HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Work of the Department 2023-24, HC 384

Monday 25 March 2024

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Mrs Paulette Hamilton; Rachael Maskell; James Morris.

Questions 61-113

Witnesses

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

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Rt Hon Victoria Atkins MP and Sir Chris Wormald KCB.

Q61 **Chair:** Good afternoon. It is Monday afternoon and this is the House of Commons Health and Social Care Committee live from the Thatcher Room in Portcullis House in Westminster. It is a special session today because we are looking at the work of the Department of Health and Social Care. That can only mean that we have the right hon. Victoria Atkins MP, the Secretary of State for Health and Social Care. It is nice to see you again, Victoria. We also have Sir Chris Wormald, the permanent secretary at said Department. It is lovely to see you both and thanks very much for making the time.

As you can see, we have a cross-party Committee of Members here, all wanting to ask an array of questions. As is tradition, I am going to kick off. Obviously, since we last saw you, we have had the spring Budget, and I was very pleased to see that health was very much at the heart of that. The Chancellor has committed the NHS to 1.9% average productivity growth from 2025-26 through to 2029-30, which obviously picks up on the productivity assumptions in the long term workforce plan. I think that the assumptions in there were between 1.5% and 2%, so 1.9% is almost at the top end of that. I just wanted to get your reactions to that. First, Secretary of State, is that realistic? I am guessing that you are going to say that it is, but, more importantly, how will your Department deliver it, working with NHS England and this massive system that, obviously, you sit at the top of?

Victoria Atkins: Thank you very much indeed, Mr Brine; it is a pleasure to be before the Committee again. First of all, can I just emphasise what a significant Budget this was for health? Not only were we able to protect real-terms spending, but, as you rightly identified, there was this enormous injection of not just money but, I think, of faith into the system as a whole. Last year, we celebrated the 75th anniversary of the NHS, and I think that we all recognise that it has to move with the times. In my speech to the Nuffield Trust, I talked about the NHS having an M&S moment, and, to me, tech, AI and life sciences are absolutely how we are going to achieve that.

If we look at the 10 years between 2010 and 2020—before the pandemic—the NHS was achieving roughly 1% in productivity gains. With the pandemic, for understandable reasons, that changed, and we have now tried to come out post pandemic to improve productivity, but we have not got to where we would all like to get to. When we look at this productivity plan, including the assessments for the future and the modelling, not only does the Treasury have confidence in those figures, but—importantly, of course—so too does the Office for Budget Responsibility, and indeed the chief executive of NHS England herself, Amanda, who has absolutely committed to the productivity gains, certainly in the final two years of the scorecard period.

How do we explain this in ways that are not filled with jargon? If we are able to roll out basic tech—or up-to-date technology—across our frontline workforce, we believe that will free up to 13 million hours of clinicians' time. If we are able to use some of the emerging technologies—when it comes to scanners and so on with AI—that is not just going to help clinicians in terms of time saved and accuracy of results but will, of course, bring huge benefits for patients. Therefore, we are absolutely committed about, and sure of, this productivity figure.

The next question you have quite rightly asked me is about how we are going to deliver this. Again, this cannot be business as usual. We have seen some great movements in this space already—for example, with the NHS app, the fact that three out of four adults now have that on their phone, and the fact that if you go to a hospital or a surgical hub such as Heatherwood Hospital in Surrey, you can see the future of having a paperless hospital and the impact that that has on improving care for patients.

But we also have to bring in external expertise to deal with some of these massive issues in relation to technology and AI, because this is a medical revolution—I have used that phrase before. It is not just in the UK—it is around the world—and of course we want to draw on the brightest and best brains that we have to help us deliver that. What that will mean is that we will be delivering logistical and procurement programmes as we go into the five-year scorecard period, but I want to ensure that we are really working with frontline staff at the very beginning, because we need them to help us understand what they need, as has happened with the federated data platform already.

Q62 **Chair:** Perhaps we can just pause there. On how the £3.4 billion breaks down, the biggest chunk of it is updating fragmented and outdated NHS IT systems—you talked about the use of artificial intelligence, for instance, in mammography. There is ending the paper records by March '26, which I know we are a bit behind on, but we have obviously had a major event in the health world and in the country. The biggest chunk of it seems to be that. Can patients be reassured that when we talk about updating fragmented IT systems—you talk about procurement—this will not be lost in outsourcing to consultants and to clever people who would borrow your watch to tell you the time? We want it front end for patients, and that is what patients would say if they were sitting where I am right now.

Victoria Atkins: Absolutely. One of the advantages of, for example, AI—this is more in the AI space than in the basic technology pot—is that we know from the use of AI elsewhere in the world that it has enormous potential to free up clinicians' time. Something like a quarter of an appointment with a patient can be spent looking at a computer screen. Imagine how it would improve patient care if, instead of having to look at a computer screen, the clinician was able to work one to one with the patient and then voice-activated AI drew up the notes for them to check at the end of the consultation.

It goes without saying that all of this has to be done with a relationship of trust with patients. In our enthusiasm—in my natural enthusiasm for this—I am absolutely clear that we have to bring patients with us. It has to be done with trust and with patients' informed consent—that is absolutely right—but we also must seize some of the opportunities that we see coming towards us very quickly with the development of tech over the coming years.

Q63 **Chair:** We published a big piece of work shortly after I took over as Chair on the digital transformation of the NHS. One of the things that was raised with us—we mentioned it in that report—and that has been raised with us in the pharmacy inquiry that we are doing at the moment is the interoperability between the tech in secondary care and in primary care, in which I include pharmacy. We have heard really good reports about Pharmacy First. There have been really positive reports in the pharmacy press about the launch of that and we will talk to Minister Leadsom about that specifically tomorrow. Does this tech revolution get into the weeds of that interoperability between the different sections of healthcare—so, secondary and primary?

Victoria Atkins: It will do, and what is more, it is already happening in parts of the NHS. I referred to Heatherwood Hospital, a surgical hub. They have a really good working relationship between primary and secondary care, so that the data is able to be shared—again, with everybody's trust and assurances about data confidentiality and security, and so on—so that when the patient comes in for their assessment at Heatherwood, they do not have to ask the same questions that perhaps their GP has already had to ask them, or the GP has the data already on file. So this relationship of trust has to work, but I would also like us to get to a place where that sort of data is being shared between different layers of care so that we get the best results for patients. I don't know whether the perm sec—

Q64 **Chair:** Permanent secretary, can I bring you in and give you an early touch of the ball, as it were? In his statement, the Chancellor said that parts of the NHS are woefully inefficient. As you pick up the point from the Secretary of State, could you touch on what you understand he meant by that?

Sir Chris Wormald: I think everyone knows that, including particularly the staff of the NHS. In some of the areas that the Secretary of State has already pointed out, as indeed you have, it is particularly around getting the basics right. What is different between this plan and the various IT plans we have seen in the NHS before—I think it is fair to say that those had varying degrees of success—is that this is highly pragmatic and highly people-driven. I think you drew the right connection at the beginning: this flows directly out of the NHS workforce plan. It starts with the workforce and what makes life easier; it is not a tech project.

