HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Work of the Department, HC 384

Wednesday 13 December 2023

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Watch the meeting

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

Questions 1 - 56

Witnesses

I: Rt Hon Victoria Atkins MP, Secretary of State for Health and Social Care, Department of Health and Social Care; and Sir Chris Wormald, Permanent Secretary.

Examination of witness

Witnesses: Victoria Atkins MP and Sir Chris Wormald.

Q1 **Chair:** The Health and Social Care Committee is back live from Westminster, and we have the new Secretary of State with us. Welcome to the Committee.

Victoria Atkins: Thank you so much.

Q2 **Chair:** We also have Sir Chris Wormald. I think this is the first time you have appeared before me as permanent secretary.

Sir Chris Wormald: No.

Q3 **Chair:** You have been before. I had forgotten: such fun we have had.

Sir Chris Wormald: It is memorable.

Q4 **Chair:** We are starting a little early. There will be a vote, so we will suspend briefly, but we will crack on as everybody is ready to ask their questions.

Well done, Secretary of State, on the consultants' deal. Good work. Hopefully, the trade union ballot will go well, with it being passed comfortably, and that will be in the past.

Not such good news on the junior doctors. Six days of new strikes have been announced, with three days from 20 December, which neatly finishes early for Christmas. What is chilling NHS leaders is three days from 3 January on top of that.

What is your message, Secretary of State, to the BMA trade union, as of today?

Victoria Atkins: Thank you very much, Mr Brine. It is a pleasure to appear before the Committee. I have appeared in front of many of you in different guises over the years, but I am honoured to do so in this capacity.

First and foremost, may I set a little background context? When I was asked by the Prime Minister to undertake this incredibly important role I was genuinely delighted, because the NHS is one of the reasons I came into politics. I wanted immediately to establish constructive relationships with everybody who works in our NHS and in social care. I was very pleased to be able to invite the BMA and other representatives to see me within days of my appointment. I had very constructive meetings with all the BMA chairs and was pleased that we were able to reach this fair and reasonable agreement with the consultants committee of the BMA.

You kindly asked me to send a message. I know that other parts of the workforce have questions about the way in which the settlement has been structured. I emphasise that it does not affect the headline rate of pay; the independent pay review board process continues. We wanted to restructure the contract under which consultants have worked for some 20 years and bring in some modern-day policies such as enhanced shared

parental leave, which has been having a real impact on female doctors in particular.

We were able to reach that agreement. I am very grateful to the BMA for agreeing to it and I look forward to the vote and, I hope, the approval of the consultants' body in due course.

I have had the pleasure of meeting the chairs of the BMA junior doctors committee, or doctors in training as they prefer to be called. It has been, as far as I am concerned, a constructive relationship. I am extremely disappointed that it decided to walk away from the discussions we were having, which were live—we had not in any way made a final offer or anything of that nature. It is disappointing, but, as I have said since they announced their decision, should they call off the strike action I will get back around the table with them.

As we approach next week's strikes and the very significant strikes in January we will begin, sadly, to see some of the impact that that will have on patients, particularly over this period, which, as everybody knows, is probably the most challenging for the NHS.

Q5 **Chair:** NHS England has, as you know, shared publicly its concerns about the impact of the ongoing industrial action on patient safety. Do you share that concern? Matthew Taylor of the NHS Confederation has said that this is a nightmare scenario, with their worst fears being realised, in many ways. How much longer can the NHS withstand this ongoing industrial action?

Victoria Atkins: I am taking the approach that it cannot be just me as Secretary of State having this discussion in public with the junior doctors committee. We need professionals—clinicians—working in the system to speak, privately or publicly, with their junior doctor colleagues to explain the consequences.

NHS England is beginning to set out some of its concerns. We will have to play it day by day to see the impact at this time of year.

Everybody realises that the strikes in January, in particular, after the Christmas period will be a very difficult time for the NHS. Even with a full contingent of workforce, seasonal factors such as flu and covid-19 will continue to take their toll on all of us.

NHS England is keen to say that although there is the Christmas break in the middle, with the Christmas period being what it is, it will continue to have a tail after the three days next week into the period before the January strikes start. It is deeply concerning.

Chair: To be continued. We shall suspend while we vote.

The Committee suspended for Divisions in the House.

On resuming—

Q6 **Chair:** Welcome back. We had to vote twice in the Chamber. They were

incredibly tight votes; the Government won by only 250.

We were talking about industrial action and the consultants, which we hope is sorted, subject to the ballot. We were talking about the junior doctors, who I know are of grave concern to you. The NHS and many patients are concerned about the impact on patient safety.

I think we covered that, so may I move on to pay review bodies? The nurses were on strike earlier this year. The Committee heard from the NHS Pay Review Body. It seemed to us that one of the emerging themes was the lateness of remit letters going out. I understand that the letter for the 2024-25 pay review still has not been sent by the Health Secretary. The letter for the 2023-24 round was sent on 16 November. Bearing in mind a general election at probably some point next year and the disruption that could cause, what is your view on remit letters? Traditionally, the remit letter would be issued in the autumn, the work would be done and the pay settlement announced in the spring Budget. We seem to have got away from that. We seem to have something announced and backdated to the start of the fiscal year. What can change under your leadership in this respect?

Victoria Atkins: I draw on my experience as prisons Minister when we had the same process for prison officers.

The Committee will understand that it is a Government-wide process for Departments whose workforces fall under the remit of pay review bodies. No one Department can issue a remit letter before everybody else. I was told that the remit letters fell out of sync because of the effects of the pandemic.

We have been trying to bring them back into sync. I very much understand how frustrating the delay is, particularly for the lowest paid. They will be reimbursed when the final decision is made if there is a gap of several months between the date from which it comes into force and the date of the announcement. None the less, I get the point about cashflow.

I will do everything I can within the Department to deal with this as promptly as we can, but we are also listening to representatives of our workforce, who have voiced concern about the way in which the bodies are structured. I very much am listening to that, because to my mind the pay review bodies are essential. They comprise people who are expert in their fields—labour market analysis or wider economic factors—and I am very keen to ensure that the full potential of the system is understood and appreciated by the workforce and unions who are contributing to them.

I went through the prison officer process. As prisons Minister, I did everything I could with my Secretary of State to find as good an offer as possible, giving evidence with great conscientiousness and a genuine willingness to assist the board in its considerations so that in the end we come to a result that, if we cannot give everybody everything they want,

is none the less a result that lands somewhere in the landing zone of fair and reasonable.

Q7 **Chair:** Permanent secretary, presumably the Department can pull in behind and ensure we get back to that more sensible rhythm of pay review body letters.

Sir Chris Wormald: Yes, everyone is working towards that. As the Secretary of State said, the more external shocks you get the more difficult it is to write the economic and fiscal analysis that underpins this.

Q8 **Chair:** And changes of Secretary of State?

Sir Chris Wormald: Not that sort of shock—not that it was a shock.

Q9 **Chair:** We had quite a few last year, didn't we?

