graduates and European and global recruitment in general. To start with medical graduates, an issue has been flagged up by the Royal College of General Practitioners, in that they have to find a sponsor because GP training is three years, whereas for others it is five. They cannot immediately apply for indefinite leave once they complete and they may have to find other things, which is a disincentive to GPs. There seems to be quite a concern that we might be losing access to people that we need. What sort of representations can you make to make that a bit easier?

Steve Barclay: Mr Day, first, there is a shared desire to boost GP numbers in training. Indeed, that is one of the key priorities. We took it from 2,300 in 2014 to 4,000, so we are boosting the number of GPs we are training. We have also been up front about our desire to have international recruitment because we recognise, given the time it takes to train doctors, in particular GPs, that we need some international recruitment to bridge that gap. If there are some specific issues that the royal college has raised with you I am very happy to look at them.

Generally speaking, one of the challenges on international recruitment for GPs is that many other countries do not have a model that directly replicates the GP role in the UK in the way that they have other clinical roles. Sometimes there are onboarding issues with GPs. One of the other things with which you will be very familiar is that, alongside the GPs we are training, we are also recruiting many additional roles in primary care.

We had a manifesto commitment to hire 26,000. We have exceeded that; we have 29,000 additional roles, and that is bringing in pharmacists, physios, paramedics and so forth into primary care so that people can get the right care they need, whether that is from a primary care GP or those additional roles.

Shona Dunn: It would be very helpful to get more information on the concerns of the royal colleges, but the discussions that the Department has with the Home Office are relevant to this question obviously. The Home Office itself is very supportive and keen to make sure that the sponsorship requirements around different routes are streamlined, and that we are working together to make sure they can be managed as effectively as possible. We continue to have that dialogue with the Home Office about what we can and cannot do, but in the context of sponsorship arrangements they are very focused on making those as streamlined as possible.

Q100 **Martyn Day:** That is good to hear. The college's own survey shows that 30% of respondents found the visa system so difficult they were considering giving up their plans to work in the UK. I think it needs further work on it.

To move on to recruitment more generally, if we look at what the Nuffield Trust has done, essential specialties in different medicines are facing chronic shortages. We have seen a huge drop-off in EU and EFTA recruitment. Things like cardiothoracic surgery previously had a huge reliance on European staff. It has slowed to almost nothing, and there is almost no other world recruitment as well. Anaesthetics used to have a very high number of European staff. It has dropped from 20% to 5%, so we are losing people from Europe. Obviously I have a political view. I think that Brexit has not helped us on that, but we need to make ourselves more attractive to people and make it easier for them to come.

If I can roll in my third question, which is more global, you can probably answer them together because they are basically on the same theme. On NHS dentistry, Dr Sandra White, clinical director of the Association of Dental Groups, indicated there was a global market for the recruitment of dentists. We are just not attractive enough. Canada is much more attractive because it offers citizenship and other financial incentives. How do we compete at that level?

Steve Barclay: Both are extremely important points. Sometimes we get criticism the other way—that we are recruiting too much internationally rather than that there are too many barriers to people seeking to come to the UK. The numbers show that we are recruiting more; international recruitment is up. We have over 5,000 more doctors this year compared with last year so we have more in the system, but we all recognise there are more pressures as well on the NHS from the older population, with more complex needs, the pandemic and backlogs as well.

We are looking at how we remove some of the barriers. Within dentistry, for example, it is thinking not just of dentists but the wider skills mix within dentistry. What more can we do with dental therapists and dental hygienists? How do we use the wider skills mix? It is thinking about how long it often takes for people to go through the registration process with the GMC, the Nursing and Midwifery Council, and likewise on dentistry. Often, it can take quite a while for people to complete their registration. Those are independent bodies, so we also need to be mindful of their independent remit. I think there is scope to streamline some of that onboarding process. That is something we are looking at, and, as we touched on earlier, we are looking to boost our domestic supply as well so that over time we have less need for international recruitment.

Chair: There was a pregnant pause there, Martyn. It was beautifully closed. We are going to talk now about winter preparedness, among other things.

Q101 **Paul Bristow:** Secretary of State, what lessons were learned from last winter? Notwithstanding some of the pressures we may have due to strike action, what lessons can we learn for the current winter?

Steve Barclay: It is extremely important that we take on board the lessons from last winter. There was a whole host of them, but among them was a continuing focus on discharge and thinking about the integration between health and care, which is a key part of integrated care systems reforms, things like discharge lounges and how we ensure that we are thinking early about those who are clinically fit to discharge. It is about the earlier part of their journey when they come into hospital rather than waiting until they are about to leave.

We have been thinking about bed occupancy numbers. We have invested £1 billion in 5,000 additional permanent beds in hospitals and looking at their flow. We are looking at how we invest in technology in things like the electronic bed management system and the control centres. If I take an example at Maidstone, in the past, nurses would often spend time phoning round to find out which beds were free. That is now all automated and it saves a huge amount of staff time, but it is also much more efficient in terms of flow.

We are thinking about the opportunities for technology and things like virtual wards. I was talking to nurses directly involved in virtual wards. They said how excited they were as clinicians, but also how patients much preferred to recover at home. They want to know that there is some additional care while they are recovering at home and that people are checking on them, but they would much rather recover at home than be on the ward for longer periods of time.

Then there are huge opportunities. I would split it three ways. There is the opportunity with discharge and care at the back end; there are the opportunities in hospital with the flow and how we are looking at the patient journey same-day observation emergency departments. There is

the opportunity at the front with demand management, thinking about things like frail elderly patients. When they go into hospital, often they are there for a long period of time. They tend to be stickier as a patient in the challenge of discharge. So it is about what more we can do looking at frail elderly services upstream in the community, and which are the care homes that frequently call ambulances. How do we use AI technology to pick up and identify issues quickly? That demand management in the community is also a huge opportunity coming out of last winter.

Q102 **Paul Bristow:** Many of these initiatives may be self-evident and may be adopted because they are obvious. What levers and drivers does the Department of Health and Social Care have to ensure that these are adopted at pace and scale by trusts which probably have not thought of these?

Steve Barclay: NHS England is operationally independent, but it is very much across this in a number of ways: first, through the urgent and emergency care recovery plan, which sets out a number of shared commitments as to a number of the issues like virtual wards and discharge that I have touched on. We also have work from the Getting It Right First Time team that is looking at best practice, not just in electives but more widely.

We are working with the royal colleges. For example, the Royal College of Emergency Medicine came in for a meeting recently looking at variation between different areas. I am very interested in site-specific data rather than simply trust-level data, and, through the work particularly of NHSE colleagues and their regional teams, we are looking at variation in performance. What we still see within the NHS is very marked variation in performance. Coming out of your first question about lessons, how do we narrow that variation in performance and take a more system-wide approach? If there is a particular hospital under pressure, how are we responding to that at system level rather than simply allowing blockages in that local trust?