If you look at what NHS staff say gets in the way, it is interoperability, as you have already picked up. But it is also outdated equipment. In the morning, it takes a long time to log in. A lot of it is not the dramatic, cutting-edge stuff; it is about getting the basics right. I think that is what

will be different: the fact that that is where it starts, and that we have set out a very pragmatic and long-term approach. That is what will hopefully make it different from some of the previous projects.

Q65 **Chair:** Thank you for that. The Chancellor referred several times to an NHS productivity plan. I am presuming that a lot of work has been done on that, and that that work informed the assumptions he made in the speech, the stuff that he pushed to the OBR and what he brought through into the Red Book itself. What is the NHS productivity plan? How formed is it, and when will we and the public be able to see it?

Sir Chris Wormald: It is a thing developed by the NHS, on which the policies that the Chancellor set out were drawing. I am not quite sure about the plans for publication, but—

Q66 **Chair:** Do you think there is a plan for publication? There is no reason why it should be—

Sir Chris Wormald: What I was about to say is that the NHS is viewing this very much as a living thing that it works on with the sector. As I say, I do not know what the plans for publication are, but we ought to get away from the sort of model of reform that says, "Here is the published plan." This ought to be a much more iterative thing, with the NHS working with the sector, on a very pragmatic basis, on the things that are actually going to make a difference.

Q67 **Chair:** Colleagues may wish to follow up on that later; I am going to move on. Secretary of State, we touched on primary care. Pharmacy First has made quite a splash. I suspect that there is probably still a lot of publicity work to do, but anecdotally, as an MP and as Chair of this Committee, I hear lots of stories of people going to general practice and being pushed straight to the pharmacy. My wife did the other day, with my son. It seems to have had a good start.

One of the challenges with it is the shortage of medicines. If you spent any time in disguise in a pharmacy, the conversation that you would hear time and again is this: "I've come to redeem my prescription," and the pharmacist says, "We don't have that item; it's out of stock. There is a similar item I could prescribe you, but you have to go back to the GP to get the prescription reissued for that item." Obviously, pharmacists only have so many prescribing powers, and they can prescribe only certain items. We recently did a pharmacy roundtable as part of our pharmacy inquiry, and this came up again and again. You can see how people are being drawn to pharmacies first, but in many cases, when they are getting prescriptions, they are pushed back to general practice, which is defeating the object of getting them away from general practice. On your desk, how big of an issue are medicine shortages? I think a lot in the sector would want to hear that it is right at the top of your worry list.

Victoria Atkins: Just to put this into some context, there are around 14,000 medicines licensed for supply in the UK and, just to reassure people, the overwhelming majority of those are in good supply. Of course, we know that there have recently been some very high-profile examples.

A range of reasons—everything from manufacturing difficulties to the availability of raw materials, sudden spikes in demand or issues related to the distribution of the product—can affect the supply of medicines to our high street pharmacists.

The Department has a very established process for when that happens. They work first of all with the pharmaceutical companies concerned. There will be occasions where a medicine may not be as readily available in a particular dosage but it is agreed that other dosages can be administered in order to try to replicate the dosage that is missing. That doesn't work for every medicine, and we don't pretend it does. There may be alternatives as well. Again, where that is appropriate, as you have said, that can be prescribed. There is always a lot of background work going on to try to free up the supplies, either from elsewhere in the country or, indeed, elsewhere in the world. I say that as somebody who is very conscious of the difficulties that this causes for people living with these conditions, particularly where the medicine required is highly specialised and does not have the same competition of supply as paracetamol, for example. We understand that, but there are, as I say, very established processes for the Department to try to get to the bottom of this.

You may have been asking in your question whether we want to expand services to pharmacists to cover those alternative medicines. I am very happy to hear thoughts and evidence on that, but we have not made a decision on it. I think we are all clear that we want to be able to help people.

Q68 **Chair:** It is the case, isn't it, that there are serious shortage protocols in place, which Parliament has to agree? Our understanding is that there are more of those coming forward to allow more of those replacements to be made by pharmacists in store. Is that your understanding?

Victoria Atkins: We keep these protocols under close analysis. I have not received that advice, but I—

Sir Chris Wormald: It is all a question of balance. It links very firmly to the first discussion we were having. Everyone working at the top of their licence, including pharmacists, is one of the absolute key drivers of productivity. In terms of pharmacists doing replacement prescription, which, as you say, we do allow in some circumstances, it is a very carefully balanced clinical judgment. While you want the convenience of being able to do that, for all the reasons that you say, it of course has to be safe. There are circumstances, of course, where you have to know the whole history of the patient in the way that a GP does to be able to conclude that medicine B will be as effective as medicine A.

Q69 **Chair:** To go back to our first conversation, the ability to fully see and interact with that record can be achieved through interoperability and technology.

Sir Chris Wormald: It can, but it also goes with the skillsets of the people concerned. We cannot give you a generic answer; it has to be a clinical decision, case by case, to allow that.

Q70 **Chair:** You will appreciate, though, that if the pharmacy sector were sitting here, they would say, "Well, we are the medicine experts." Actually, in many ways, they are more expert than the general practitioners on the medicines.

Sir Chris Wormald: Yes, but they are not more expert on the patient. Of course, when you are taking these judgments, you need to be able to do both of those things. You are absolutely right that we have traditionally underused the skills of pharmacists, and we want pharmacists to be able to do more—that is the whole point of Pharmacy First—but we of course have to balance that with safety considerations. As I say, we can't really give you a pat answer to, "Are there more or are there less?" It is about asking, "What's the right thing that balances those safety aspects with the kind of service that you are describing?"

Q71 **Chair:** The Secretary of State answered on this. Okay, it's about replacement, if there's a replacement available and we are happy that it is safe to allow that to happen, but it's really about addressing the shortage at source, isn't it? If the shortage at source wasn't happening, the written prescription would be honoured in the first place, wouldn't it?

Sir Chris Wormald: Exactly, and we have seen a rise in shortages—not a huge one compared to the 14,000 drugs that, as the Secretary of State said, are licensed for use. Some of the shortages are for geopolitical reasons; this is a world market that is affected by all the world affairs that we have seen. Some are for very good reason. For instance, we are seeing more and more specialist drugs to treat conditions that we could never treat before, which is a wonderful thing, but it normally means a very complex supply chain and a very small number of supplies. Therefore, when you get the kind of things that the Secretary of State was describing, there is no fallback, as it were. The nature of the market is changing in a very positive way, but it does give us greater supply problems.

I think it is right to say that a combination of the work that we did around Brexit and the work that we did around the pandemic means that we have a far closer grip of the supply chain than we have ever had before as a Department, and we have far more intervention powers than we ever have before both with the industry itself and in terms of the things we can do to get medicines into the country when there are shortages. Nevertheless, that does not make the whole problem go away, and exactly as you were suggesting in your question, you need to get to the root of the problem—ask whether it is a manufacturing problem, a supply problem, a distribution problem or a cost problem—and then deal with the matter accordingly.