Sir Chris Wormald: It is much more the underlying economics that are the issue. When you get an energy price shock because Russia invaded Ukraine, a pandemic or any other economic shock, it is vital that, as well as being timely, the analysis is right. That causes problems, but we will go as fast as we can.

Q10 **Chair:** Super. On 4 December, the Government announced changes to the UK legal migration rules. The Home Secretary set out a five-point plan "to end the abuse of the health and care visa. We will stop overseas care workers bringing family dependants, and we will require care firms in England to be regulated by the Care Quality Commission in order to sponsor visas".

The Home Secretary told the Commons that he had "crunched the numbers in great detail" on the impact of changes to the migration rules on the social care sector. What is your assessment of the impact that the changes will have on the social care sector?

Victoria Atkins: I hope that it has been universally welcomed that we have required employers and providers seeking to use this highly sought after visa route to bring people into the UK to look after people to use CQC-certified establishments. I heard from many people concerns about how some unscrupulous people are trying to use this route to exploit and to bring people over who are then put to work elsewhere. That is not right, so we are fixing it, and I think it has been widely welcomed by the sector.

The Prime Minister has been clear, the Government are clear: we need to tackle legal and illegal migration. The numbers are too high according to the most recent publications. One of the ways of addressing this is by looking at how the health and social care visa works. We have got to a very sensible place. We are ensuring that we have exemptions in relation to salary thresholds and so on to reflect the realities of our being in the international market to encourage world-leading oncologists to come to the UK to work in our hospitals. We would like that to happen and we will pay them through the NHS.

We also wanted to reflect that, sadly, a career in social care remains among the lowest paid, so we have that sensible carve-out.

We had got to the point where more people were coming over as dependants than people who were working under visas. We have to address that and I think we have got to a very sensible place. My understanding from Minister Whately's conversations with the social care sector is that it understands and is broadly relaxed about this.

Q11 **Chair:** What impact assessment was done on removing the right of care workers bringing their dependants to the UK?

Victoria Atkins: The Home Secretary has said that he is happy to publish the data, which we have been looking at. This visa route was much more popular than we could have hoped for, but we are confident that we will still be able to maintain the level of interest internationally for care workers, given how many—

Q12 **Chair:** International care workers who come to work in the sector have proved that they are internationally mobile by the fact that they are prepared to come here. Given that, if it is a choice of coming here but having to leave behind a husband, wife, partner or children or going to a country where they can be taken, what would you do?

Sir Chris Wormald: It is important to remember that we are heavily over-subscribed. The limit on the number of people who are coming into the country is the number of jobs available, not the supply of international labour. Because of the thing you mentioned about unregulated care homes, we will be reducing our demand on the world supply by, I think, 22%.

If you put all those things together, the assessment by our Home Office colleagues is that there is a robust market, and we will monitor this very carefully with our Home Office colleagues. As the Secretary of State said, the Home Secretary committed to publish further analysis.

Q13 **Chair:** But aren't there 152,000 vacancies in the care sector?

Sir Chris Wormald: Yes, there is still a substantial number of vacancies. International recruitment has helped to stabilise and improve the situation, but, as you say, we still have a number of vacancies.

Q14 **Chair:** On the sector being comfortable with this, we asked Care England and it said it was not consulted on the proposals prior to the announcement last Monday. Does that surprise you?

Sir Chris Wormald: No, that doesn't surprise me at all. That is not how immigration decisions tend to be made. There is a very formal process, which you are aware of, for analysing immigration and making decisions. The Secretary of State said that Minister Whately's conversations suggest that the care sector understands what we are doing, the rationale for it and how we are moving forward. That is obviously different from being consulted prior to the announcement, which you wouldn't normally expect.

Victoria Atkins: It is consistent with our wish that we recruit more British people to do these really important jobs. As you will know, over the summer we invested a further £600 million in trying to help local areas with some of their supply issues—to recruit locally, making sure that where necessary parts of the country can increase their wage levels for social care work.

We very much want to raise the status of social care as a career. At the moment, it can sometimes be seen as a job and does not have the status it deserves. This workforce is looking after our parents and grandparents. It is important, caring work.

We think that there is a real market here in the UK, and it is consistent with what the Education Secretary is trying to achieve with skills-based learning throughout our lives. We want to include social care as part of the programme of work so that we recruit and retain high-quality people committed to work here in the UK. That is how we are going to make this sustainable.

Chair: Perhaps we should get the care Minister back to deal with this in more detail. We will ask the sector, including Care England, for a little more detail.

Q15 **Rachael Maskell:** Although it was three months late, thank you for the response to the inquiry into NHS dentistry. We are pleased that the Government are still committed to everyone who needs an NHS dentist having access to one. However, last year 12 million people were unable to access NHS dental care. In my constituency, people are waiting seven years to see an NHS dentist, and we know that it is currently the main reason children go to hospital, with 169 extractions every day.

When will we see the NHS dental recovery plan? We were told it would be before the summer of 2023. Will you explain the delay?

Our report has been described as "an instruction manual to save NHS dentistry". Will you adopt it in full and review the recommendations, which the Department has declined?

We understand that there is a delay at the Treasury in processing the dental plan. Will you tell us what the reasons are?

Victoria Atkins: Gosh! Thank you for your welcome. That was a lot of questions, but let me try to give you an overview.

I have been in this role for three-and-a-bit weeks. When I heard from the Chair that the report had not been responded to, I dealt with that quickly; apologies that it was a few days later than when I first started looking at it. I personally looked at the response and wanted to ensure it met the standards I set for myself when we are responding to Select Committee reports. You have it now.

I hope that response gives you a sense of the ambition we have in this area. I very much understand the concern about dentistry. I represent a

very rural area that has a coastline, so believe you me I am very aware of how important this is to our constituents.

Minister Leadsom and I are looking at options for the plan and will publish it in due course.

Q16 **Rachael Maskell:** Can you give the timeframe for that?

Victoria Atkins: I won't at this stage because, as you will appreciate, today is a snapshot and next week we are heading into a very difficult week with junior doctors' strikes. I am very aware of the urgency of this, but forgive me if I don't give you a date. I don't want to give you a date but we miss it because we have taken another look at it and think there are things we want to add to it.

I very much look forward to being invited back to the Committee to discuss the plan that we will publish.

Q17 **Rachael Maskell:** Some changes have been made to the UDAs in the contract, but there are 500,000 fewer dentists than before the contract changes. Retention is the big issue in NHS dentistry. Recruitment is important—the NHS long-term plan does not address that for another three years—as is attracting returners to NHS dentistry. What are your proposals to do that?

Victoria Atkins: May I correct a couple of figures? I am told that we had 1,352 more dentists doing NHS work in 2022-23 than in 2010-11. There has been an increase. That is welcome news. I understand why the Committee is looking at the previous year—of course I do—but having had that difficult period through the pandemic we all understand why dentistry took such a knock with the conditions placed on us by social distancing, lockdown and so on. None the less, we have made some improvement. I am not for a moment saying we have got there, but we know that 1.7 million more adults and about 800,000 more children saw an NHS dentist last year compared with the previous year. We are moving in the right direction.