Chair: Can we pause at system level approach? Let's suspend the sitting and go downstairs and vote—I think there will be a couple of votes—and then we will continue.

The Committee suspended for Divisions in the House.

On resuming—

Chair: We have been voting in the House of Commons, which was why we had to suspend the sitting. The Health and Social Care Committee is with the Secretary of State and deputy permanent secretary. We will now continue our questioning. Paul Blomfield, it is your turn.

Q103 **Paul Blomfield:** We thought we would open part two by talking again about the opening issues in part one related to industrial action. Secretary of State, I think you set the context for that in looking at all of

the other pressures facing staff. Clearly, it is having an impact on morale. I guess you could also look at it in the context of 13 years of pay constraint, which has just found a tipping point with the levels of inflation at the moment, so there is clearly a real issue about pay.

I want to explore the point you made about flexibility with junior doctors. You are right. Talking to junior doctors in Sheffield, it is not just about pay, although that is hugely important. I think you said you were prepared to talk about things like exam costs, because clearly those are quite important for junior doctors in their early years. There probably are not very many other comparable professions where the employer does not pick up the costs of sitting exams for required qualifications. So you are prepared to talk about that, are you?

Steve Barclay: The junior doctors committee itself suggested a number of things and that was one of the areas it highlighted. It talked about exam fees and GMC fees; it raised parking, flexible pay premia and so forth.

The point, Mr Blomfield, I was trying to highlight earlier was that, as with the discussion with the NHS Staff Council, a range of issues was raised with us, and our agreement with the NHS Staff Council reflected that. Pay was an important part; so was the lump sum, and the commitment to work in a number of other areas. There were three elements to the deal. As part of our discussions, I thought there was merit in junior doctors having a conversation that looked at the workforce pressures they face in the round. That could include, for example, where rostering means they have to move around a lot. One of the specific issues a number of junior doctors raised with me was that often they had to cancel their holiday at the last minute. They booked annual leave and suddenly they were asked to make changes at very short notice.

The point of bringing in an intermediary at their request through the role of Kathy McLean was to say, "Yes, let's have a discussion about pay and any potential non-consolidated or additional amounts; and let's have a conversation about the other factors that shape morale." That was what we were open to discussing, but in calling the strikes they took the decision to collapse those talks.

Q104 **Paul Blomfield:** I take the point about rostering and all of those other issues, which must be difficult, but, just to be clear, you are prepared to open a discussion about the non-pay financial pressures that junior doctors face, not only the initial professional exams but continuing professional development costs; you are up for a discussion about supporting them on those issues.

Steve Barclay: The junior doctors said there were a number of issues of concern to them—

Q105 **Paul Blomfield:** I am asking you whether you are prepared—

Steve Barclay: We were open to discussing those. Obviously, there is then a question within government as to what extent in essence they come off the headlined pay award, so what is used for the pay award and what is used for additional elements; and that is part of the wider negotiation. The point I was signalling was that we were open to continuing discussions. It was the leaders of the junior doctors committee who chose to collapse those talks and did so before we had had as full a discussion as I thought we could.

Q106 **Paul Blomfield:** But you certainly recognise that there is a combination of financial pressures facing junior doctors, as well as the corrosion of their pay value.

Steve Barclay: There are a number of factors.

Q107 **Paul Blomfield:** And the level of graduate debt that they have, which is much larger than for other graduates.

Steve Barclay: There are a number of factors. I would apply it more widely in terms of the NHS estate. That is why we have committed to the biggest ever investment in the NHS estate—over £20 billion—in the new hospitals programme. Tech is often raised when I go on visits. I am sure that when you are talking to medics in your constituency that is often a bugbear of those on the frontline. That is why I signalled in the NHS Confederation speech how much I was keen to prioritise the investment in tech. The overall numbers of staff is also a factor. That is why we have the long-term workforce plan, and of course pay is an element. A range of issues feeds into morale. We are keen to discuss those in the round, and it was regrettable that the junior doctors committee chose not to.

Q108 **Paul Blomfield:** Perhaps I could move on to one of the issues in relation to nurses and their settlement. You will know that questions have been raised about why NHS bank staff have not had the one-off pay settlement which was part of the deal for NHS staff more widely. I think I heard you quoted yesterday as saying this was always the intention; it was not something that happened by accident. How do you justify not paying NHS bank staff the one-off supplement that was important for others?

Steve Barclay: I respectfully take issue with your assertion that it was always part of the deal; quite the opposite in fact. The discussion with the NHS Staff Council was always on the basis of those staff within the Agenda for Change employment terms. Many bank staff will be covered by that in terms of a significant proportion of their contributions to the NHS. They may do some bank in addition to that, but it was always clear in the eligibility criteria we discussed pre-negotiation. That was communicated to trade unions again during the negotiations, and that was always the basis on which we negotiated with the Staff Council, so it was not part of the deal and that change. That was always communicated to the NHS Staff Council.

Q109 **Paul Blomfield:** Perhaps I was not clear in my question. I was probably paraphrasing something that I thought you had said yesterday, which is

absolutely in line with what you have just said. It was never the intention to pay bank staff the one-off component of the deal. My question is: in what way do you think that is fair or reasonable, which is how you have described the settlement overall?

Steve Barclay: Many of those who are doing hours of bank work will also be working within the Agenda for Change and will be covered. If what you are really alluding to is less bank and more things like social enterprises—in essence the wider scope of the AFC deal—those services will be uplifted through their usual funding routes. That has always been the case, with the exception of one year—I think it was 2018—when a different approach was taken, but in all other years that has been the way the negotiation has been done.

Q110 **Paul Blomfield:** You are not saying that all bank staff, for example in NHS Professionals, received the one-off payment, are you?

Steve Barclay: No.

Q111 **Paul Blomfield:** Do you not think there is a risk that bank workers might opt to leave that form of employment and become agency workers where there will be a greater cost for the NHS?

Steve Barclay: As agency workers they would not qualify, so I do not think that would be the driver of moving to agency. One year was an exception—2018—but, consistent with past years and the discussions we had from the outset with the NHS Staff Council, the discussion was in the context of a 5% pay award plus a lump sum. That was what we agreed with the Staff Council and that was what the Staff Council then put to its members.

Q112 **Paul Blomfield:** I understand the mechanics of what happened. My question is: in what way do you think that is fair and reasonable for people who are working alongside each other but with one in a different category not getting that one-off payment, which you thought was an important component of the deal?

Steve Barclay: Because, as per past years, those services are funded through a normal commissioning model. That has been the way those services have been funded in the past.