Your first question was whether we take this seriously, and the answer is yes—very seriously indeed. We are successful at mitigating the vast majority of problems that arise. Indeed, no one ever finds out about most of the issues we are managing, because we have found a way to mitigate them. That does not help with the individual cases that you describe, but we take it incredibly seriously when these things do happen.

Chair: Right. We have already covered a plethora of subjects, but we are going to talk a bit about the MHRA now.

Q72 **James Morris:** Secretary of State, in your opening remarks you talked about a medical revolution that is happening across the world, with AI, the life sciences coming up with all kinds of new breakthroughs, and drugs. Is the MHRA fit to help us take advantage of this revolution?

Victoria Atkins: We know that there was a significant backlog arising out of the pandemic. I think they made considerable progress in restoring performance of clinical trials throughout last summer, and I welcome the fact that those backlogs have been eliminated.

I think the fact that we have looked at the international market and said, "Look, the MHRA is respected and we want to be able to help them approve medicines that have been approved by similarly respected regulators around the world, as quickly as possible" will be a very significant step forward.

Q73 **James Morris:** Lord O'Shaughnessy, in his review back in 2023, said that a "major contributing factor" to the underperformance of the MHRA had been a "loss of strategic capacity and capability". Do you still think that is an issue in terms of resourcing, particularly in relation to emerging technologies like AI? Has the MHRA got the expertise to be able to regulate a world where people are bringing forward lots of new applications in artificial intelligence?

Victoria Atkins: New tech, in fact—med tech? Absolutely. That is a really interesting question. I think that the MHRA itself acknowledges that it has got to identify new pathways with this. There is a programme of work going on in the Department at the moment to try to ensure that the MHRA is finding ways of having the capability to assess the emerging tech, but to do so in a way whereby we are content with its governance. I do not want innovations in med tech to be lost or in any way delayed because there is a regulatory issue, so I absolutely understand the Committee's interest in this.

Q74 **James Morris:** Do you think that we are a bit parochial in relation to regulation, in the sense that this is a global market? There are regulators in other jurisdictions, like in the US and the EU. Do you think that we could short-circuit things by learning from other countries? Don't we have a rather parochial approach in this country—that we feel as though we need to reinvent the wheel?

Victoria Atkins: In fairness, that was very much the thinking behind the spring Budget '23, whereby in the world of medicines we were saying, "If a comparable regulator of similar international esteem and respect has approved a medicine, we want to short-circuit what the MHRA must go through to enable that to happen here."

Q75 **James Morris:** Do you think that should apply to AI?

Victoria Atkins: You are demonstrating the complexity of this, if I may say so. There is a difference between that and devices such as the

FreeStyle Libre, which type 1 diabetics now use, and which have a huge benefit. I declare an interest: I am wearing one at the moment. That sort of technology will have and is already having a huge impact.

When we look at the use of AI, it may take many forms—including, as we have already talked about this morning, sitting on clinicians' computers and in scanners—so there will have to be a way of governing the regulation of all these different forms of tech. With the pathways that we are working on, we will get there, but this is very cutting-edge—it is cutting-edge around the world, in fairness—so we have got to find ways to bring the public with us and ensure that we maintain their trust.

Sir Chris Wormald: That was the thing I was going to add. I do not think that you will find a medical regulator in the world that thinks that it is on top of what will happen with AI. It is a very different concept of regulation. I will simplify this appallingly, but when you regulate a drug, you take a yes/no decision on whether it is safe. With AI, the whole point is that it evolves as you use it, so what is it that you are regulating—the underlying system or its use at each point? The point that you raised about the major regulators working together is absolutely vital, and the MHRA would say that if they were sitting here too.

Q76 **James Morris:** And they are doing that, are they?

Sir Chris Wormald: They are doing that. Of course, in a number of ways, as the Secretary of State said, they are one of the most respected regulators in the world, so I do not recognise the "parochial" bit. Everyone was coming to us about how you regulate vaccines, and the fact that we got our vaccine regulation quicker than everyone else is recognised across the world. There is a lot that we do not want to lose. I think that with the things you raise about the complications of, as it were, the new world that we are going into, if the MHRA were sitting here they would recognise exactly what you say because they are going to have to build their capabilities to deal with that sort of world.

Victoria Atkins: Indeed, I have just reminded myself that during the AI safety summit in October last year, the MHRA announced the AI airlock to reflect the ambition for the UK to play a leadership role in the future regulation of AI alongside the FDA in the US, so we very much see the potential.

Q77 **James Morris:** Sir Chris, can I ask you a slightly techy or nerdy question about the accounts? I was surprised to see that the Comptroller and Auditor General issued a statement or a disclaimer on the UKHSA and their accounts, as they were not prepared to sign them off.

Sir Chris Wormald: Yes, this was on one specific thing. We covered this a few weeks ago in detail with the Public Accounts Committee, so if you want a full description you can look at the very exciting transcript. It was a disclaimer related to one issue around a spreadsheet that managed the vaccine programme. No money went missing and nothing went wrong. In the time available, however, UKHSA could not reach the audit standard that the National Audit Office wanted to see, so it is a very specific thing

that did not involve either a failure of the vaccine programme or any public money going missing.

Clearly—if you look at the transcript, you will see this—UKHSA knows that it needs to improve across its financial systems. There was also a statement from the CAG that they had improved a lot of their underlying capabilities in this area, but they did not get there on that one thing.

James Morris: When you say capability, do you mean forecasting or just—

Sir Chris Wormald: It is the system that manages the deployment of vaccines. It was around the omicron period, when we were deploying, and there was essentially a communication breakdown where the change of system that the UKHSA had implemented was not registered with the National Audit Office at the right time. That was a mistake—absolutely clear—but as I say, it did not result in any public harm. The most important thing is that the vaccines got in the right arms at the right time. If UKHSA had a fault in this area, it was that it prioritised the health protection bit of its remit, rather than the public audit bit of its remit. That is the right way around, but clearly we want it to do both and that will be its challenge going forward.

Q78 **James Morris:** Thanks for that. Switching to another subject, in our session before Christmas, Secretary of State, I asked you about the Mental Health Act. Minister Caulfield, I think, produced a letter last week that talked about the fact that the Government had responded to the recommendations of the Joint Committee. I wondered whether there had been any progress on the non-legislative aspects of us improving the situation in acute psychiatric care, where people are detained under the Mental Health Act.

Victoria Atkins: Of course, this is something that we keep under very close review. On the practical aspects, would you indulge me by just setting them out, because there are so many aspects?

Q79 **James Morris:** To break it down, I think according to Minister Caulfield's letter, two reviews had been initiated on acute psychiatric settings, largely as a result of concerns that had emerged in relation to the treatment of people—high acuity mental health in acute settings. As you will know, there is a pretty poor record of data sharing in that area. We are talking about some of the most inadequate NHS estates for people with the most acute mental health problems. That is related to the Mental Health Act because Mental Health Act reform implied a larger investment in the capital estate. Do you think we are treating our most acute mental health patients well? What do we need to do to improve that?