You are right to bring in the long-term workforce plan. I hope we will talk about the plan in other areas, but in this year when we are celebrating the 75th anniversary of the NHS I describe the plan as how we look forward to securing the next 75 years of the NHS. The NHS is about its people, its workforce, and through dentistry but also in medicine, doctors, clinicians, nurses and so on we are able to set out ambitious plans to train more dentists, doctors and other members of the workforce.

Wait for the plan, but equally I accept your point about retention being as important as recruitment, and those are some of the issues that Minister Leadsom and I are considering.

Q18 **Rachael Maskell:** Funding is really important. The Prime Minister did not get his figures right at Prime Minister's questions today. An additional £1.5 billion is needed to get to the 2010 levels, with England having the

lowest funding of all the UK's countries—significantly so—and lower than anywhere else in Europe.

Our report called for radical contractual change, moving from the system of UDAs to a capitation approach to ensure that everyone can access NHS dentistry, because we know it is a major driver of inequality.

Will you set out your proposals for levelling the money to ensure that the service is brought in line with where it should be on funding and for future contract management?

Victoria Atkins: I understand that capitation was looked at many years ago. I am searching my memory; I don't know whether the permanent secretary can assist me. I think it was looked at but did not bring the results we wished for. If I may, I will write to you on that because I am pretty sure I read some evidence about capitation. I appreciate it has been a subject of debate.

The NHS receives £3 billion of funding each year for dentistry. I was asked about this in orals. This year, NHS England has provided guidance for ICBs that requires dental allocations to be ring-fenced, with any unused resources being redirected to improve NHS dental access in the first instance and not spent on other services.

It is important that I acknowledge that in November NHS England confirmed that where ICBs had not spent all their allocation on improving access to dentistry they would be able to retain underspend and use it to balance their bottom line.

Q19 **Rachael Maskell:** Which is different from what you said at oral questions.

Victoria Atkins: No, forgive me. The wording I used in orals was the wording I had in front of me at the time. I was very particular about it in the first instance. I have since asked precisely what colleagues were trying to get at. I respect colleagues when they ask questions. I want to know that we are giving as full an answer as we can. The underspend is in relation to that individual ICB.

Some ICBs had no underspend and had been able to find innovative ways of dealing with dentistry over and above their usual ways of working. That is what NHS England is trying to encourage. Those that have not yet found that are permitted to keep it in their local area. Someone suggested they have to send it back to the centre: they don't; it is for the local area.

We are trying to bring transparency to this process so that through ICBs' finances we will be able to see exactly what they are doing with their dental spend. If your ICB is not spending money on dentistry that it has received, you as a constituency MP and your constituents deserve to know that.

Q20 **Rachael Maskell:** We are talking about £400,000—a significant amount. We know that the flexibility that has been applied by certain ICBs is

bringing results, particularly in challenging new cases. It is important that that money is not lost to dentistry. Even if it was to be carried over into next year, it would certainly alleviate some of the pressures.

Sir Chris Wormald: I want to be absolutely clear about the change in the November guidance. It was that underspends would be retained locally by ICBs to go towards the bottom line, as opposed to it being returned to NHS England.

Q21 **Rachael Maskell:** This is health dentistry.

Sir Chris Wormald: I want to be crystal clear about exactly what that change was.

Victoria Atkins: Why isn't the ICB spending that money on local dentistry?

Q22 **Rachael Maskell:** That is answered by my previous question about the workforce and handing back contracts, which I know is a big issue.

Dentistry is important in the detection of oral cancers and abscesses. That makes sense: our mouths are major vectors for infection. As a result we are seeing a correlation being understood around how central this is to our wider healthcare, particularly bacterial infections, infections of the blood and sepsis.

As a result of that, when are you going to reintegrate dentistry into the NHS?

Victoria Atkins: We are looking at dentistry at the moment. There are many ways in which we can address the needs of our local communities while having some of the flexibility of the current arrangements—for example, enabling us to let our constituents know where the areas are with a choice of NHS dentists. In city centres, that very much is the case.

It is one of the reasons why, as far as my aims for our NHS and social care system are concerned, I apply three words to every proposal: "Does this make our NHS and social care system faster, simpler and fairer?" One of the reasons for the word "fairness" is that, as a rural MP, I am very conscious that it can be easier to access NHS services in a densely populated city centre than it can be in rural and coastal areas.

One message that, perhaps, is not widely understood about dentistry is that you are not registered to a dentist in the way you are to your GP, where you probably have a family relationship with that GP practice or an individual GP. You are registered with the dentist only for the course of that treatment. That might just be a check-up. It might be a filling. But if you are able to use the NHS app—or the 111 helpline in the most rural areas, where we have put in a little bit of extra funding, such as the south-west—you can find other dentists and go to them.

We are trying to work with what we have to ensure that we get some very quick answers for our constituents because I do genuinely understand why we are all concerned about this.

Sir Chris Wormald: Could I just add on that?

Chair: Very briefly.

Sir Chris Wormald: I do not think it is a matter of political debate that restructuring the NHS does not always achieve results. The key thing we have done here is the ICS system. ICSs look across the NHS, social care public health and take integrated decisions about the whole of healthcare, even if we are not restructuring the underlying services, which you can make arguments for but, undoubtedly, has a very long lead time before it has any effect.

Regarding how we are integrating the thinking, it is in the ICS system. As I say, on structural form, people can have their views.

Victoria Atkins: Which is why your local dentistry funding goes to your ICB.

Q23 **Rachael Maskell:** Thank you ever so much. The previous CDO did say, "It is time to put the mouth back into the body, and that is the purpose of my body." So, I hope you hear my question. Please consider that in your review.

Sir Chris Wormald: I do not think anyone is disputing your thinking that this needs to be seen in an integrated way. It is whether structural reform is the best way of getting there that I think is important.

Chair: You did indeed say that.

Q24 **Amy Callaghan:** Heading into the autumn statement, the Chancellor had around £27 billion of fiscal headroom that he chose to spend on two tax cuts instead of investing in public services. Do you believe this was the right decision?

Victoria Atkins: Yes. The Scottish Government impose higher taxes on their residents when it comes to income tax. The easiest way we can help our constituents with the difficulties of the cost of living is to keep a little less of their money and allow them to keep it in their pockets—their hard-earned money.

The Prime Minister set a very clear target of halving inflation. We have achieved that. It was not inevitable. It was because we have had to make some very difficult, fiscally disciplined decisions and we are in a position now where we are able to allow people to keep a little bit more of their own money.

I appreciate that the health system is devolved in Scotland. In England and Wales, we are spending record amounts on the NHS. We were, as part of the autumn statement, able to announce a further £800-million package over five years to support mental health initiatives. Interestingly, we were able to reform how we treat people who are living with conditions that may mean that some forms of work are not open to them, but whose potential we want to fulfil, none the less, and see whether there are other forms of employment open to them. Through

those reforms, we are spending around £30 million of funding to help support people back into the workplace. The evidence shows that work is not only good for our pockets and purses; it is also, we believe, good for our wellbeing, if it is possible for the person living with the condition.