Q113 **Paul Blomfield:** To move to a different issue, but still on workforce, you talked earlier about apprenticeships. I want to raise with you problems that the apprenticeship levy presents for NHS Employers. This is based on discussions I have had with the local teaching hospitals trust in Sheffield. I know there are general issues about the apprenticeship levy, which we all appreciate, but clearly the NHS is not a normal labour market, which makes the rules governing the apprenticeship levy particularly unsuitable. It can be used only to pay the training providers for the cost of the training and assessment; it cannot be used to pay apprentices' salaries; it cannot backfill; it does not cover procurement costs. I am told by my local hospital trust that the result of it is that it is

returning half of the money it receives as a consequence of paying the apprenticeship levy. It gets £3.5 million annually and half of that is returned to HMRC, so money is seeping out of the NHS. What assessment have you made overall of the money returned to HMRC through NHS Providers?

Steve Barclay: This is something the Secretary of State for the Department for Education has spoken to. I know that, nationally, pretty much all the apprenticeship levy is now being spent. What is sometimes lost in some of the figures is that, where a particular organisation does not spend all of its levy, it is often used in terms of SMEs, because they get further support. I think they pay 5% of the cost and the additional is paid. Organisations can also spend unallocated levy within their supply chain. When I was in the Department five or six years ago one of the key issues raised with me at the time—indeed, I went and spoke to the Department for Education Skills Minister at that time about this—was the amount of levy being returned. Part of the challenge then was that there was too much variation across the NHS. Near to your constituency, Mr Blomfield, certainly five or six years ago, Leeds was an exemplar as a hospital that was funding all of its levy. It may be that Sheffield is still not doing that, but other hospitals and trusts in the region are.

I am very happy to look at any specific issues, if it is Sheffield to which you are referring in terms of its use of the levy, but one of the changes we discussed some years ago, where I know there has been flexibility, was allowing employers more flexibility in the supply chain, or how that is spent elsewhere. If there is a particular issue with Sheffield, I am very happy to look at it, but I know that other trusts are spending their full levy. There is one thing I would be very keen to understand at a time when skills are so important to staff. At the roundtable with nurses yesterday, one of the key things they were talking to me about was how in certain trusts in which they had worked there had been huge support for continuing professional development, and in other trusts they had worked in they did not feel that support was there. I would be very keen to understand whether there are any particular issues locally that are getting in the way which are not the case elsewhere.

Q114 **Paul Blomfield:** I recognise there will be variations, but I imagine that the sorts of challenges being presented would be fairly similar within other teaching hospitals and trusts, which was why I asked whether you had made an assessment of how much money across the system was returned by NHS Providers to HMRC—because I would be surprised if you had not.

Steve Barclay: I do not have anything recent. Five or six years ago when I was last in the Department I spent some time on that specific issue. I had a very recent discussion with the Secretary of State for Education on the levy more generally, because increasing skills is also extremely important to productivity. There are assessments that it could be 30% across the economy as a whole in terms of the addition skills can make in productivity gains. There is a real push in vocational and

apprenticeship levy training. That is a big part of the long-term workforce plan and the thinking there. The direction of travel that you are identifying is one we absolutely support. I am very keen to understand if there is some local variation, and we can look at that.

Chair: Rachael Maskell, you want to come in on the back of that, and then you will take us into some dentistry pain.

Rachael Maskell: I think I will go straight into dentistry.

Chair: You just can't wait.

Q115 **Rachael Maskell:** Unfortunately we are having to. Next week we will lose another dental practice in York. Patients are now being told they have a seven-year wait to see a dentist. As a result of that, the oral health of my constituents is declining quite rapidly. That is clearly putting pressure on secondary care as well, if you look just at children, at a cost of £63 million. What steps are you taking to address this in the now, not in the future? Earlier, you said, "I am thinking about—"; "I am thinking about—". My constituents want answers to ensure that both children and adults have access to NHS dentistry. When will the recovery plan be published?

Steve Barclay: There are some steps we have already taken to increase capacity. There are 6.5% more dentists working in the NHS now than was the case in 2010. We are also looking at the wider skills mix. In Mr Day's questions we touched on international recruitment. There are opportunities for feeding into dentistry, but there are also opportunities to think about the wider skills mix of dental hygienists and dental therapists and what additional roles they can play.

We are very aware of the pressure in registering new patients. One of the things the recovery plan will be looking at in particular is the additional work often required when a new patient is taken on. Some changes have already been made with the UDA in terms of the minimum payment of £23 for treatment. There are some steps we have already taken, but within the dental recovery plan the areas we are looking at are: how we boost capacity; how we use the skills mix more; what more we can do in terms of international recruitment; how we address some of the particular pressures in terms of new patients; looking at the training of dentists; and where we might put in some new facilities. We are looking at a number of things in the context of the recovery plan.

Q116 **Rachael Maskell:** When will the recovery plan be published?

Steve Barclay: I do not have a specific date to share today with the Committee, but we are very aware of the interests of parliamentary colleagues. Colleagues around the table will put health and social care questions to the House. They will know that dentistry is often a prominent issue raised in health questions. We absolutely recognise that it is an issue of importance to parliamentary colleagues as well as our constituents. That is why we have been doing more work on it. Within the

Department, as the second permanent secretary will say, we have also boosted internally the number of staff we have working on that. It is an area where there has been significant additional work since I arrived.

Shona Dunn: As the Secretary of State says, it is definitely an area of the Department with increasing focus, in addition to the things the Minister has said about the criticality of this. There is the point about making visible through dentists' websites what services they are providing and supporting their ability to take on NHS patients. Your point about children is particularly important. The changes that have been made to allow ICBs to release unused funding and be able to go up to 110% of the contract are the sorts of things we are doing now. As the Secretary of State said, there is a lot of focus on how we can go further through the work that the team is doing.

Q117 **Rachael Maskell:** At our evidence session we drill down into numbers and data around NHS dentistry. You say there is a 6.5% increase. Could you tell us if that is in full-time, part-time or sessional dentistry? What exactly is that composed of? What is the amount of time spent on NHS dentistry, as opposed to private dentistry? One of the things that neither the Department nor NHS England could tell us was exactly what the demand is and what the supply of dentistry is with regard to time, other than the fact we clearly know it is under capacity. How is the dental plan being put together in the light of the lack of data, and how will you measure that?

Steve Barclay: I sometimes get some criticism in the trade press about my interest in data, but I think your point is a good illustration of that. Often, there is a difference between the number of full-time roles and what percentage of the roles is related to NHS treatment, where that is geographically and how we are looking at health inequalities. Are there certain areas that are particular outliers in provision?

