HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Work of the Department, HC 387

Wednesday 18 December 2024

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Deirdre Costigan; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 1-77

Witnesses

I: Wes Streeting MP, Secretary of State for Health and Social Care, Tom Riordan, Second Permanent Secretary, Department of Health and Social Care, and Matthew Style, Director General, Secondary Care and Integration, Department of health and Social Care.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

House of Commons

Examination of witnesses

Witnesses: Wes Streeting MP, Tom Riordan and Matthew Style.

Q1 **Chair:** Welcome to this Christmas edition of the Health and Social Care Committee. We have our Secretary of State with us today. We have been keenly anticipating having him in front of us, so this is an early Christmas present for us all. Thank you, Secretary of State, for coming; it is much appreciated. With him is Tom Riordan, second permanent secretary at the Department of Health and Social Care. The permanent secretary has been promoted to head honcho of the civil service, and we wish him well in that role. We also have Matthew Style, director general, secondary care and integration, at the Department of Health and Social Care. Thank you to you both for appearing in front of us as well.

We will start with the money. The Department looked like it did very well out of the Budget, with £22 billion in day-to-day spending over two years. Secretary of State, how was that figure arrived at?

Wes Streeting: We went through the spending review and Budget process with the Chancellor. We made clear what the pressures are in the system. We obviously came into Government with a manifesto that we were determined to deliver and hit the ground running with. The Chancellor and the chief secretary took our pressures and ambitions into account alongside the rest of Government. I think it is fair to say that across the Cabinet we have walked into Government with a series of unprecedented pressures and a whole series of choices and trade-offs. I might think my job is difficult, thinking about the year ahead and how we manage priorities, choices and trade-offs in my Department, but I am glad I am not the Chancellor and the chief secretary having to do that right across Government.

This Government prioritise the NHS and social care. They are going through what is objectively the worst crisis in their history. We know that we are not going to be able to turn all of that around in a single Budget, but it is important that we make real progress. I welcome the fact that against the backdrop of plugging an enormous black hole, which was a very real black hole, and making sure that we are fixing the foundations, the Chancellor has put us in a position where we can start to put the NHS and the social care sector on the road to improvement after years of

mismanaged decline.

Q2 **Chair:** On the ambition to improve it, we are all of one voice. It sounds like a lot of money—the £22 billion—but when will patients and families start to actually feel the difference?

Wes Streeting: I know that by the end of this Parliament we need to be able to see demonstrable improvement in the NHS. The Prime Minister has particularly emphasised through our plan for change the 18-week target from referral to treatment. We want to achieve that by the end of this Parliament. We will only be able to do that if we see overall system improvement. I want people to feel that it is easier to get access to a GP. I want them to feel more confident that if they dial 999 an ambulance will reach them in time. I want them to see real improvement in waiting lists and waiting times. We know that turning around 14 years of mismanaged decline and the crisis we are in is going to take time, but it is not unreasonable for the public to want to see and feel real improvement over the course of this Parliament.

Q3 **Chair:** Over the course of this Parliament, not this year? This is a medium-term ambition, not a short-term ambition.

Wes Streeting: Waiting lists are coming down, and there are other things. If I think about this winter, which I am sure we will come on to, there are already demonstrable improvements. The fact that we are going into winter without the backdrop of national strikes for the first time in three years is a real improvement for people. They can now plan for winter instead of planning for strikes. We have hit the ground running.

Q4 **Chair:** So you are expecting the numbers for winter pressures to be better this year than in previous years?

Wes Streeting: That depends on the wider contextual factors. For example, we are already seeing pressures this winter at this moment that we do not normally see until the winter peak—as far as I'm concerned, that is next month, not this month. It is challenging, but there are things that we have done as a Government in the last five months that make us as well prepared as we can be. I will be out on the frontline in the coming days and weeks both to make sure that we are responding as best we can this winter, with the hand we have been dealt, and to start to learn this winter in order to prepare better for next winter, so that over the course of this Parliament people see a steady, substantial improvement in the performance of the NHS.