Q25 **Amy Callaghan:** The real-terms reduction in capital spending in NHS England means a reduction in Barnett consequentials for the Scottish Government.

Victoria Atkins: The Barnett consequential system is a long-established process for dealing with our devolved nations. As I say, we are spending record amounts on the NHS. We want very much to be future-facing in how we try to deal with some of the huge health issues facing not just us but the whole world.

For example, the Chancellor was able to commit some seed funding over the next couple of years to support a new centre to tackle antimicrobial resistance. We and all our friends around the world understand that this could be an enormous challenge for humanity if this continues to develop. So, that sort of investment, as well as the investment that we have seen over the last couple of years into life sciences—we have the most successful life sciences industry in Europe here in the UK; we are extremely proud of it.

I was delighted, when I was Financial Secretary to the Treasury, to meet representatives from the Scottish life sciences industry. We are able, here in the UK, to support businesses and companies and people who are trying to find cures for the diseases that this Committee spends an awful lot of time thinking very carefully about.

There is a raft of investment, not just in our NHS but in looking at what we can do to help to prevent some of these conditions that we know are coming down the train tracks towards us.

Q26 **Amy Callaghan:** Coming back to migration issues, the social care sector in Scotland is not broadly relaxed about the visa changes coming into force next spring. We have a decline in population in Scotland and, specifically, a decline in working age population. The last thing Scotland needs is for people to be further disincentivised to come to work in our health and social care sector. Do you recognise the need for the approach to migration to be different in Scotland from elsewhere in the United Kingdom?

Victoria Atkins: No, because we are the United Kingdom. For the needs of people who are in social care, I do not believe it matters whether you are in Glasgow or in Garstang. You are entitled to dignity and respect and care and compassion in the way you are treated.

In England, we are very much looking, as I say, to help to support people who work in our social care system. We recognise that we would like to encourage training and retention in that area, but this is about raising the status of social care as a career. International recruitment is an important part of that, and I very much welcome people whom we have welcomed

into our country to work in the system. None the less we, as a country, must tackle high migration and do so in a way that is fair to all residents.

Q27 **Amy Callaghan:** I appreciate what you are saying. We know we need a tailored system in Scotland. We have too many skills gaps that we are desperately trying to fill. We know from the Fresh Talent—Working In Scotland Scheme, which was in place from 2005 to 2008, that a Scotland-specific work visa is possible. Would you approach Cabinet colleagues to consider that?

Victoria Atkins: That is a matter for the Home Secretary. The Home Secretary has control of migration policy, as a whole, and, of course, it is informed, as the permanent secretary said, with very careful, detailed analysis and, indeed, the contributions of the Migration Advisory Council. Again, I would hope that we were thinking not just about international recruitment but about how we can use the potential of our citizens to help support our social care system.

Chair: Top marks, Amy. Spot on; one minute early.

Q28 **James Morris:** Secretary of State, you will have possibly heard my question to the Prime Minister today, which I raised in orals. I know that you have been in post for only two to three weeks. Can you give any insight into why the Government decided not to reform the Mental Health Act, given that it had been a manifesto commitment? In 2019, there had been a White Paper and a draft Bill. Why abandon it at this stage?

Victoria Atkins: I did hear your PMQ, Mr Morris, and thank you for that. I do not think I can hope to improve on the Prime Minister's answer. What I hope I can do is to emphasise that while we are reviewing the outcome of the Joint Committee's pre-legislative scrutiny report on the draft Bill, we are continuing to invest at least £2.3 billion of additional funding a year by March next year to expand and transform NHS mental health services.

I know sometimes when we talk about these enormous figures it is difficult to comprehend what that sum can buy. We believe it will mean that an extra 2 million people can receive the mental health support they need.

Q29 **James Morris:** I accept that more money has been put into mental health services, but it has been patchy over time.

According to the Joint Committee, "As of August 2022, NHS digital figures show that 1,970 people with learning disabilities or autistic people were in hospital detained under the Mental Health Act in England. Of those in hospital for the end of that month, 57%, that is over 1,000 people, have had a total length of stay of over two years. That also includes 350 who had been in hospital for more than 10 years."

For people with learning disabilities and autism, the average length of stay, having been detained under the Mental Health Act, was 5.4 years in comparison to somebody else who may have been subject to the Act, which was 27 days.

The policy problem, which the Mental Health Act was designed to solve, goes back to the commitment in 2017. This is a national scandal, is it not?

Victoria Atkins: Yes, and this is why we are trying to address some of these very practical problems through non-legislative measures. As we all know, it can take a very long time to bring through a private piece of legislation. In fairness, the Government have wanted to ensure that this very important legislation is in the right place that it needs to be, which is why—

Q30 **James Morris:** I am sorry to interrupt, Minister. It is not going to happen, is it? Despite the words, "We will bring it forward when time allows," it is not going to happen before an election, is it? So what are the non-legislative things? What, apart from the money, are we going to do about this long-standing issue with autism and learning disabilities?

Victoria Atkins: The answer is that we are very committed to bringing forward the Bill when parliamentary time allows. The practical measures we are taking include, for example, culturally appropriate advocacy pilots. The facts that you have read out are shocking. I am also shocked by the fact that black people are four times more likely to be detained than white people. These pilots are being set up to try to ensure that people are not disproportionately detained, if you like, if that is the correct phrasing, and that ethnicity is not disproportionately represented in decisions to detain. Through measures such as this, we will be able to make changes much more quickly—whilst the work on the PLS report and Bill continues.

Again, I am very grateful to my hon. Friend for raising this, because of course our understanding of neurodiversity and learning difficulties is much better than it was 10 years ago. I do appreciate the understanding.

Sir Chris Wormald: We understand. I know that you know as much about this as I do.

Of course, the other part of the equation is the community services that allow people to be moved from the settings that you describe. As you know, there has been an NHS programme on that for quite some time.

I do not have an exact update—I will get it from the NHS—but the legislation gives you a framework, which is very important for reasons that you know, but, even more important, you have to have safe community services for people often with very high levels of challenge. I will get you an update on exactly where the NHS is with that bit of the programme.

Victoria Atkins: It is also about making sure that when people are in hospital they receive the most appropriate and the best care—for example, removing and replacing dormitory beds so that we have proper, dignified care for people within a hospital setting. Indeed, when I was a Home Office Minister, I was determined that we stop using police cells as

places of safety in a moment of crisis. In fairness, we have done incredibly well across the country with that.

Q31 **James Morris:** Thank you for that. May I ask a secondary question on mental health?

If you look at the sweep of time—probably the last 15 years—there has been progress on talking about mental health, attaching stigma and the development of strategies, specifically for mental health. If you go back in time, we had a five-year forward view for the first time.

A previous Secretary of State made the decision—I cannot remember if it was the one before last or the one before that—to abandon the development of a mental health strategy and fold it in with the catch-all major conditions strategy. That was quite dismaying for many service users and for many mental health charities, who were very clear that they wanted a specific mental health strategy for the reasons that we want parity of esteem between mental and physical health, and focus on mental health needs to get towards that parity.

Would you consider extracting it from the major conditions strategy and putting it as a stand-alone strategy once again?