To answer your question directly on the increase in numbers, there are 1,473 more dentists doing NHS work, but I absolutely take your point. We are also looking at the skills mix of dentistry as a whole; it is not just what dentists themselves are doing and how much of their time is spent on NHS work versus private work, but whether they have to supervise other dental staff. Can we look at greater regulatory flexibilities around using the skills mix as a whole?

For me, the more important issue is how many patients are being treated. Are we addressing some of the more complex cases, which often can be the ones that find it most difficult to get access? Within the data, there is an issue not just on workforce but how many patients are being treated, and, within that, which types of patients are being treated. In particular, are the more complex cases getting picked up? One of the ways into that data comes back to where I opened, which is about empowering the ICSs much more. The ICSs now will be leading on dental commissioning. That is a new role. As part of that, that gives us an

opportunity to start to look at some of the variants within data in a place-based way.

As you know, we protected dentistry during the pandemic with the extra £1.6 billion funding that went in. One of the commitments we have with the dental recovery plan is to ringfence the £3 billion of dental spend, because there had been a temptation in previous years for some of the dental underspends to be used in other areas. We are very keen to look at how we maximise the £3 billion, but then to devolve and empower the ICSs in how they use that for commissioning.

Q118 **Rachael Maskell:** The ICSs cannot be empowered because they cannot get hold of the data either. This is a real challenge for them. Within the 1,400-odd dentists you mentioned you cannot tell me whether they are part-time or full-time, or the proportion of the work they are doing for the NHS and privately. This is the problem we have. We do not have the rich data we need to develop a recovery plan or workforce plan around dentistry. I am wondering what you are going to do to achieve that. Clearly, without knowing what the demand and supply is, we are in the dilemma of pulling figures out of the air and not being able to concentrate it. Can you set out what you are going to do about drilling down into the data and collecting the right datasets so that we can have a discussion about what is going to be in that plan and for that plan to be effective?

Steve Barclay: I have to say how heartening it is, because I have had quite a bit of flack, Chair, for drilling into the data and asking for it, and having the temerity as a Minister to want to understand the variation in performance across the system. I absolutely share your desire. We all recognise that it has to be data that drives decisions, not data for its own sake, but that is exactly what is being done by Neil O'Brien, who has been spending a considerable amount of time on the dental recovery plan, much more so than perhaps was the case previously. He is delving into the data; he is looking at that blend of the workforce, the number of patients and which sorts of treatments are being prioritised. When we bring out the recovery plan, we will be able to say more about what we are doing on the data side.

Chair: There is nothing wrong with a spreadsheet, Steve, whether that be Barclay or Brine. We want detail and that is never a bad thing in our book.

Shona Dunn: I am a data geek too.

Chair: Thank goodness. There is a consensus.

Q119 **Rachael Maskell:** Looking at UDAs, you mentioned they had changed. I was at an LDC conference where they said very clearly that they need more flexibility to determine their professional priorities and ensure that they are treating those most in need, and also able to focus services on children, for instance, to ensure they are getting that early intervention in place and get them on to the right course. I have a two-part question.

First, will you provide that greater flexibility, i.e. sessional work instead of UDAs, which is holding back some of that? Secondly, will you ensure that by March of next year all children will be able to access NHS dentistry?

Steve Barclay: On the detail, I do not want to pre-empt the recovery plan announcement and we will set that out, but the direction of travel in terms of flexibility I hope you can see from the steps that we have taken already. There is the decision to allow up to 110% of the contract by a dentist, so those who wish to do more are able to do more, and to enable the ICBs to release unused funding to commission care. We are already looking at what flexibilities we can offer. The actual detail will be for the recovery plan, but what we are keen to do is ensure that we are maximising the available capacity and, where there is unused capacity, we are keen to exploit that.

Q120 **Rachael Maskell:** I would like to turn to the complaints system within the NHS. I am really concerned about the reports that have come out from University Hospitals Birmingham. We have seen the reports that have come out of a number of mental health trusts. These trusts are clearly not safe for patients, as the data show; they are also not safe for many of the staff who are raising concerns. After the Robert Francis report we thought this would come to an end, with duty of candour being put very much at the front and whistleblowing being accepted as part of NHS culture. However, we have not seen the culture move on and risk still prevails. Even looking at the PHSO, there is insufficiency in being able to have leverage over what is happening and in their reporting back of what is happening at many of these trusts. I am really concerned that we do not have a robust complaints system. What steps are you taking to look into that, and what measures have you taken to date to move that forward?

Steve Barclay: I think it is a hugely important issue. When I was on the Public Accounts Committee as a member for four years, one of the things I particularly focused on, which is on record, was gagging of whistleblowers particularly in the NHS and how we have more transparency and a culture of learning where things go wrong. In a Department that is allocating over £180 billion and employing as many people as the NHS does, there will be issues that go wrong. The key is how we identify them quickly and how we learn from that. I know the Committee will share my concern about the reports of some of the sexual abuse data that came out. That was something I urgently met with NHS leaders to discuss to ensure that was being gripped.

You allude to the issues of mental health. I hope to have more to say very shortly on that specifically, particularly in the context of the Essex issues. I am in discussions with a number of Members of Parliament on that. It is not just in Essex; there have been concerns more widely. The point you raise is a very valid one. It is one I take extremely seriously. I hope colleagues can see it is one that, throughout my time as an elected representative, I have taken very seriously. It is something that I have discussed with Amanda Pritchard as the chief exec of the NHS and with

senior leaders such as Ruth May, the chief nurse, and others, to ensure that we are learning the lessons from these issues, and ensuring that where an issue is raised, whether by patients, members of staff or others in the community, we are addressing it.

Q121 **Rachael Maskell:** This is my final question. Because of what has been described as quite a bullying culture in many of these organisations, and bullying being very prevalent across the whole economy—27% of workers experience bullying—but when it comes into the health context it clearly puts the system and patients at risk, not to mention the impact on staff and staff retention, will you look at a central place where people can raise concerns independently to be able to whistleblow safely and raise those concerns so that they are properly investigated, and a top-down approach can be put on trusts to deal with these issues? Without it, as hard as the Robert Francis report tried to address these issues, it has not delivered.

Steve Barclay: I am keen to understand, if there are areas where the complete system is not working, why that is and how we learn from it. It is an area that has already had lots of focus. We have a patient safety commissioner. We have guardians. We have had a number of initiatives over many years in this space. You touched on cases such as Birmingham that still generate significant concern.

For me, it is about understanding why, when issues are known about locally, too often they are not addressed, and how we are learning from that. That includes things like the trust board and what visibility and line of sight the board has on such issues. What accountability is there for senior managers where wrongdoing is established? Are they just rotated through the system, or are people held to account?