Victoria Atkins: There are many aspects to that. For example, clearly, those who are required to live in in-patient facilities must have safe care, as well as respectful care and the right medical care. That applies whatever their age range. The needs of, for example, children and young people in an in-patient setting will be different from adult patients perhaps, or those who have to be kept in a secure environment.

Through the way that we are looking after people in in-patient care, we are trying to ensure that, first of all, some of those high-profile concerns and complaints that have featured in the press are themselves being scrutinised. We have the HSSIB investigation into in-patient facilities to ensure that those very serious allegations are being looked into. We are also looking at the relationship between community care and in-patient care.

The Committee will know that I asked the CQC recently to look into Nottinghamshire because of the horrific case that that area has seen. I also wanted to ensure that the wider community was receiving the attention and reassurance that it rightly deserves, and that people expect. I wanted also to look at the provision of the highest-security facility in Nottinghamshire—namely Rampton. When that CQC report is published, I think there will be some very important learnings for mental health systems across the country, particularly for that relationship between community care and the next step of in-patient care—when people need that help at a very intensive period in their lives.

Chair: From MHRA to NICE—Paul Bristow.

Q80 **Paul Bristow:** I will just ask a couple of other questions first, if I may. Sir Chris, in response to my colleague's questions earlier, you talked about the regulation of AI through the MHRA and how that might be a challenge. With drugs or pharmaceutical problems, you have got a yes or a no. With AI, you quite rightly identified that the challenges will be that it is iterative and that it relies a lot on user application.

That is very much like devices, which are obviously iterative—new devices come out all the time, and depend on the skill of clinicians and how they are implanted. What lessons can we learn from device regulation for the use of AI, and isn't it time we had a regulatory system that was geared towards devices rather than just pharmaceutical products?

Sir Chris Wormald: I think that were the MHRA here, they would say that that is exactly what they are working on, and they would point out the exact difficulties. In terms of the lessons, I think you put the most important one in your question: getting the right link between the piece of equipment and the human, as it were.

When we look at where medical devices have gone wrong—and there have been some very difficult examples—it has very frequently been about the quality of the clinician using the device, as opposed to whether the device itself is intrinsically safe or not. Again, that is one of the big differences with pharmaceutical products. Obviously I am simplifying, but that is the key difference, and that is what the MHRA is working on.

I think they would say that they are not there yet because that is an extremely difficult thing to do. Of course, historically we have regulated the humans in one place and the medicines in another, and we are really talking about how you bring those two things together. It is an

exceptionally difficult challenge. As I say, I think the MHRA would recognise that that is an area they need to get better at.

Q81 **Paul Bristow:** I guess my point is that it has been a challenge for a while. What we have is a reimbursement system with NICE or a regulatory system with the MHRA. I feel I must declare my interests here; I should have done that at the start, forgive me. I point Members to my entry in the Register of Members' Financial Interests.

I think critics would suggest that we have a reimbursement system and a regulatory system that favours a pharmaceutical model rather than a med tech model, and I think the advance of AI will prove that even more.

Sir Chris Wormald: I think there is some truth in that. The system was developed, exactly as you say, largely to deal with traditional pharmaceutical products; it needs to evolve as medicine evolves and as the technology evolves. That said, it is very important that we do not lose the huge benefits that we get from the system that we have. As I said, the MHRA is highly internationally respected, as is NICE. We therefore take the view that those systems need to evolve, as opposed to us needing something completely different. As I say, we have there two institutions that countries across the world do look to as examples of good practice.

I think your general point is right. The development of medical technology is hugely important, hugely valuable, an unadulterated good thing, but it creates quite a lot of challenges for our traditional ways of running these systems.

Paul Bristow: Forgive me: I went slightly down a rabbit hole there.

Sir Chris Wormald: Quite an interesting rabbit hole, if I may say so.

Q82 **Paul Bristow:** Secretary of State, let's just talk about NICE—let's stick with the MHRA and NICE. I think you have referred a couple of times in your comments to the international recognition procedure, which the MHRA have established to ensure that, as you say, we can take lessons from other jurisdictions internationally. That is good, because it will lead to quicker licensing of medicines and devices, but it will not have the desired impact if we do not have in place with NICE similar systems that look at reimbursement and evaluation there. What efforts are going to be put in place to ensure that NICE and the MHRA have complementary mechanisms?

Victoria Atkins: Well, of course, they have different roles, in that NICE have to make very considered and often very difficult decisions as to whether a medicine can present value for money for the taxpayer. This is an incredibly difficult—

Q83 **Paul Bristow:** But you would accept, if the MHRA says that this procedure, device or drug is absolutely safe, that there is no point in having that there if then NICE does not have a fast-track system to evaluate the cost-effectiveness. There is no point in having a fast-track system for licensing if it is going to take another two years to—

Victoria Atkins: Yes. With the way in which the two systems operate, I think that is a fair comment. But there will be occasions, and indeed we have had high-profile ones recently, where NICE have arrived at a conclusion on the basis of the discussions that they have had with the pharmaceutical company, which lead to very—it is a very, very difficult result, if it is a refusal on the grounds of cost-effectiveness, for those patients and families who could potentially benefit from it. I very much take your point about not duplicating effort, but we still have to give NICE that space to be able to conduct their role in terms of cost-effectiveness.

Q84 **Paul Bristow:** Can I encourage you to ask the two bodies to work together so that their regulatory procedures, and evaluation procedures on the part of NICE, are streamlined? We do not want NICE doing something over here and the MHRA doing something over there, because there is no point in doing it over there if it is not—you understand what I mean.

Victoria Atkins: I see that—thank you.

Q85 **Paul Bristow:** I want to move on to the major conditions strategy. Are we going to see it in May?

Victoria Atkins: I am very excited about this strategy. The Committee will understand that, sadly, purdah gets in the way of big announcements, but I am very much working towards post purdah and over the summer. I want to launch it; I'm very excited about it.

Q86 **Paul Bristow:** Every single person we talked to, when we discussed cancer, told us that we should have a cancer-specific strategy. Everyone working in the cancer arena—every clinician; every person in the cancer area—said that it was a mistake to include cancer within the major conditions strategy. Are they all wrong?

Victoria Atkins: Look, there are a range of views on this. The reason why the Government have gone for this strategic approach to the six major conditions is actually that we know now that one in four adults has at least two health conditions. We know, from some of the discussion we have seen in the press in recent days and weeks, the impact that those conditions can have on people's ability to take part in the workforce, but also, of course, the emotional toll that these very serious conditions can take on them and their loved ones.

When I listen to, for example, the chief medical officer, what he—and others—talk about is that as we are living longer, we are accumulating conditions that, sadly, come with older age. We want to expand the period of life when we are living in good health, and also recognise that if you are living with two or three major health conditions, the health system viewing your conditions individually is not necessarily in your best interests as a patient. The CMO puts it in a way that I could not hope to improve on. He says that we have got to treat the patient the person, rather than the sets of conditions with which they are living. That is the thinking.