Victoria Atkins: I hope the Committee will appreciate that there are areas that I want to commit some time to think about, to mull over, and to look at what has happened in the past. This is one of those areas. I know that the permanent secretary is able to provide some of the history.

Sir Chris Wormald: Yes. The first thing to say is that the debate you point to is a very genuine debate and there are different opinions, and different opinions in the clinical world.

We went for a major conditions strategy rather than a specific-by-specific one for two reasons. First, the causes of different major conditions are frequently the same, so what is done about prevention—smoking, obesity, some forms of other environmental issues, housing, employment —is frequently common to many of the conditions.

Secondly, it is very common for an individual to have more than one major condition at once. There is, for example, a very big overlap between cancer and mental health, between cancer and cardiac and the range. The move that we are trying to make is to treat the whole person, not the individual condition.

James Morris: I understand that.

Sir Chris Wormald: That is the argument.

Q32 **James Morris:** I understand the rationale. I will put it to the Secretary of State, as she considers it. Because of the history of the fact that mental health has not had parity of esteem in its treatment—it still does not have parity of esteem in funding—it requires its own focus to galvanise attention in the system. In a major conditions strategy, it just becomes a sort of subsidiary. That is what I would posit to you.

Sir Chris Wormald: As I say, I completely recognise the argument you are making. Those who argue the other way would say that mental health being treated the same as all those other major conditions is parity of esteem. I come back to the fact that there is a very large overlap between people having a physical condition and a mental health condition. When it gets to the interaction between a clinician and the person, you want them to treat the whole person, not a series of separate conditions.

As I say, you can argue this case both ways, and people do. But it is not that there is no logic to a major conditions strategy that looks across the piece as opposed to, as some people argue, a series of individual strategies.

Q33 **James Morris:** It does sound like there is an opportunity to have a further debate about whether the strategy that was set by the Secretary of State requires some conditions.

Sir Chris Wormald: The last point I will make—and, as I say, it is a completely fair debate that you have started—is that it is more important to debate the actual content than whether it is one strategy or several strategies.

The debate that we want to have, as the Secretary of State said, is that we are putting our additional money into mental health. We have additional workforce in mental health. We made a whole series of commitments in the workforce strategy around mental health, so we have a lot of extra resources. As you know, we have a huge challenge that got even bigger in the pandemic.

The most important policy question for us is: of those new resources—all those new people—how do we use them best to meet the need? That should be our top question, as opposed to how we structure our documents.

Chair: Okay. Not got a "no" there.

James Morris: Sounds like it, Chair.

Chair: Progress.

Q34 **Paul Blomfield:** Secretary of State, a case was recently brought to my attention of a woman with a brain tumour. It was benign, but, as it was developing, it was causing progressive and irreversible sight loss and seizures. She had an operation scheduled for September; it was cancelled. It was rescheduled for October; it was cancelled. It was rescheduled for 22 December, but without any guarantee it could proceed then. Given the impact this was having on her life, she chose to go private. Her family managed to scrape together a not inconsiderable amount of money that was necessary for that.

Healthwatch recently commissioned a survey that found that one in seven NHS patients had been advised to go private by an NHS professional. Is

Healthwatch right to warn that we are moving towards a two-tier system: one for those who can afford treatment and one for those who cannot?

Victoria Atkins: Mr Blomfield, your question sets out very starkly the consequences of waiting lists but, importantly, also the consequences of industrial action on waiting lists.

Your reaction is interesting, because since industrial action started in December last year 1.1 million appointments have been rescheduled. In October alone, 40,000 appointments were being rescheduled. We have industrial action next week, starting on 20 December. When you remove our highly qualified, highly prized doctors and clinicians from the hospital setting, that has real-life consequences for our constituents, for the patients waiting for those appointments.

I am doing everything I can to cut waiting lists because I absolutely understand that people are in pain—they are in distress, they have conditions such as you have just described. But we do also have to be realistic about the impact of industrial action.

I can say that we are making progress on the different tiers of waiting lists, and I can give you the national figures. Fifty-eight per cent. of people now are treated within the standard 18-week timetable for first treatment, but we know that many are waiting longer.

I absolutely understand why you raise this. I want to tackle it, but I need the help of clinicians in so doing, which is why I am so pleased and determined to try to reach a settlement with the consultants. I have tried to do the same and remain very keen to do the same with doctors in training. But I need them, please, to call off their strikes and come back round the table.

Q35 **Paul Blomfield:** Let me explain their reaction because I am sure you will know that—and clearly, the industrial action is a major disrupter that has added to the problem. The sooner the Government are able to resolve it, the better.

Victoria Atkins: As I say, Mr Blomfield, I am trying. I have said to the doctors in training, "Call off the strike action." We have not given a final offer. They walked off, and I am incredibly disappointed. I have said, "Please, please come back round the table, but call off your strikes. Come back round the table and we will continue those discussions." In particular, I genuinely think they have a point on some of the things that they are worried about.

For example, if you take pay out of it for a moment, given some of the conditions that our doctors in training face on a shift and so on, I genuinely think there are some lessons that health trusts should learn when it comes to looking after their workforce. I am very happy to have those conversations. I sadly do not—or perhaps with relief—have the power to change rosters and things like that. What I can do is say we want to retain, look after and cherish our workforce, and we have to find better ways of helping to do that.

For example, on the consultants' pay restructuring, I listened, we listened, to parents who said that they would like the shared enhanced parental leave that is available elsewhere in the workforce. We said, "Of course we will put that in the new structure. That is a modern requirement and we are very, very happy to do that."

There are some ways in which we can try to meet some of the genuine concerns of doctors in training.

Q36 **Paul Blomfield:** I am sure, as you will be aware, that, although industrial action is a factor, the Nuffield Trust did some work that concluded that the strikes were not the main cause of long waits, pointing out that even prior to the strikes planned operation rates had not returned to pre-pandemic levels—so, they are a factor. My reaction was based on your exclusive explanation of any problem in the NHS being due to the strikes. Can I just pressure you—

Victoria Atkins: Mr Blomfield, on that—forgive me if that was the impression I gave. There are other factors—of course there are. But I am sitting here with strikes starting next week and that is what my primary focus is on at the moment. I want junior doctors to come back round the table.

As for other factors, we all know the strain and the stress that the NHS was put under during the pandemic; of course, that has had an impact. But there is, interestingly, a question about productivity. As we are investing in our NHS, as we are employing more doctors, more nurses, there is a question about productivity. In fairness, NHS England recognised this and commissioned a report on productivity, which will be very interesting reading.

Q37 **Paul Blomfield:** Perhaps you could share your thoughts with us on the action you will take—whether it is about productivity or whether it is about some other aspect of the challenges—to bring waiting lists down. When the Government published the elective care recovery plan in February 2022, there were 6.2 million people on the waiting list; there are now 7.7 million.

Victoria Atkins: No, no—sorry, to correct you on that. This is a common mistake and, indeed, full facts have corrected it. The 7.7 million refers to the number of pathways. Is it 6.5 million people? It is 6.5 million people now—so it is different, because some people have more than one pathway.