Q5 **Chair:** The £22 billion also needs to pay for pensions, inflation and provider costs—you will be unsurprised that we will come to NICs later. I just want a breakdown. Where does the money lie in years 1 and 2, and what percentage increase does each one of those mean for the NHS and the UK as a whole?

Wes Streeting: It is a very live issue at the moment. I am currently deciding allocations for different parts of the NHS and social care, taking into account the range of pressures that we are under and the determination to deliver against our manifesto commitment.

Q6 **Chair:** What is the timeline for that? I ask because I have been contacted by a number of providers, such as charities that provide mental health adult social care workers. They tell me that, if they do not get this information quite soon, they are basically going to have to shut up shop. They are such small providers that do quite specialist things, and there is no one else to do it. When can the sector expect to know when it is going to get this money and how much it is?

Wes Streeting: Over the course of the coming days and weeks, we will be setting out those allocations.

Q7 **Chair:** Will it be before February?

Wes Streeting: Yes, I think we have to do so very early in the new year. I recognise what you are saying, which is that people are making decisions for the next financial year. I would just point out that, notwithstanding the wider pressures on the public finances and the economy, we are in a much better position than we would have been, had the Chancellor not done the heavy lifting. I understand that people want to know where they are on things like employer national insurance contributions, but we would not have £26 billion to invest in my Department without the heavy lifting that the Chancellor did in the Budget. That is why I welcome the investment. You are right to say that one Budget is not going to be a panacea for all the problems that we have inherited, but thanks to the heavy lifting that the Chancellor has done, we are in a stronger position than we would otherwise have been.

Q8 **Chair:** I understand that you cannot give us exact figures, but are we expecting there to be increases after spend in both year 1 and year 2?

Wes Streeting: We are in a much better position with the £26 billion of investment for the coming year. The spending review is now under way, and the Chief Secretary has just written to the Cabinet to get that process going. We will obviously go into that spending review making a strong case for both investment and reform in health and social care.

However, this is the broader strategic challenge that we have, which I wanted to surface with the Committee as well. If I think about what we have just been through with the Budget process, and what we will go through in the spending review process too, I am conscious that the NHS has been the stand-out winner in that process. Therefore, every penny that has gone into my Department is an opportunity cost either for another Department or for money that could have gone back into people's pockets. For me, this comes to the heart of the longer-term sustainability challenge for the NHS. Unless we start to bend the curve of cost and demand, we are going to end up with an NHS that looks financially unsustainable.

We already know there is enormous public anxiety about an NHS that is free at the point of use, with seven in 10 expecting to pay charges for their healthcare over the course of the next decade. That is not the future that I want to see. I believe very strongly in an NHS that is free at the point of use. I think that is the fair and equitable principle that has existed

for 76 years, and I see no reason why things in this country should be worse in the 21st century than the 20th. That is why, alongside the investment that we have secured from the Chancellor, we have to deliver the reform that is needed to put the NHS on a more sustainable footing.

Q9 **Chair:** Reform is going to cost, isn't it? We are going to come to that point and the specifics of it later, but we are trying to get a sense of your approach to this, Secretary of State. How much will be going into the day-to-day running and how much will be going into the reform part? These are the thesis questions that we really want to get under the skin of. Before that, however, I do not want us to move on before we talk a bit about capital.

Q10 **Danny Beales:** Hello Secretary of State. On that point about enabling transformation, we heard compellingly from Darzi, regarding his review, about how far the NHS has slipped behind European averages for capital investment, and how the secondary and primary care infrastructure is holding back efficiency gains. There is £22 billion, plus some, for revenue spending and an additional £3 billion for capital. Is that the right balance to enable long-term sustainable reform?

Wes Streeting: Again, we have done well on capital out of this Budget. We were never going to be able to deal with 14 years of under-capitalisation and the stark picture painted by Lord Darzi in a single Budget. But what this enables us to do is to invest in the estate and also prioritise some of the investment, particularly in technology, that will deliver the productivity improvements that we need to see to put the NHS on a more financially sustainable footing. That is the approach we pitched to the Treasury as part of the Budget and spending review process, and that is how we will be determining capital allocations.