Q87 **Paul Bristow:** Let me give an example. Kidney Research UK is excellently

placed in the wonderful city of Peterborough; it is a charity based in my city. When you appeared on Laura Kuenssberg recently and talked about prevention as part of the strategy, Kidney Research UK contacted me and pointed out that if there was early diagnosis and treatment of kidney disease you would be able to identify diabetes much more quickly and improve outcomes for people with heart disease. Is that the sort of thing that you are looking at with the strategy?

Victoria Atkins: With the strategy itself we are focusing on the six major conditions that we know have the greatest impact on the health of the nation as a whole: cancers, cardiovascular disease, chronic respiratory disease, dementia, mental ill health and musculoskeletal conditions. It should not in any way be interpreted that, if a condition does not fall within those six, somehow the Government's attention is not focused on them. We are just trying to have a strategic approach, as opposed to the siloed approach that can happen at the moment. We want to treat the patient.

I appreciate that there are a range of views on this. For example, I say to those who do so much work to raise awareness and help sufferers of cancer that all our work to continue driving forward progress with cancer services will of course continue. It absolutely will.

What we are trying to do is instil in our ways of thinking for the future that we cannot see those conditions in isolation. Prevention is a critical part of that. We know that if someone is living with obesity they may well also suffer from cardiovascular disease, mental ill health or a musculoskeletal condition, for example. I am just using those as examples; I am not for a moment saying that everyone who does live with obesity has those conditions. We are trying to break it down so that we have a strategic approach to the person, because prevention is how we are going to help with many of those issues.

Sir Chris Wormald: Common causes is the other point that the chief medical officer would make. For example, if we are trying to create a smokefree generation, that hits several of our major conditions. As the Secretary of State says, if you are cracking down on obesity, you are doing that. When it comes to what you actually do about these things, you are very frequently talking about the same causes.

That said, and this conversation has brought this out, you can argue this both ways. We work very closely with the cancer charities, and we completely respect their views, but there are arguments that go the other way—both in terms of cause and, as the Secretary of State says, in terms of treating the whole person, which argue for that broad approach.

Q88 **Paul Bristow:** It seems slightly strange that not a single person gave us that alternative view. Anyway, I fully accept the point you are making.

On a positive note, I completely support the increase in physician associates. I think they are a good way of ensuring that clinicians operate at the top of their licence. But we have heard some worrying calls and trends to say that PAs should not be involved in diagnosing particular

conditions or prescribing, even though nurse-led prescribing has existed for a long time. What are you doing to satisfy and address public concern about the role of physician associates, considering that they are going to form a significant element of the NHS's workforce in the future?

Victoria Atkins: Physician associates have worked in the NHS for more than two decades, and they already form an important part of clinical teams across the NHS. They look after thousands of patients every day, but they do so—and should do so—under the supervision of doctors. We have always been clear that the role of associates is to work with doctors, not replace them, and we expect healthcare organisations to have very robust governance processes in place to ensure that associates are working to the right level of oversight and supervision.

We have very much heard the concerns expressed, which is why we are bringing in regulations to ensure that physician associates are subject to the sort of governance and regulations we would expect. We are pleased that that legislation will be in place by the end of this year. It is really important.

Paul Bristow: Thank you.

Q89 **Chair:** To follow up on that, the House of Lords Secondary Legislation Scrutiny Committee said that those regulations would provide the GMC with powers to amend the regulation process on physician associates without oversight by Parliament. Is that your understanding, and are there any risks to that? That is what the SLSC has said.

Victoria Atkins: I am going to take that away, if I may, Chair. I have not been alerted to that.

Chair: That would be helpful. Let's bring in Paulette Hamilton.

Q90 **Mrs Hamilton:** Good afternoon, Secretary of State. I want to follow on from Paul's questioning relating to cancer services and waiting times. I am going to call out a few figures that were given to us. The faster diagnosis standard is 70.9%, down from 74.2% in December 2023, and the target is 75%. Another example is the 62-day referral to treatment standard, which is 62.3%, down from 65%, but the target is 85%. Following that, do you still believe that we will be able to focus on a cancer plan when it has been swallowed up in the major conditions strategy?

Victoria Atkins: Thank you for your question. I am going to try, if I may, to add a bit of context to what we are seeing with cancer diagnoses across the NHS at the moment.

What we know is that demand has risen significantly since the pandemic. To put that into context, that means that the NHS saw more than 3 million cancer patients from February 2023 to January '24, which is an increase of 26%, or 612,000 people, from the same period pre-pandemic. That increase has of course had an impact on services.

None the less, please don't take me as being in any way complacent, but I want to add some reassurance because I know that there will be people listening who may already be living with a diagnosis or awaiting a diagnosis, which is an incredibly worrying time for them and their loved ones. We know that nearly six in 10 people are diagnosed at stages 1 and 2. That is really good news, because we know that the earlier we can catch it, the recovery outcomes are better both in terms of survival rates and quality of life afterwards. So that is a step forward. Of course, we want to improve that even further.

We also know that nearly nine out of 10 patients are treated within 31 days of a decision to treat. Again, it is a very worrying time once they have had that decision to treat, but nearly nine out of 10 patients are getting that treatment within a month or just over. That means that one-year and five-year survival rates have increased for most cancers. For example, with early breast cancer diagnoses, I think women are 66% less likely to die from the disease within the first five years than they were two decades ago.

Of course, there is more to do, and you have rightly identified those targets. I want those targets to remain because I want ambition in the service. I want people to be striving to meet and exceed those targets. We are going to achieve that through a number of ways—for example, the roll-out of community diagnostic centres. Some 156 CDCs have been set up across England. That helps with testing, scans and diagnoses—not just in relation to cancer, but obviously that is a major part of it.

The most recent figures I have show that there have been some 7 million tests, scans and so on in the last year. That is really significant. We also know that we need to ensure we have the workforce in place to support and treat patients, so we have seen more doctors working in clinical oncology and more radiology doctors, and that will lead to better outcomes for patients.

To return to your question about the strategy, all this focus has happened even before I have published the major conditions strategy. I absolutely understand why cancer is such a focus for all of us, both as constituency MPs and, frankly, as human beings—mums, dads, brothers and sisters.

Q91 **Mrs Hamilton:** I absolutely get what you are saying, but you have literally made the argument for why I believe that the cancer strategy should be set aside: it is because of the large increase in numbers. Things are being buried within this long-term conditions strategy—I always get the name of it wrong. I think you have articulated your point very well, but would you ever consider making an exception for some conditions because of the large increase in numbers?

Victoria Atkins: Well, look—we have not published it yet. Invite me back when we have published it and see what you think. As I say, it is a finely balanced judgment. Our motivation is not that there is some philosophical disagreement with having a separate cancer plan; it is that we are genuinely trying to have a strategic, people-centred approach. I know the

Committee will invite me back when the strategy is published, and you have quite rightly set me the challenge of ensuring that there is the focus within the strategy that you and others would like to see. I hear that loud and clear, and feel it myself.

Q92 **Mrs Hamilton:** Right. My last question is: do you see any risks in the phased roll-out of the federated platform, and what work has been done to ensure that pharmacy and dentistry are included in it? You have talked quite a bit to the Chair about hospitals and other areas, but I am on a little kick at the moment: what about these other areas that have been left out and have not really been mentioned at all in the £3.4 billion for IT that has been talked about?