Q38 **Paul Blomfield:** We are comparing like with like. The relative direction of travel on waiting lists is the opposite to which the elective care recovery plan set. What measures will you take to begin to change that direction of travel and to see waiting lists fall?

Chair: As concisely as you can if we want to finish on time so that you can get away.

Victoria Atkins: NHS England achieved its target of virtually eliminating long waiting times of two years or more for elective procedures in July

2022. Thanks to the very hard work of our workforce, waits of 18 months have been reduced by over 90% since September 2021.

We are tackling the waiting list issue in three ways. First, we are increasing activity and spending an additional £8 billion from 2022 to 2025 on additional elective care.

We continue to open more community diagnostic centres, which are critical parts of this. I think it is part of the modern way the NHS can help to look after people. I think that 5 million scans, tests and checks have already been done through those.

We are also trying to manage demand. You will have seen that in the past few weeks we made changes to what we call Pharmacy First, helping with primary care, because that can have an impact on secondary care, giving patients more control and choice over where they can receive care. Waiting lists in their local hospital may be longer than those in a hospital a little further away. I appreciate that will not suit everyone, but some people will be able to travel a bit further afield to have their operation or treatment that bit sooner.

We are also looking at productivity. We want to ensure that we get patients flowing through hospital as quickly and safely as we can through managing discharge. We want to look at how NHS England works with trusts to challenge them on their performance. We are putting everything into trying to reduce these waiting lists, because we absolutely understand everyone's concerns about them.

Q39 **Paul Blomfield:** I have one last quick question that requires only a quick answer. When we publish the waiting lists—this touches on James's point—we are talking only about those physical elements. We do not publish the mental health waiting lists at the same time. There are between 1.2 and 1.4 million on the mental health waiting list. Whatever the number, I asked your predecessor whether it would be sensible to consider publishing the two together, recognising parity of esteem, and he said he would go away and think about it and come back to us. Will you?

Victoria Atkins: Yes, I will.

Q40 **Dr Johnson:** Like you, Secretary of State, I am very concerned about the strike action occurring over the next few weeks. I declare an interest as a consultant. You mentioned the ones after Christmas, but I am really worried about those before Christmas. I know it is three days, but it is three days just before a weekend and two bank holidays. Without any recompense, there will be seven days when we will have a reduced service, which really frightens me.

You talked about the figures for rescheduled appointments, but that is not a complete record of the reduction in activity, is it, because with the notice period for strikes some things are never booked, so the overall reduction in activity in the NHS is quite considerably more than the number of cancelled appointments?

Paul has highlighted the very real patient consequences, not just waiting lists but the very real consequences for individual patients. I am certainly aware that some appointments have been cancelled due to industrial action on more than one occasion. Personally, I think that a doctor walking away from their patients and leaving them to suffer in the ways described to obtain more money for themselves is a morally outrageous thing to do.

That said, it is your job to keep patients safe; you are the Secretary of State. Can you provide the Committee with a full record of the reduction in activity in the NHS caused by these strikes? Have you considered the effect on doctors' training and the number of missed days of work, particularly in key rotations?

What is your plan regarding minimum strike legislation? With minimum strike legislation—you have done a consultation—an SI could give you some increased safety for patients as we go into next week.

Victoria Atkins: Dr Johnson, thank you very much for bringing not just your professional expertise but your professional experience into this discussion. You made some very interesting points about the ramifications not just for patients, which obviously is my primary concern, but individual doctors spending time away from their training programmes.

If the junior doctors committee will call off the strikes and come back to the table I will be there waiting for them, but we cannot have the threat of strikes hanging over the system like this.

You will be able to imagine how much work and effort is happening on the part of NHS England to prepare for these strikes. I do not want anyone to think that these strikes happen and we all turn up at work and expect it to be like it was yesterday. There are incredible amounts of work, effort and people hours put into preparing for these strikes once they are called. Frankly, that is time that could be spent on the other issues facing our health system; instead, it is being diverted to prepare for strike action. There are many repercussions.

You make an interesting point about patients not being booked in. I do not have that information to hand, but I take what you say on that.

We have announced a consultation on minimum service levels in hospitals, and that consultation is ongoing, I think. It is due to close very shortly, if it has not already done so. With ambulances, we have just put that in to pass the legislation. Again, this is our national health service. We all pay our taxes to pay for it. The reason we do that is that we have faith it will be there for us when we and our loved ones need it, so it is right that patients and the public can expect minimum service levels in their moment of need.

That is the thinking behind that legislation. As I say, we await the results of the consultation in relation to hospitals more generally. I should correct the record. That consultation has just closed.

Q41 **Dr Johnson:** I wish you the best with your endeavours in your preparations.

I want to pursue a different topic. Dr Jonny Acheson, a Leicester-based emergency department consultant, is running a campaign, "get it on time". This is looking at drugs that need to be given at a specific time. When they are not given at a specific time, it has potentially serious consequences for patients with conditions like diabetes, epilepsy, Parkinson's disease and HIV. They have done some research that shows that fewer than half of patients receiving such medication may be getting them within half an hour of their due time while they are in hospital. Clearly, that is not good enough and potentially has quite serious consequences. There is training in just over half of hospitals on the importance of medication timing for people with certain medication. Is the Secretary of State aware of the campaign, and what is she doing to support it?

Victoria Atkins: Thank you so much for raising this. I suspect I should declare the fact that I have type 1 diabetes, so I very much understand the impact of what you are describing.

I am not a clinician, so I will not presume to give a clinical response. I can only imagine that there will be other sectors as well. If one is living with one of those conditions it puts an extra duty on the patient to be assertive and say, "Can I have my medicine? Why haven't I had it yet?" and so on. As we all know, people live with many vulnerabilities and may not have the ability, confidence or the language to be assertive and ask for their medication when they need it.

If I may, I will take it away because I would want to understand at trust level what is going on and whether some trusts are better than others. I will raise it with NHS England because I am very concerned to hear what you describe.

Q42 **Dr Johnson:** I have another question, which was probably one you were expecting from me. I have been campaigning on children's vaping and am concerned about the sheer number of children now engaging in that habit, if one can call it that. There was a consultation. The consultation closed; it is complete. When do you expect to bring forward measures to curb vaping? In particular, I am concerned about disposal vapes, the colours and flavours, where they are advertised, where they are placed in shops, etc.

Victoria Atkins: Again, Dr Johnson, you have done a great job in raising the concerns of pretty much every mum and dad, grandparent and carer watching this. We are now having to deal with not just the risks of smoking, alcohol and drugs but vaping. It is very clear that vaping is there as a product for adults who need to stop smoking. They think that may help them to achieve that. It is not meant for children.

We are looking at the consultation responses, but the reason we are having the consultation in the first place is that it is part of the Prime Minister's determination to create the first smoke-free generation. I think

it is a very exciting and welcome public health announcement by the Prime Minister. We will be helping children and preventing them from taking up smoking through legal means, which we hope will help to avoid the sorts of deaths we see, sadly, at the moment. There are 80,000 deaths a year in the UK and one in four of all cancer deaths.