There are, of course, choices and trade-offs. I would be surprised if you did not surface your own challenge in relation to Hillingdon hospital, which I think you have done in every single conversation that we have had since you were elected to Parliament—and every single conversation we had when you were a parliamentary candidate, which was many; that is exactly what you should do.

The trade-off on the new hospital programme is a really good example of where, when we came into Government, we had a timetable that was a work of fiction and a budget that was due to run out in March. Public expectations were up here and the plan to deliver was down there. I have to balance capital investment in hospitals alongside the wider range of other capital pressures.

That is why, early in the new year, we will come back to you personally, to other MPs affected, including myself—I feel your pain—to Parliament and to the public with a clear and deliverable timetable and plan for investment that people can have confidence in. But these are all choices and trade-offs.

Tom Riordan: The change in the rule means that capital and revenue are separate, moving forward. Having run capital programmes myself over the

years, I think that will make a big positive difference to the capital planning that we can do.

Q11 **Danny Beales:** That is a welcome change that I was going to come to. The second shift, which I hope you will also agree with, is that what we have seen traditionally is that, despite a lack of capital investment to meet need, capital was still being unspent—although some of it was raided because of revenue pressures. Can you assure us that the capital budget will be fully allocated and spent, and that we will not be in the position of previous years where that inadequate capital budget went unspent through delivery issues?

Wes Streeting: I will bring in Matt as well to reflect on performance and experience over time. On this point, Tom is absolutely right. The Chancellor's fiscal rule will sometimes be challenging. If I think back to the pressures and choices that some of my Conservative predecessors made, there have been points at which they relied on capital to revenue switches to plug gaps in day-to-day spending.

The problem with that is you are effectively raiding the fund for tomorrow to pay for today's pressures. By the way, we have had to do some of that in the early months. We are determined, thanks to the fiscal rule, not to do that, because it becomes self-defeating. That is how you end up with the situation that we inherited, which is an NHS that pays an extremely high price for failure, because you have not invested in the underlying capital that delivers better performance and better productivity.

Ironically, given that we keep on raiding capital budgets to pay for day-to-day spending, that is how you can bring down some of the cost pressures that increase day-to-day spending. We will be in a much better position and, because of the way we are restoring some norms to the management of public finances, including multi-year spending review settlements, we can plan to invest over time in a well-managed and structured way. Matt, do you want to come in on that point?

Matthew Style: The most important point is the one you just made, Secretary of State, and it is relevant both to the Chair's questions about the deployment of revenue resource and the reform agenda and to the capital agenda. Getting back to multi-year planning, with stability and certainty for frontline leaders taking allocative decisions, is critical to what we are trying to achieve. As soon as the fiscal cycle and the spending review cycle allow, we are committed to doing that.

To your specific point on capital, of course we are committed to continuing to improve our performance on forecast accuracy and eliminating any underspends. There are challenges on that in terms of pressures on the capacity of the construction sector across the whole economy, for example, which are not unique to the NHS, and the particular challenges of trying to undertake capital programmes on frontline sites that are under particular operational pressures. That is a challenge for both physical construction and some of the digital transformation, but our job is to work

through those and, exactly as you say, ensure we make the best possible use of every pound.

Wes Streeting: That brings us to the final point on our new hospitals programme. As well as the palpable frustrations our communities have experienced, seeing projects delayed and delayed, with promises made and promises broken, there has been a real knock of confidence in the construction industry and supply chain. One thing I have had to spend time doing in my early months as Secretary of State is reassuring the industry that we are committed to the programme and that, when they see the details of the programme, the funding, the timetable and the phasing, we will stick to that. Frankly, there are a lot of pressures on their industry at the moment and lots of opportunities elsewhere, and they need to see Government as a reliable partner. Part of the consequence of the chaos we have seen in our country in our recent years is that it has really knocked industry confidence. That is bad for the NHS and our partners, but it is also bad for growth. If we get the construction industry building these projects, that means more jobs and more investment in the supply chain, which is good for growth.