There are a number of issues. It is one, sadly, that has been with us for quite a while. I spent a fair bit of time on it in a previous role. I share your absolute desire to tackle it. You touched on it in the context of the wider duty that we have to NHS staff and things like staff absence, which is why these things often then manifest themselves, or in retention because people just vote with their feet and leave. It is a hugely important issue. We have a number of people in roles in the NHS to tackle it. There is also a role for the royal colleges and others within the wider NHS family, and I am extremely keen to work with them on it.

Chair: Okay, great. We were going to finish at 5-ish but there were the Divisions. You have very kindly said you have a little bit longer, so I am going to try to finish at 5.15, which is 15 minutes ahead of when I think you said you had to anyway. Let us do that. We are going to go to two colleagues and then a bit of Chair speed-dating from "Spreadsheet Brine". We are going to start with Paulette Hamilton.

Q122 **Mrs Hamilton:** I swear I have two questions. This Committee formed an inquiry about prevention, but we did not just do it as a Committee. We went out there and we consulted on it. We then had 10 different areas

that we are actually quite proud of. Where would you focus on prevention in your role as Secretary of State?

Steve Barclay: I would say two things. First, following the data, one can start by saying: which are the conditions that cause the most deaths and how are we targeting those? You can see the approach we have taken with some of the health missions that we have launched. What are the lessons coming out of covid that we can apply from the covid vaccine into the big health challenges on obesity, mental health and dementia?

How do we work with our life sciences industry? How do we innovate, for example, with Moderna and BioNTech, and the announcement last week about the use of new obesity treatments? It is not just the new treatment but using different delivery mechanisms. In the past, weight loss was done through secondary care and hospitals. That would cover about 35,000 patients. We could scale it more if we could use primary care. Let us have a pilot to test that, which was the announcement there.

We are looking at doing quite a lot nationally on prevention. We may come on to things like vaping and what our approach is there where the call for evidence closed last week. There are areas that we should be focusing on nationally, and we have a significant amount of work going in for that.

At the same time, I come back to consistency. When I looked at the 10 that you had, all 10 were important. I am very keen that we do not try to set all the priorities on prevention from a desk in Whitehall. ICSs should lead on that. It should be done in a place-based way.

I am extremely interested in social prescribing as a personal thing. I think it has huge merit. I looked at my past role in the Treasury. It was always more sceptical because of the challenge of evaluation. As technology advances, there is a lot more we can do around demonstrating the value of social prescribing. Very interesting data is coming out of primary care. What is interesting is that GPs themselves have opted to embrace social prescribing with the linked workers in terms of the additional roles. That is a silent success. It is not really talked about, but within the 29,000 additional roles that have gone into primary care several thousand have gone into social prescribing roles.

There is a lot more that can be done in the social prescribing space. I am not going to say, "I have a particular interest in that." I am not going to say, "Here's a load of targets, and here's what everyone must do on social prescribing." It has to come from the ICSs. Let us be consistent; devolve much more to them. We have been very clear in the NHS mandate. We have a priority to cut the waiting lists, the three recovery plans, tech and workforce. Within the prevention space, they should have much more discretion. We should be devolving for them to decide locally what is most important for their population for prevention. All of the 10 that you highlighted are important. I actually think that prevention is one of the most exciting areas of healthcare at the moment. There are huge

opportunities with the growth in technology, with AI, and with the life sciences industry. There is a lot more we can do.

Q123 **Mrs Hamilton:** My follow-up question—not No. 2—is on ICSs because you highlighted them. I love ICSs. I love what you have said about their independence and what they can do. The problem I have with it is that it is similar to what has happened in public health. We started off with a sum of money, and over the years you have said—not you personally—they have to lead on issues around public health, and then we have reduced the funding year by year. I am concerned that, although at the moment the ICSs and ICBs seem to have enough funding, over the next two to three years it has already been announced that the funding will be cut. It means that some of the very good work that you are talking about will not be as sustainable as they want it to be because the funding is being removed as soon as it is given.

My question to you is: how are you going to maintain this work—you have talked about prevention and ICSs doing things on their own—if at the very top of the tree, even though you have said you want to give them that freedom, you are cutting them off at the legs by removing the funding?

Steve Barclay: I slightly take issue with that because, first, the public health grant has increased, but also can I point to some specifics? If I take drug and alcohol misuse, we have put in an additional £421 million to 151 local authorities. I think that is really important. It comes to a conversation I had with a nurse who works in outreach particularly with the homeless. To take a specific example, when people leave prison, we know that the real challenge is whether they have a home, whether they have a job, and whether they are using drugs. Therefore, having a concerted effort in all three of those areas makes a huge difference to people's reoffending. Obviously, it makes a difference, from my point of view, in terms of public health as well.

From the point of view of "show not tell", if I take the funding we are putting in specifically for drug and alcohol misuse—we made that announcement as recently as February—that is the sort of area that shifts the dial specifically. I touched on the social prescribing. That has been funded through the additional rows into primary care. I touched on the announcement last week through our life sciences funding in terms of the obesity treatment and the roll-out of the pilot.

The point is that from the point of view of prevention we need to look at the investment in life sciences, some of the work that we are doing in the primary care recovery plan and some of the targeted programmes on drug and alcohol misuse, for example. There is a range of things that we are looking at in terms of getting upstream of problems.

Q124 **Mrs Hamilton:** Okay, I will leave it there because of time. In 2019, the Government set an ambition for England to be smoke-free by 2030, which means that under 5% of the population would smoke tobacco.

They wanted to reduce smoking rates in three groups: young people, pregnant people and people with mental health conditions. The Khan review was published in June 2022, which promoted vaping to stop smoking and offered more support via the NHS, plus a few more. What progress have you made in implementing the Khan review, and when can we expect to see the new tobacco control plan?

Steve Barclay: It is a hugely important issue because we all recognise that smoking is the No. 1 cause of cancer. Part of the reason for the announcement last week is that the second biggest cause of cancer is obesity, which is why we are very keen that we do further work on that, Chair.

On smoking specifically, you mentioned pregnant women. We have put in place financial incentives for pregnant women to stop smoking. We are consulting on introducing mandatory cigarette pack inserts. We are putting in place support for 1 million people to swap from smoking to vaping. There are particular issues, which we may come on to, with vaping, particularly with children. On smoking, that is part of the strategy. We put £3 million into tackling illegal sales. That is more to do with targeting vaping and those going to children. We are putting additional funding into enforcement. There is ongoing work, but what stands out is the support for pregnant mothers because that was one of your particular recommendations, and we are taking that forward.

Q125 **Mrs Hamilton:** Is there any date for the tobacco plan that has been talked about—the strategy—but we just have not seen yet?