If we are able to stem that demand among our young people that will paint a very bright future for them. I am really pleased with the Prime Minister's announcement. I hope it will attract support across the House and we will be able to help deliver that for our children. Vaping is an important factor in that, and we will have look at the consultation and see where we get to.

Q43 **Dr Johnson:** My last question is about a particularly vulnerable group of children: those with gender dysphoria. A phenomenal increase in the number of children presenting with symptoms of gender dysphoria has somewhat overwhelmed clinical provision for them. On top of this, many of these children have other issues like mental health illnesses, ADHD, autism and other experiences, so they are particularly vulnerable children.

The Cass review, which started in 2020, produced an interim report in March 2022. The plan was to close Tavistock and replace it with something better. Although the consultation closed and interim service guidance was consulted on last October—I was Minister briefly when that happened—the Government seem to be dragging their feet in managing and dealing with this. Why is that?

Victoria Atkins: I am very much aware of the sensitivities and vulnerabilities of not just children and young people on this subject matter but the wider ramifications for society, and some of the debate we have seen both online and offline.

We want to get these policies right. We are at the beginning of this debate. I was Minister for Women when this debate started to come to the fore. It is important that we are able to talk in a respectful and caring but careful manner about some of the issues that this subject matter brings forward.

We want to protect children. That was why the Government took the right decision to ask Dr Hilary Cass to review this and submit her report, but also to ensure that when children do need care, help and support they get it in the right way from clinicians and there is no other agenda there, or that they are getting it in a clinically appropriate way.

NHS England has taken time. I appreciate there is a great deal of pressure for speed on this, but it is important we get this right. NHS England is taking time to transform the services available to children and young people. I am very grateful to all the clinicians and other professionals involved in this; I fully accept that it is difficult. NHS England is very much looking to launch this to help to ensure that those children who need these services are getting them from the right experts

and in the right environment to help them with some of the issues they are facing.

You alight upon the fact that there may be other issues that these children and young people are facing. We should all understand and acknowledge that. It will not be every child or young person, but we know some themes have emerged as we have all begun to understand this better. We want to ensure that we are treating these children as one person, as the permanent secretary said in an earlier answer, rather than siloing the different conditions or symptoms they may be facing.

Sir Chris Wormald: We are updated regularly by the NHS on the progress. This is technically a very difficult thing to do; for this service, it is establishing a whole set of new institutions. They are pressing ahead but are very conscious that the consequences of getting it wrong are very high indeed. I do not think it is foot-dragging. They are properly assessing the complexity and risk while pushing forward on the new service in the way you describe.

Chair: There are two Members left and they have 16 minutes: you do the math, as they say.

Q44 **Mrs Hamilton:** Secretary of State, I have been sitting here for a long time. This year, 39% of cancer patients have not received treatment within the Government's two-month urgent referral target. This is the equivalent of 36,000 people. I also read that 33,000 cancer deaths in the UK are linked to deprivation. My first question is: how do you plan to address the systemic challenges within cancer services?

Victoria Atkins: First, Mrs Hamilton, may I acknowledge your experience over many years working as a nurse, I understand? Thank you for your service in the NHS.

We are working to tackle cancer. We have recruited almost 11,600 more staff into the cancer workforce since 2010. We want to ensure that clinicians and others can help to treat people who have had a cancer diagnosis, or are awaiting one, as quickly as we possibly can.

We have seen some progress in the diagnosis of cancer faster. Almost 70% of patients were diagnosed, or had cancer ruled out within 28 days of being referred. I would like that figure to be 100%.

This feeds into some of the discussions we have already had about the pressures on the system as a whole and some of the ramifications of industrial action and the pandemic historically. For example, we know that people did not seek help perhaps as quickly as they would have otherwise because they were so careful to observe the notices about the NHS being under strain during the pandemic and so on. There is more to do, but we believe recruiting people, as we have done, is one of the ways in which we will tackle that.

Q45 **Mrs Hamilton:** It is well documented that we are lacking a long-term strategy for cancer. I know that you have been in your new role for only

three weeks, but would you be considering, similar to James's point, the arguments put forward about separating the cancer strategy from the major condition strategy because of the particular issues with people needing very early diagnosis?

Victoria Atkins: I will very much look at this. I am, however, reminded of the answer given by the permanent secretary, which you have articulated very well, if I may say so, in that we have here two Members deeply concerned about mental health and cancer. For some, not all, there can be a co-existence of those two conditions. I understand that finely balanced decision taken in the past, but I am very keen to look at everything and ensure that we are where we want to be.

Sir Chris Wormald: The arguments are exactly as I set out so I will not rehearse them, but you know, probably better than I do, that what we need to do is very well researched. While strategies are important, we all know the key things in cancer: prevention in the first place, going back to the question of smoking; fast diagnosis; and fast treatment. We do not need a strategy to tell us to do all those things; they were in the 2019 five-year plan for the NHS. There is a lot of stuff here we can just get on with. It is important to have a long-term view, but it should not distract us from doing all those things that we all know are part of the answer.

Q46 **Mrs Hamilton:** If you do not mind my saying so, the fact is that we do not have a clear strategy—this was articulated earlier, and I have only a few minutes—to address cancer. We have been conducting an inquiry into cancer and people tend to go off at a tangent.

The third question I have is about pancreatic cancer. It is one of the deadliest and most common cancers, with only 7% of people surviving for five years. More than 10,500 people are diagnosed with it in the UK each year, with only 26% of patients surviving for longer than a year. What plans are being considered for earlier diagnosis of a condition like pancreatic cancer and brain cancers, which Paul mentioned? Early diagnosis is absolutely vital. It is no good saying we do not need a strategy. Forgive me for being ignorant, but I think we do.

Sir Chris Wormald: To be absolutely clear, I was not saying we do not need a strategy; we do need it, and it is in the major conditions strategy.

Q47 **Mrs Hamilton:** I am sorry for my ignorance.

Sir Chris Wormald: Not at all. My point was a separate one. As you have just described, there is a whole series of things that we already know are part of the answer, particularly early diagnosis. I am not a clinician so I will not comment, but I will come back to you. I think that in the case of pancreatic cancer, which is technically very difficult to spot, that is part of the challenge, but I will come back with the latest science on what we are doing on that.

Q48 **Chair:** Presumably, you are very happy with the Galleri trial that NHS England is doing with the Government.

Sir Chris Wormald: Yes.

Q49 **Chair:** That does hold great hope for the less survivable cancers.

Victoria Atkins: This is a very good example of what I spoke about at the beginning. There are some really exciting developments on the way and we are very much at the front of some of them. As well as the strategy, wherever one comes down in that debate, we have committed £8 billion up to 2025 to help to drive up and protect elective activity, including cancer diagnosis and treatment activity, because we want to reach people and diagnose them as soon as we possibly can and give them the treatment they need.

Q50 **Mrs Hamilton:** I am really keen that we are seen as world leading. We had the absolute pleasure of going to Singapore. Many of the consultants and people doing all the research there were trained here. The issue at the moment is that we are having a bit of a brain drain. People are leaving the country. People have done research and want to get it to market. What we are being told is that they are having difficulties in these areas.