Victoria Atkins: That is a really interesting question. To take a step back, the federated data platform is a system that has been designed by clinicians for clinicians, and when I went to Chelsea and Westminster to see how it works for myself, one feature that most struck me was the enthusiasm of clinicians using the platform. It has huge benefits in terms of freeing up theatre time. It has helped them move—as one of them described it to me—from endless Excel spreadsheets to having the information in one place, where they can swap people in and out quickly. If, for example, somebody cannot come in at short notice because they have a stomach bug or something, clinicians can move people around. We need to be nimble and able to use our valuable theatre time as best we can.

We are doing this as an iterative process because we appreciate it is a big change for the trusts involved. More than 40 trusts are in the process of transitioning from one of the pilot programmes to the platform. We have also very much heard the concerns about patient consent and patient trust, so we have sitting alongside the FDP a separate data confidentiality programme so that we maintain that trust, because it is critical that we bring patients and, by definition, their clinicians with us.

In terms of how we roll this or similar systems out across the piece, I think that is a very fair challenge. My ambition would be to get to a stage where this data is shared between primary care—however that is defined—and secondary care. Again, though, that has to be done safely, and it has to be done with the consent of both clinicians and patients.

Q93 **Mrs Hamilton:** We do not have much time, so just to round off: none of the money that has been identified at the moment has really been identified for the pharmacy service or dentistry service, to update them or include them in any of the IT systems that are coming on board.

Victoria Atkins: We are not looking at those two types of service at the moment because, as we have already discussed—although we have not touched on dentistry so much—the relationship between a general practitioner and one of their patients who is going in for surgery, say, is different from that of a very qualified and experienced pharmacist and somebody popping in off the high street for one of the seven basic conditions.

We are not necessarily there at the moment, but that is because of how the services are provided by the separate primary care systems. In the future, let's take it a step at a time. I am really keen on seeing what we can do to encourage GPs to become part of this. I think we have to do it step by step, but it is an interesting challenge.

Sir Chris Wormald: Just to draw the distinction, you are asking about the federated data platform; the wider £3.2 billion productivity plan is for the whole NHS. The federated data platform is for acute only at the moment.

Mrs Hamilton: That's all I wanted to know. That has answered my question.

Sir Chris Wormald: I think it is worth pointing out, as we touched on earlier, that—I'm wondering how to put this—big bang solutions in IT for the entire NHS at once have gone quite badly, as I am sure we all remember.

Chair: Understatement of the afternoon.

Sir Chris Wormald: As I said, I will think carefully about how I put it. We are very keen that we do this step by step and do it right, both from the technical point of view and because of the very important patient privacy and confidentiality issues that the Secretary of State remarked on.

Q94 **Mrs Hamilton:** Those sectors feel as if they are left behind; more people will talk about that this afternoon. My only request to you would be to please ensure that they are highlighted in whatever you have planned going forward, if you are staging it. Just mention them, because they are being left behind.

Sir Chris Wormald: I think that that is a very important message. There are very good reasons for doing this carefully in a staged way, but I think your message is exactly right, if I might say so.

Mrs Hamilton: Thank you.

Q95 **Rachael Maskell:** Sadly, cancer has been back in the news over the weekend. I want to focus on breast cancer. First, on 5 March, you made a statement on the 1,487 women who had not been called for their MRI scans. Could you update the Committee on what has happened since?

Victoria Atkins: Yes. Thank you very much for raising that, because I imagine that we will all have been contacted by constituents about this. We are being very careful to ensure that the extent of this issue is fully understood, so that we are not worrying women who have no reason to be concerned because they are not part of this group.

To recap, there is a historic issue that women who received radiotherapy above the waist to treat Hodgkin's lymphoma between 1962 and 2003 were not given annual check, as they should have been because they are at higher risk of breast cancer. The NHS has written to the 1,487 women who are affected to inform them, and we expect all women affected to be

offered a scan within the next three months. Local services are lined up to ensure that that happens.

What is more, NHS England has established a helpline for women who worry that they may be affected and has briefed GPs and relevant charities to provide advice, because they may be the first port of call for a lot of people—not by way of comfort, but to ensure that the women affected are working within the facts as we understand them and that we are not worrying people unnecessarily. I am told that the vast majority of women in this group will already have been receiving screening on a three-yearly basis, but we want to make sure that they have their annual screens in line with clinical guidance.

Alongside that, we have asked NHS England to carry out a national audit so that we can be reassured that people at high risk of cancer will be systematically referred to the right tests and treatment when we need them. Since I made the statement, the NHS has also written to another 110 women who received radiotherapy between 2003 and 2013 and who therefore need to be invited for an MRI scan. That is what we have done to try to help that group of women who, as we will all understand, will be very worried if they have received a communication from NHS England along these lines.

Q96 **Rachael Maskell:** Thank you for the update. Clearly the women affected will be very concerned, so I ask that those appointments be expedited if possible. Breast cancer charities have said that the administration has previously failed. We hear "This will never happen again" all the time, but how will you ensure that systems are put in place so that it never happens again?

Victoria Atkins: That is exactly the question that I asked NHS England. We have—I should say "NHS England has", because it is operationally independent—a specialist team that identifies women at high risk and ensures that they are properly referred. We have all understood the historic nature of this, and it is because of that audit.

Rachael Maskell: If I may broaden it out a little bit, it may be in this situation or other similar situations that the administrative procedures do not fail those individuals within recall.

Victoria Atkins: Yes, and this is where the national audit is significant. Again, this has happened on the particular facts described, but other people who may have received other types of treatment will be wondering about it. One can understand that they will want reassurance. That is where the national audit is critical.

I have made it clear to NHS England that if any such issue is identified in future, we have to first inform people as quickly as possible. We have to identify the group and contact them as quickly as possible, and I have to be able to update the House because of our collective responsibilities as constituency MPs. As I say, NHS England is conducting this audit to try to

ensure that there are no other groups of people who may be similarly affected.

Rachael Maskell: We want to avoid a situation where you have to make further announcements.

Victoria Atkins: Absolutely. If I may, I am being really careful. I hope I have been able to furnish the Committee with the facts that I have before me, but, as you understandably raise, I do not want to make statements or give categorical assurances and then have to come back a year hence, or whenever, to correct them. This is where the national audit is so important.

Q97 **Rachael Maskell:** If a woman has gone on to receive a diagnosis, will she be eligible for compensation?

Victoria Atkins: I have to confess that our focus has been on trying to reach the women and ensure that they are given those scans as quickly as possible. I want to make sure that those 1,487 women have the reassurances they need, and then we can look to the consequences.

Q98 **Rachael Maskell:** I want to broaden this out slightly to breast screening programmes. Fewer than two thirds of women attend breast screening sessions, but as we all know, the earlier you diagnose breast cancer, the more treatable it is. That is an incredibly low success rate. It doesn't even meet the Government target of 70%, and yet if it were raised to 80% we would see another 3,758 diagnoses. Could you set out for the Committee why the Government have such a low ambition for breast cancer diagnostics? How will they raise that? Will they consider raising it to at least 80% of women undergoing screening for breast cancer?