Steve Barclay: We do not have a set date for that. Neil O'Brien gave a speech setting out a number of measures to one of the leading think-tanks, which covered a number of the points that I have just flagged. That is part of our wider commitment. Obviously, the Khan review went further. It talked about raising the age at which people can buy cigarettes. Our approach has been very much focused on targeting how we best protect children particularly from the risk of vaping, and then in terms of adults how we get the right incentives in place for pregnant women and so on, and some of the schemes we are doing through that.

Q126 **Mrs Hamilton:** I will shut up there. In areas like Erdington, Kingstanding and Castle Vale, it has been reported that we will not see the area being smoke-free until about 2044. Because there is no clear strategy going forward and because of the way we are just implementing bits and pieces and leaving other bits out, poor areas are suffering, and disproportionately they are not getting the benefits from what you just talked about a couple of seconds ago.

Steve Barclay: It is quite the opposite; we are absolutely targeting the most deprived areas, if I think, for example, of our lung cancer screening programme. It may surprise the Committee to learn that we are now detecting more stage 1 and stage 2 cancers in the most deprived communities than in more affluent communities, and that is because of

the lung cancer screening programme that we have in place targeting those areas. If I take the vaping population in England of 3.5 million vapers, 47% of those are ex-smokers. So we are bringing those down. The number of smokers has come down.

Q127 **Mrs Hamilton:** I will stop there because I do not agree with you about vaping. There has not been enough research done in the area. Too many children are now vaping. The fact that there are different flavours like bubblegum and what have you is causing its own issues, which I do not think we have researched enough. On that note, I am going to stop, and I am going to hand back to the Chair.

Steve Barclay: On that, it is interesting. We are learning more about vaping. You challenged me quite fairly in terms of the Khan review. Vaping was one of the recommendations of the Khan review.

Mrs Hamilton: But I do not happen to agree with it.

Chair: Hold that thought because our Committee specialist on vaping just happens to be next. We do not just throw this show together, as they say.

Mrs Hamilton: Exactly.

Chair: Dr Caroline Johnson will pick up the vaping theme.

Q128 **Dr Johnson:** I would be delighted to. Thank you, Chair. The Secretary of State is aware that, like Paulette, I have huge concerns about vaping in children. I have been pushing for reform on it for some time. I met the Prime Minister to talk about vaping in children specifically last week. I know that he is also very exercised about preventing children from getting into vaping. As Paulette said, the change from a stop-smoking device to becoming a lifestyle product in terms of its marketing and the change to all these colours and flavours like unicorn milkshake that cannot possibly be designed for an adult, middle-aged smoker to quit—because clearly they are not—is of huge concern to me.

This is about more than just health. One disposable vape is about 40 or 50 cigarettes, which, if you were paying full tax on the cigarettes, would cost you about £30 to £32, whereas it is only £4 or so for a vape, and you can get special offers on them. There is scope there for quite considerable taxation to raise revenue while still allowing it to be cheaper for smokers. There is also trading standards and whether it is doing the right things.

What work are you doing specifically across Government? This is a health issue. This is something that requires you to work in a cross-government way to try to tackle it. What are you doing to try to tackle it across the whole of government?

Steve Barclay: You are right that this is a cross-government issue. HMRC will publish an updated illicit tobacco strategy, which is about targeting them and how it will catch and punish those involved in the

illicit market. Perhaps further to conversations you had with the Prime Minister, you will know that the Prime Minister has also announced that he is prohibiting the supply of free vaping samples to minors.

More widely on the concerns, there are two issues. One is the issue of tax on products. As you would expect me to say, that is an issue for my colleague, the Chancellor. Of course, we would have cross-departmental discussions in the context of public health, but tax policy would sit with the Chancellor.

In terms of vaping, there is a recognition in that we have been having an annual review since 2014 that vaping is not risk-free, and it poses potential risks, which are not clear. The current view of the Department is that those risks are a fraction of the risks of smoking cigarettes. Clearly, it is an area where the data is evolving and people are learning more about the risks specific to vaping. What is coming through in the debate is particularly the concern about the uptake of vaping among children and the way that products are being marketed in a way that particularly looks like it is targeted at children. That is something that Neil O'Brien in particular has been looking at in the context of the call for evidence that closed, I think, last week or the week before. We have announced some initial measures on that. It is something that the Prime Minister gave a speech on a few weeks ago, making some changes, but we are also open to looking at more, and we are working through that.

Q129 **Dr Johnson:** The rate at which the number of children are taking up vaping is increasing all the time. The proportion of children is increasing not quite exponentially but certainly very quickly. This is an urgent problem. The consultation, as you said, closed, I think, on 4 June—certainly a couple of weeks ago. How long will it take you to analyse that consultation and come up with concrete plans that you can put into place?

Steve Barclay: It is very helpful to hear the view of the Committee on this, which the second perm secretary and I will relay to colleagues. I hope you can see that the Prime Minister has been engaged on this issue and that we have already taken some steps. We are very live to the ongoing issues around single-use disposable vapes, the amount of nicotine content that is allowed, on minimum quality standards in terms of flavours, how they are packaged and so on. In fact, I had a meeting with a leading Australian figure this morning on some of the lessons around the vaping industry in Australia, how we can look at what is being done there and whether there are any lessons that we can share with each other.

I look to the chief medical officer and others with the clinical background to advise me in terms of the focus on smoking cessation, looking at how vaping relates to that, and how we improve our evaluation and understanding of the risks. What comes through from the Committee's questions and certainly from the discussions I have had is that there is concern over vaping in children, and we are very actively looking at that.

Shona Dunn: Do you mind if I briefly add something? There is no shortage of focus on this issue in the Department. On the point about children, even the incredible increase in the profile of this issue, education in schools and people talking about this is an incredibly positive thing. We need to get to the point of having the response as soon as we can, but there is also enforcement action particularly in those areas where you have the sort of very strong and often illegal versions that you are talking about. That enforcement action has already also been noted.

Q130 **Dr Johnson:** That is good to hear. Eight children from one school, St George's Academy in Sleaford, have collapsed at different times following vaping and required hospital treatment, with some of them becoming quite unwell. This will no doubt be replicated in other schools across the country, so it is a very significant problem.

Moving on to another problem affecting people of all ages, I want to ask you about electronic prescribing, which lots of general practices have. They are able to send a prescription. I could phone my GP and say, "I need some migraine tablets," and I could ask a pharmacy in Westminster to supply it for me without me having to go home and get a prescription.