Adding to what you have said, we are brilliant. I was in the health service and would defend it to within an inch of its life, but the problem is that at the moment people are not feeling secure, for whatever reason, and our young, very talented people are leaving. Some of the other people we want to keep within our services who are doing research and other things also feel they are not getting the support they need to get things to the market. We find that some of them are leaving. What do you plan to do in that area?

Victoria Atkins: Three or four weeks ago I had responsibility for research and development tax credits. From that, I promise you we have the strongest research and development life sciences community in Europe. We are genuinely looked upon around the world with great jealousy, because we have engineered an ecosystem of support through R&D tax credits but also, importantly, because of the investment through NIHR, within the Department and the wider work of the Life Sciences Council, in order not just to help start-ups but to nurture them to a point where they can expand.

I give you the example of Abbott Laboratories. It is responsible for one of the most exciting developments in diabetes care. I am wearing one of them at the moment. It has not just researched and developed that medical device, called FreeStyle Libre; it is manufacturing it in Witney in the UK because it says it is a great place to do business.

Because of the way the market works in pharmaceuticals and so on there is a tendency that, when we nurture small start-ups that come up with brilliant ideas and work them out, larger pharmaceutical companies will often snap up those ideas and manufacture them. That was why the Chancellor had such a focus on investment zones and, in the autumn statement, on helping with clinical trials, because if we can secure more commercial clinical trials in the UK it will have a huge impact on retaining that talent. Indeed, I have just reminded myself that the Chancellor committed some £20 million this year to support our response to the

commercial clinical trials review, particularly our work on a new dementia accelerator. There is a lot of good work going on and it is very exciting for the future.

Q51 **Chris Green:** Secretary of State, the Health and Care Act was introduced in 2022 and came into force in July that year. It put on a statutory footing the 42 integrated care boards across England. What would you say are the most observable achievements of that to date that people around the country would see?

Victoria Atkins: It goes back to what the permanent secretary said in a previous answer. It is bringing together the different forms of therapy and treatments so that we as patients, I hope, are treated as one person rather than lots of siloed effects. I accept that it is early days. We debated dentistry and the responsibility of ICBs to ensure they have dental treatment that serves the needs of their local communities. We are beginning to see some interesting results across ICBs when it comes to things such as elective care.

You may have seen this weekend an article in one of the papers about Guy's and St Thomas' doing hit lists where they have elective surgery over the weekend. Not every hospital or trust can do that, but it is that sort of innovative thinking we are encouraging with ICBs as well.

Q52 **Chris Green:** A straightforward change ought to be the relationship between health and care and the pressure of bed blocking. What has been the difference in the number of people bed blocking a year or a year and a half ago and now? How has it improved?

Victoria Atkins: I will find the figure in a moment, but while I find the piece of paper that has my stats on it, we know that, as well as through the investment of the £600 million that I referred to earlier, we are seeing real changes in discharge rates in some areas. We are not there uniformly; I accept that. That is a really good example of what ICBs are meant to help to improve. It is that flow from the health system through to social care so that we can get those settings in place and ready for people when they need that care.

Q53 **Chris Green:** That is a huge challenge, because this is one of the observable things that ought to have changed in people getting out of hospital and into a more appropriate setting. The figures that I got from the House of Commons Library were for June, where it was a little over 12,000 this year, and it was a little over 12,000 in June last year, so it does not seem to have shifted a great deal.

One of the other observable concerns that people would have—certainly in my constituency—is that we are currently getting a new health centre being built in Horwich, which is incredibly welcome, but when I talk to constituents in Blackrod and Westhoughton their biggest health concern is GP services. How much is that your responsibility? How much is that the responsibility of the integrated care system? What mechanisms are there to put pressure either on you or on that local system to deliver this vital service?

Victoria Atkins: As always, I admire the way you bring your constituency into your questions.

In terms of responsibility, there are three answers to that. It is for me to set the policy and the direction of travel—what I would like NHS England to achieve. We have some levers through which we can achieve that—of course, funding and the direction of travel through documents such as planning guidance. It is for NHS England to operate the NHS and through that the ICBs at local level. NHS England will issue its guidance, and it is then for ICBs to work out operationally how they can achieve that.

We want to ensure good practice. One thing I am looking at very carefully is, where there are areas of good or great practice, why that is not being replicated across the UK or across England and Wales. That is one of the things I am really interested in.

Q54 **Chris Green:** That is one of the challenges.

Sir Chris Wormald: I have found the answer to your previous question. It has actually gone down—from about 13,500 to about 12,500 on the numbers that I have. We should also note that the vast majority of discharges are not into social care. It is an important facet, but it is by no means the whole amount.

Q55 **Chris Green:** People from the outside observing this would think it has not really transformed that relationship between care and health.

Sir Chris Wormald: I was going to come on to that. Those numbers and that reduction is at the same time as admissions have gone up. Hospitals are admitting more. As I said, it is not as low as we want it to be, but it is coming down.

The test of this will, of course, be over the winter, but a lot of systems report to us that the dialogue between health and care is considerably better this year than it has ever been before, obviously, in a very challenged thing. The fact that we have a forum where people can talk about common problems has made a difference.

Your challenge is absolutely fair, but we now need to see that better dialogue and people working together turn into better outcomes, and, as I say, the winter will be the big test. Given how new this is, that stage of development is not surprising, and, as you know, it is quite variable in different places depending on what they were building on.

Q56 **Chris Green:** Ever so briefly—I appreciate time—on pharmacies and the challenges pharmacies are having up and down the country, it is a key part of what the Government want to use to deliver better services to people. There is also the relationship between ICBs and the hospice movement. The existing relationship between local health providers and hospices has been undermined in the short term in some places.

I have had conversations with hospices about having a new relationship, and cost pressures on ICBs being transferred into things that are not, narrowly, strictly within the national health service.

Can you comment briefly on pharmacies? Are you aware of concerns that the hospice movement has? If you are not, could you look into it?

Victoria Atkins: On the second, yes, I will look into it.

We want to use our pharmacists to their full potential. I think they are very good at hiding their light under a bushel, if I can put it that way. These are highly qualified professionals. They have spent many years training to be pharmacists. Their advice is sought from doctors when it comes to prescribing medicines. I would like to use them to the full extent of their licence.

That is why I was really pleased to launch Pharmacy First a few weeks ago whereby people will be able to walk into pharmacies and for the seven most common conditions—things like a sore throat and inner ear infection—they can go to the chemist, who will be able to prescribe what they need. Of course, if the chemist is worried, they can refer them to the GP for a full medical examination. It is those sorts of ideas that would not only realise the full potential of our pharmacists but also free up, importantly, up to 10 million GP appointments, which means that GPs are then able to look at more complex needs.

Chair: That concludes our evidence session. Thank you very much, Secretary of State and permanent secretary at the Department of Health and Social Care. It is very nice to see you. Have a nice Christmas, which will no doubt be peaked with work, such is the life you lead. Thank you very much for appearing before us.