Victoria Atkins: I am not unambitious about this. As Health Secretary, I have prioritised women's health, and of course breast cancer forms part of that. That includes maternity services and the setting up of women's health hubs in every ICB area by the end of the year. I want to get the message out to women that if they get contacted, they should please undergo the screening. We know the very real benefits that early-stage diagnosis can have for women. Breast cancer remains, sadly, the most common cancer in England—some 47,000 people are diagnosed every year—but more women survive it than ever before.

I know not whether the Committee knows that when I launched the second year of the women's health strategy, I also announced funding for investigations research into lobular breast cancer. That form of breast cancer forms some 15% of breast cancer diagnoses, but it is incredibly difficult to identify at the moment. Frankly, there has not been the research into that form of breast cancer that there has been into other breast cancers—that is around the world, by the way. I want to bring that up to speed because the impact of that diagnosis, with the difficulties that women are having with the availability of diagnosis, has consequences on their wellbeing and health.

The more we can do to encourage women to get screened, the better. Women's health hubs will play a really important part in that. We want these centres of expertise so that a woman can go in, have conversations with a clinician about her health—whether it be about her periods or about changes she sees in her breasts—and get the expert help that we would all love to see for the women we care about in our lives.

Q99 **Rachael Maskell:** Thank you for that. I really do encourage more ambition, and I hope to see that when the major conditions strategy comes forward.

I want to turn to whistleblowers and NHS complaints. There is a very high level of NHS complaints. NHS Resolution says that the cost of harm in 2022-23 was £6.6 billion, which is quite an extortionate amount of the NHS budget, so we clearly have to see a reduction. There were 13,551 claims that year. What focus are you placing on reducing the number of claims coming forward? That can be misdiagnosis; we have seen over £1 million spent on that. In a short snippet—I am conscious of time, and I have one last follow-up question—what are you doing to reduce the number of claims?

Victoria Atkins: Patient safety has to be at the heart of everything that NHS England does. People want, expect and deserve the very best of care, whether it be in the primary sector or in the secondary sector, but with that has to come a non-defensive transparency within the system when mistakes happen. Over the last decade or so, I think we have seen some very significant examples of care being frankly not good enough. People have been hurt or worse as a result, and we have tried to drive up standards to ensure that those sorts of events never happen.

In the arena of patient safety, at my last count there were some 15 or 16 offices or cohorts of organisations that are responsible for patient safety. It is absolutely right that that is the golden thread that runs throughout NHS care. One of the ways in which we will help to ensure that good care is delivered is by supporting clinicians and other members of staff when they feel that something needs to be raised. That is why, for example, I welcome the development of freedom to speak up guardians, who are a very important part of the workforce, and the recent announcement of Martha's rule, enabling patients and families to have another opinion when they see their loved one deteriorate. That can be a very significant step forward.

Q100 **Rachael Maskell:** Thank you for that response. Sadly, the number of complaints goes up, not down. We are particularly concerned about whistleblowers having the freedom to raise issues. I certainly want to put this on your agenda, not least the comment from Robert Francis that the process is "limited in its effectiveness" and that there need to be legislative changes. We have heard from Rob Behrens about a "cover-up culture" in the health service, and the NHS staff survey says that 29% of staff do not feel safe raising concerns, and indeed that there is a risk of psychological harm. Clearly the system is not fit for purpose at the moment. How do you intend to ensure that it is robust and that staff are

protected if they raise concerns?

Victoria Atkins: From next month, it will be a contractual requirement for all providers of NHS-funded care to adopt the new patient safety instant response framework, which is a key part of the NHS patient safety strategy from 2019. It is believed that this represents a significant shift in the way the NHS responds to patient safety incidents. We also have the wonderful Henrietta Hughes as our patient safety champion, and the work that she has already done in the short time that she has been in the role shows the focus that we have on patient safety. I also point to Martha's rule, because I think that that is a very significant step forward for members of the public who have issues they want to raise.

This is about culture change. The NHS cares for us as patients, but it also needs to care for its members of staff, and that includes supporting them when they raise concerns about their workplaces and the impact that those have on patients. That culture change has to run through all this work, because we need clinicians not just to be maintaining their own high standards, but to be ensuring that their colleagues are doing so.

Chair: Finally, no session would be complete without talking dentistry, so we are going to talk about that with Paul Blomfield.

Q101 **Paul Blomfield:** Thanks very much, Chair. Secretary of State, you will know that we had a session last week with the dentistry Minister, and I would like to follow up on a few points from that. She told us that the promise in the dental recovery plan of 2.5 million new appointments had "a high likelihood of not being reliable". Do you think that you were being entirely straightforward with the British public when you led the announcement of the recovery plan with that commitment, and made it a minimum commitment?

Victoria Atkins: Yes. I don't know, Mr Blomfield, whether you have had the chance to see it, but Minister Leadsom wrote to the Committee today setting out the background and the methodology underpinning the modelling of the impact of our plan to recover and reform NHS dentistry. Indeed, I am looking at page 2 of the letter. The modelling of the appointments in fact comes to 2.760 million appointments. In other words, we under-promised because, according to the modelling, it was in fact 2.7 million appointments. Have you had sight of that?

Q102 **Chair:** I think it is worth saying for the record that at the time of this meeting starting, and as of my inbox at this moment, we have not received that.

Victoria Atkins: Mr Brine, I apologise for that. As I say, I am happy to share my letter with you if you would like to see it, because we took it very seriously—that question you posed to Minister Leadsom. As I say, the modelling in fact shows a higher figure than the figure I quoted.

Q103 **Paul Blomfield:** That is helpful. In the discussion we had last week, you will know that Minister Leadsom said, "Well, it's modelling, and you know how unreliable modelling is. It could be higher; it could be lower." But the

statement you put out in launching the plan said it will create more than 2.5 million appointments, and that is what you are sticking by now.

Victoria Atkins: Yes. I have here the letter before the Committee, and it sets out the modelling. It very helpfully delineates the different measures and the impact that it is believed to have on, for example, the new patient premium, which switched on, as you know, on 1 March. It sets out the modelling for the golden hellos, the minimum UDA value of £28 and dental vans.

Q104 **Paul Blomfield:** Well, we look forward to dissecting that in detail. On the patient premium payments that you just mentioned, I think I am right in saying that they come out of practices' existing contract values.

Victoria Atkins: These are premiums that are paid to practices for taking on new patients. The whole idea is they will have an existing contract, but if they take on new patients, we want to encourage that. We want more dentists to do NHS work. If they have an existing NHS contract and are not using it to its full extent, we will pay them to have new patients.

Q105 **Paul Blomfield:** I understand it is paying them to have new patients, but I am trying to clarify whether it comes out of the existing contract value, because I understand that it does. Or is it additional money over and above the existing contract?

Victoria Atkins: The funding available for the plan is £200 million.

Q106 **Paul Blomfield:** No, I am going to come to that. Very specifically on the patient premium payment, does it come out of the existing contract value or is it an additional payment to those dentists for those new patients?