Hospitals—certainly, hospitals that I have worked in—are not able to do that very often in secondary care. That leads to an issue that takes up clinician time, patient time and patient quality of care, because you either have to ask the patient to travel to a tertiary centre sometimes many miles away—I know people have had to do 70-mile round trips to get prescriptions because they have to be written on a hospital sheet of white prescription paper and not GP green prescription paper, which is a funding issue—or you have to ring the GP and take the GP's time, wait for the GP to finish an appointment so that you can then say, "Please can you prescribe this drug for this patient?" That is a productivity nightmare that could be fixed very easily with electronic prescribing for hospitals. I appreciate it would not apply to the most complex, specific drugs, but for general drugs it could be quite useful. What are your thoughts on it?

Steve Barclay: The issue you highlight is very much part of the thinking in the primary care recovery plan. I had a very similar conversation with a senior GP locally in the constituency about the amount of additional work as a result of the interaction with secondary care not working as it should. In fact, that was something I discussed with NHS England colleagues just last week. Within the primary care recovery plan, one of our key focuses is how we reduce bureaucracy for GPs, such as enabling fit notes to be done in secondary care. It should not have to come to the GP. There is much more in the scope of prescription. Within the primary care plan work is ongoing to say, "How do we streamline the relationship between secondary care and primary care?" Certainly, in the conversations I have with GPs, that issue often causes disruption.

You mentioned prescribing. One of the GPs suggested to me that because they had a dispensing element to their practice they were having to hand-sign significant numbers of prescriptions. Those are the sorts of

areas that we are very actively looking at. Sometimes there is already guidance in place, but that has been implemented in a patchy way. Sometimes it may be a technology issue. Sometimes it is making sure that the relevant trust board has the line of sight and is putting in place the right interplay with primary care. It is something in the primary care plan that we are working on.

Q131 **Dr Johnson:** Electronic prescribing for secondary care provision.

Steve Barclay: I would have to look at that specific one before I get quoted in terms of that specific example. It is the interplay between secondary care and primary care and particularly the additional work that GPs sometime find because they cannot email back into a particular specialty. They may be able to email into one area of the hospital but not another. We are looking at some of the practical issues that create additional work for GPs and how we address that.

Q132 **Dr Caroline Johnson:** Thank you, that is good to know. Another question I have is about the number of medical students. I appreciate you have had a bit of a role reversal with the current Chancellor. You were in the Treasury when he was in the Department for Health and Social Care, and now the situation has reversed. You are both fully aware of the issues from both sides. It seems to me that one of the biggest challenges—you will be aware of this because I go on about it quite a lot—facing the NHS is a shortage of medical staff, a shortage of doctors. Relative to the population, we have fewer than some other comparable countries. To give credit where credit is due, Jeremy Hunt has opened five new medical schools, including one in Lincoln that will help to serve my constituents, but it is still my view that we need to increase the number of medical students quite dramatically as much as we can and to look at the proportion of overseas medical students that we have relative to UK medical students, particularly in terms of keeping them to work in the national health service. What are you doing as Secretary of State to ensure that Mr Hunt continues to think the same way as his book suggests he does on funding the number of medical school places?

Steve Barclay: The Chancellor has a track record from when he was doing my role. He recognised that, and that was part of the expansion that led to the five new medical schools and the 25% increase. It is part of the cross-government discussion with NHSE colleagues in terms of the long-term workforce plan and the additional number of domestically trained medics that we need. As I alluded to earlier, it is not simply about the numbers, important though the number is; it is also thinking about the fact that we will need more general skills as to the balance with specialist skills. As more patients have multiple conditions, we will probably need more clinicians to have a wider range rather than specialising very narrowly. We need to think about the skills mix as whole. We need to think about the progression through different roles. We need to think about the interaction with technology and where that can unlock clinical capacity. There is a range of issues within the workforce plan that we are looking at, but it is something that the

Chancellor absolutely understands, having been the longest serving Health Secretary, and it is something that he has long been very supportive of.

Q133 **Dr Johnson:** As a general paediatrician, I can definitely say that general skills are a good thing to have. In paediatrics, we generally do more general specialties and fewer specific specialties.

Steve Barclay: Good.

Q134 **Dr Johnson:** The other question I want to ask you is about social care funding. The Government made significant announcements about the bulk of money that is available for social care, but obviously your budgets are under huge pressure at the moment. Can you confirm that the money that you promised will go to social care will go to social care and will not be dragged off into other priorities?

Steve Barclay: That is something, again, that the Chancellor has been incredibly supportive of. He was one of the early voices calling for much more integration between the NHS and social care, and that then manifested itself in the reforms with the integrated care systems that have been set up. You will have seen the flagship announcement of the autumn statement that there would be an additional £6.6 billion for the NHS over two years and an additional £7.5 billion for adult social care.

We have been thinking a lot about how we support the workforce within social care. International recruitment was added to the shortage occupation list as one element. Additional funding has gone in. A sum of £250 million recently was announced for trying to develop skills more within social care. There has been real prioritisation of that from the autumn statement and from the Chancellor.

Mr Bristow asked earlier how we are learning some of the lessons from the winter challenges. One area in particular is thinking about the interplay between health and social care. To give you a very practical example, because Blackpool attracts lots of tourists, one of the challenges Blackpool Victoria Hospital has with discharge is that it is dealing with lots of different local authorities, all with slightly different forms. One of the questions for me with NHS England colleagues is: what can we do to standardise across local authorities, and how do we work with DLUHC colleagues on the data, so that we can see just before the Christmas holiday period, for example, what capacity there is on domiciliary care and where are the handover pressures there?

How do we better use our volunteer network for people who are being discharged to make sure the house is warm, there is shopping in the fridge, and someone is calling to check in on them? Are there some things we can do with some of our very respected voluntary organisations to support them—not to replace what is done through professional services, but as an addition and as an enhancement to that? Helen

Whately made an announcement recently on the roles of volunteers and what more can be done there.

It is very heartening that there is lots of good practice out there in this space. One of the opportunities is the fact that that is still more patchy than it should be. We are putting more money into social care. We are very keen to learn from where it has worked well and where it has not. That is a key opportunity for the ICSs to start to bring that together in a more integrated way between health and social care.

Chair: We have to move on, just to be fair, because I promised Mr Bristow, who was interrupted by a Division, that we would give him another run around the block, as it were. So the aforementioned Mr Bristow.

Q135 **Paul Bristow:** I only have one quick question, Chair. I want to come back to smoking cessation, if I may. I am very pleased about what you said about vaping, by the way. I am horrified by the number of young people I have seen vaping. It is absolutely accepted that vaping has an important role as a public health tool to try to stop smokers who are addicted. I fully accept that. I am just wondering what weight has been put on to other tools such as heated tobacco products as opposed to burning tobacco products. I know the Science and Technology Committee looked at this. A special Green Paper also looked at this. The Khan review also talked about heated tobacco products, whether there is a need for any independent research into their effectiveness, and whether this will appear in any smoke-free plan in the future.

Steve Barclay: I am very happy to go and look at that specifically. In the context of vaping, Mr Bristow, the suggestion was made to me of 50,000 to 70,000 additional quits per year in England potentially from vaping, but at the same time there is growing concern more generally about the way vaping is being marketed, the take-up in schools, and how we get that balance right between what it may offer in terms of smoking cessation and the risk particularly for children. For that, it is very much a question, as a non-clinician, of me speaking to the chief medical officer and others, who obviously bring the professional expertise as to where we set the right balance on that.

I am very open to looking at what concerns the Committee has on other products, and, Chair, where issues are raised by the Committee I am very happy to take those away.

Q136 **Chair:** Vaping has had a lot of talk today, and rightly so because it has gone so far up the agenda. We have a session on 28 June on that subject, which I know you will be interested in.

Finally, I have a few quick-fire things, if I may. I know you do not have the NHS workforce plan out yet, but I know it has been such a lovely process that you have enjoyed so much, because you said earlier it was like pulling teeth, I think.

Steve Barclay: I do not think I did say that, just for the record, please.

Q137 **Chair:** Okay; others have said that. I will correct the record; you did not say that, but maybe it has been—I don't know. How much desire do you have for there to be a long-term workforce plan for the adult social care sector? When this was mentioned by Patricia Hewitt at the Confed conference last week, there was quite a big applause for that. I know you have to get this one out the door first, but is that on the cards?

Steve Barclay: Having just given a speech to the NHS Confederation, which was, "Here's the NHS mandate. Here's what we are prioritising on," which is cutting waiting lists, the three recovery plans, tech and workforce I would be loth to start straying into other areas. Of course, there are many other areas that are of interest. Part of the reason the Government commissioned the Hewitt review was to ensure that we can better empower the ICSs and devolve that. Within the ICSs, there is a huge opportunity to work with social care. Part of the reason we delayed the social care reforms was to put additional money into the social care workforce, which we recognise is a huge priority. I will not be willing to make commitments today. We are very clear through the NHS mandate what we are focused on.

Q138 **Chair:** Okay. You said that obesity is the second biggest cause of cancer. That is true. It is part of our prevention inquiry. Where you have made a commitment last weekend is to kick the "buy one, get one free" ban down the road again. People in the prevention space could be forgiven for thinking that is not a great indication of intent—"show and tell", as you rightly put it. Why has that been kicked into the long grass?

Steve Barclay: I will show you the impact assessment. I am just looking for my copy. Here we go. The impact assessment says that it will only save two to three calories a day, equivalent to a single grape. The important point with issues like that is we need to get the balance right between the effectiveness of the measures that we are taking and the cost of living impacts. As a Government, we have been willing to take measures such as restricting locations and addressing some of the "pester power" that was a real concern for many parents. We have taken steps like that. We announced the innovative treatment on obesity last week. It is about finding that balance between the two.

Q139 **Chair:** Therefore, if it is not that effective, taking the grape analogy—I asked you the question to give you the chance to say—why postpone it? Why not just cancel it altogether?

Steve Barclay: That is a fair challenge. The decision was on the basis of balancing it with the cost of living pressures. As the discussion on vaping has shown, we are always open to looking at the data. The initial data that we have in the impact assessment was not compelling, and at the same time we have challenges on the cost of living.

Q140 **Chair:** I think the Obesity Health Alliance would probably want to come back to you on that through this exchange, which I know it will be

listening to, so maybe you would be willing to look at that.

You know that I took part in the HIV Commission, which I had commissioned when I was public health Minister, and then with your opposite number I was part of the HIV Commission. We got opt-out HIV testing in certain emergency departments, and that has been incredibly successful. Well done to the Government on the progress that has been made on new HIV transmissions. I chair the all-party group in Parliament, as you know, Secretary of State. Will you commit to expanding opt-out HIV testing in emergency departments in all areas that the UK Health Security Agency deems to be high prevalence areas, because this is really moving the dial?

Steve Barclay: It is a huge tribute to you. I have been and seen the programme in action. It was extremely effective. It is targeted at the moment at the areas of highest risk. There is always a balance in terms of wider funding pressures when these decisions are taken. The fact that I cited it at the last Committee hearing I attended I hope underscores it. The reason I find the prevention agenda so exciting is that there is a huge opportunity particularly on the screening side—HIV screening to pick up cases when people do not know they have HIV, hep B or hep C. It is a lot more effective and cheaper to treat early, and you avoid them inadvertently passing it to anyone else.

The data coming out of the scheme today is very compelling. There is always a balance to be struck on roll-out. We touched in the course of the session on some of the other funding pressures we have—the long-term workforce plan, the pay agreements, the investment in the NHS estate, and protecting the tech. As you know, as a health Minister there are always competing priorities. The data coming out of the HIV screening is extremely compelling.

Q141 **Chair:** That is good to hear. You will know that the overall suicide rate in England is the same as it was 20 years ago. Where is the national suicide prevention strategy, which I know Maria Caulfield is working on? Can we expect that before summer recess?

Steve Barclay: I talked about that with Maria just a little earlier. We are not in a position to give a firm date as yet, but we are hoping to get that published before the summer recess. If not, it will be very shortly after. There was additional funding of £10 million, as you know, allocated in the Budget. We are also looking at how we use some of the digitally enabled tools within that strategy. It is an extremely important issue across the House. I have spoken with some Labour colleagues who have personal experience through their families of this. My predecessor as Secretary of State, Sajid Javid, speaks extremely powerfully on this issue about his experience. We are acutely aware that, similar to dentistry, it is of very strong interest to colleagues across the House, and we are moving as quickly as we can to get it published.

Chair: Finally, some good news, and I thank you. You know that I have

been pestering you about the children's hospice grant. I understand that one of your colleagues has spoken to an all-party group and confirmed that it will return beyond April, when it was due to end. So thank you on behalf of Naomi House & Jacksplace in my constituency and all the children's hospices in England that will be really relieved to hear that. Thank you for responding. I have a plea. The sector is pretty united—and Together for Short Lives will definitely be in touch about it, I am sure—that it should continue to be distributed centrally and not through ICSs. Are you aware of that debate that is going on? Can you take that away?

Steve Barclay: Chair, first, it is a tribute to you and colleagues in terms of the representations made. Hopefully, the Committee can see that we are actively listening and responding, and that is a good example. On the funding allocation mechanism, I am very happy to take that away.

Chair: That is very good. Thank you very much. We have covered a huge number of subjects, and everyone has had a go, so we really appreciate it. We got two votes in there as well. Secretary of State Steve Barclay MP and Shona Dunn, deputy perm sec at the Department, thank you very much for joining us.