Victoria Atkins: Forgive me: the two figures are not separate. Of the at least £3 billion we spend on dentistry—

Paul Blomfield: No, I am going to come to—

Victoria Atkins: No, no, no, Mr Blomfield: I am not accepting the premise of your question. Of the £3 billion that we spend on community dentistry, we have £200 million that we have been able to use to fund the dentistry recovery plan. Within that, new patient premiums are a major part. When you see the letter, you will see that it is responsible for up to 1.9 million appointments. We see that as a really good way of switching on services.

Paul Blomfield: With respect, Secretary of State, you are putting two issues together.

Victoria Atkins: No, I am just not accepting the premise of your question. I am allowed to do that.

Q107 **Paul Blomfield:** Very specifically, the question I was asking was: does the patient premium payment come out of practices' existing contract value?

Victoria Atkins: We have a contract with dentists to perform their contracts. We know there is an underspend within the £3 billion, and that is the £200 million—

Q108 **Paul Blomfield:** I am talking about individual practices. When dentists get that patient premium payment, does it come out of their individual existing contract value? The concern is that if it does, which is our understanding, it will mean that although they are being paid to take on new patients, there will be fewer courses of treatment for existing patients, so it is an important question.

Victoria Atkins: I have not seen that analysis. I would be interested to know who produced that analysis. As I say, all I can go off is the modelling, which is that this is up to—in fact, higher than—2.5 million appointments.

Q109 **Paul Blomfield:** Can I then ask you that same question again? It only needs a yes or no answer. Does the patient premium payment come out of practices' existing contract value?

Victoria Atkins: Forgive me—the point of this is that, of the £3 billion contract, we have the £200 million that we are funding the plan through. We are asking dentists to use the full extent of their contract. That is where we want to go, so that when we have dentists providing services, they are not just using—I don't know—20% of their contract. Name a figure; they're going to the full extent. This is also, as I say, alongside the other measures that we are bringing in, including dental vans and so on, to try to reach those underserved areas.

Q110 **Paul Blomfield:** You are keen to talk about the £200 million. Let me ask you a specific question on that, then. When you introduced the plan, you assured the House that it was funded with "new" and "additional" funding. You said in the Commons, "There is £200 million on top of the £3 billion that we already spend on NHS dentistry in England." You were pressed on the issue, and you went on to say, "As I have said, this is additional money. I have prioritised dentistry across the board, but this is £200 million of additional money—in addition to the £3 billion". Last week, Minister Leadsom said that wasn't the case. She said, "It is all coming out of the £3 billion". Who was right?

Victoria Atkins: I have corrected *Hansard*, Mr Blomfield. I gave the answer in good faith, and I have corrected *Hansard* on this point. The point is that this plan is fully funded with £200 million of funding. It is very different—I am bound to make a political point from Labour's ideas, but we have secured the funding for this and we are trying to deal with the very real and immediate problems that we see across dentistry around the country. We are trying to get immediate-term measures alongside the longer-term work to reform the contract that I understand dentists and the public wish to see.

Q111 **Paul Blomfield:** Okay, so Minister Leadsom was right that it is not new money.

Victoria Atkins: As I said, I have corrected the record.

Chair: We do have the letter, but Members did not see it. Paul Blomfield certainly did not see it before he asked his questions; I do not want anyone thinking that he is not informed when he is asking his questions because quite the opposite is true.

Victoria Atkins: Not at all. No.

Q112 **Chair:** Members have not seen it yet from it coming in to the Clerks. I will conclude. We need to finish, but I know you will want to discuss this, Secretary of State: the Tobacco and Vapes Bill. You published it last week and it had its First Reading. It gets its Second Reading in the House on 16 April, the second day back after recess. It is a landmark piece of legislation—credit to the Prime Minister and yourself for bringing it forward.

Notably, it gives the Secretary of State powers to regulate the display, packaging, flavour and other aspects of vaping products, but the Bill itself does not make arrangements for that so the regulations will not come into force until they are made as secondary legislation. I just wondered whether you could update us and parliamentary colleagues on that because people are being asked to vote on Second Reading on something that they do not necessarily have the full information on. That is the first part of the question. The second is this: they will follow very quickly, I presume, because otherwise we are going to be taking powers that we are not using, and there is a matter of urgency to this.

Victoria Atkins: This is, I think, the largest public health intervention that we could make. It will help with the almost one hospital admission that is made every minute of every day in this country. It will help, we hope, prevent one in four of all cancer deaths. We know smoking causes that at the moment, so the long-term prospects for this intervention are significant for the health service and also for the individual.

There are two parts to the Bill. The first part is the smokefree generation where we ensure that nobody currently aged 15 or younger will be able to buy a cigarette legally in a shop. The reason is that we know the majority of smokers take up smoking before the age of 17, 18, 19, so we want to nip that and help them never gain the habit. We also understand the concerns of mums and dads up and down the country that there has been a tripling of vaping among teenage users in the last three years. On both elements of the Bill, this is not about affecting adult smokers who are already smoking. We want to support them to quit. We are not outlawing their ability to buy cigarettes. So, too, with reusable vapes, we want to support adults to quit smoking.

We are, however, getting rid of disposable vapes because we know that 69% of teenage users of vapes use disposable vapes. They are cheaper, covered in attractive colours, and have wonderful flavours that apparently appeal to younger tastebuds. Because that is more complicated, we want to make sure that we get the regulations right. With the smokefree generation that is a matter for primary legislation. We are adopting the powers for the regulation in relation to vapes because we will have to go

to further consultation to highlight the flavours and colours and so on that we are looking at.

Q113 **Chair:** When we saw Professor Khan in February, it was in his mind's eye that all of these proposals came from the Khan review. A licensing scheme for the sale of tobacco and vaping products would be a national scheme run by local authorities. He said, "Decisions on licences are made at the local level, and any local concerns can be included within the licence—for example, not selling cigarettes"—or vapes—"too close to a school, to reduce the appeal…Local authorities can do that if there is a licensing scheme." Is that something the Government might consider introducing at later stages in the Bill? Or is the licensing scheme being ruled out at this stage?

Victoria Atkins: First of all, we are not trying to outlaw smoking for adults. We want to support them to quit. This is not about stopping people who can already smoke doing so. We have, however, looked at the impact of a licensing policy—or the proposal, I should say—in New Zealand. Often I am challenged on the fact that New Zealand had stepped away from its own commitment to a smokefree generation. We understand that one of the reasons for that was that New Zealand was looking to license retailers to sell cigarettes. The figures I have been provided with were going from something like 6,000 vendors to around 600. We do not want to go down that route. We want to ensure that responsible retailers sell these products within the law, as they have to today, let alone in two or three years' time, so we do not have plans for that at the moment.

Chair: Okay. That is a perfectly clear answer. That concludes the session. We have covered 17 subjects in 90 minutes—incredible, isn't it? There is so much to discuss. We could go on for another two hours, but that fun is held over till next time. Secretary of State and permanent secretary, thank you for your time. Have a pleasant Easter. We will see you next time.