Q12 **Chair:** Can we come back to reform? I was trying to get at this point earlier: you call it double running, I hear, when looking at it in terms of the Budget. You will have to spend some stuff in the day to day in order also to spend stuff that will invest into the future. I am trying to get a sense of what this £22 billion—that is a big number to an ordinary person—is actually going to be spent on in the first instance, to try to shift the dial. With the acute pressures that are still in the system, you can easily see that, after you have spent on pensions, inflation, provider costs and NICs, there will be almost nothing left, will there?

Wes Streeting: That is not very cheerful before Christmas! I will send your representations to the Chancellor ahead of the spending review, but I do not feel that pessimistic about the settlement we received, for a few reasons. First, some of the reform agenda is not high cost; it is about spending money we already have more effectively to deliver better outcomes.

Q13 **Chair:** Like what?

Wes Streeting: On elective recovery and the waiting list, for example, across the NHS we see teams using different ways of organising their clinics to deliver more productivity and more patient throughput within the resources we currently have in the NHS. That is the approach I want to see right across the NHS. As I have said before, if all I did as Secretary of State was to take the best of the NHS to the rest of the NHS, I would have done a hell of a lot of good. We have more pilots than the RAF, but what we actually need is to ensure that best practice is consistent practice. That is part of it.

Secondly, we must ensure we have better performance of the system. For example, in my speech to NHS Providers recently I announced a number of reforms, including more transparency around the performance, both

financial and actual, of the system so that we can start to reduce the gap between the best and the poorest performers. We are making sure we send turnaround teams to places that are struggling, which is part of what we are doing on elective reform specifically. We have launched a red tape challenge to cut through some of the red tape that is tying up GPs.

Q14 **Chair:** So you are going to be releasing inefficiencies from—

Wes Streeting: And some of that is low to no cost. And then the final thing—I appreciate we want to get into talking about future finances. I am determined, by the way, to start the process in the next financial year with the budget we have just been given. I am determined to start delivering now the shift out of hospital into community. That is a big part of our reform agenda—

Q15 **Chair:** We want to save those questions for later.

Wes Streeting: I will happily take more questioning on that. But the final thing I want to say is that, as well as thinking about how we spend the new money we are being given by the Chancellor, we spend a huge amount of money on our health and care services today. I am not convinced—neither are the frontline staff and patients—that all that money is being well spent. Going back to the point about choices and trade-offs, we have a responsibility—

Q16 **Chair:** Whose fault is it that it is not being well spent?

Wes Streeting: I think it is primarily the fault of our predecessors. One of the things about the Darzi investigation is that it spelt out very clearly the consequences, for example, of Andrew Lansley's disastrous top-down reorganisation. The churn of Secretaries of State in recent years has not helped.

Q17 **Chair:** Do you feel that you have a system now with the ICSs? Darzi's report, which you mentioned, speaks very clearly about this. If you are going to achieve this shift, you do need to start shifting into communities and allowing a little bit of that control from the centre to pass down to local communities. I want to get a sense of that culture that you talk about—the approach I want to see across the NHS. You as Secretary of State cannot decree culture. How are you going to actually shift people's mindsets in the NHS? It is not just about money.

Wes Streeting: That is a very good question. I would say a couple of things about that. First, I think culture is set from the top. One of the reasons I came in and on day one said, "The NHS is broken"—it is not beaten, but it is broken—was to acknowledge from the start a culture in which we can be honest about NHS failings. A political culture that is geared around sparing political blushes and the reputations of Governments is one that very quickly bleeds into backside-covering by senior leaders, who think that if they surface problems and challenges, or acknowledge problems within their organisations, they will find themselves in news headlines or getting a punishment beating from the Secretary of State via the telephone. It persists into a culture, right down to the frontline, where patient safety is not taken seriously, where whistleblowers

are silenced in the most extreme cases, and you end up in a situation where, on pretty much every single front, care in this country is not as good as that of our counterparts. So that is the first thing about culture.

The second thing I would say is—

Q18 **Chair:** That is a description of the culture. The question is: what levers do you have to change it?

Wes Streeting: But the point is, to go to the solution, that is why I wanted to establish a culture up front where we are honest about challenges within the system. If you are honest about the problems, you can start dealing with them. And that cascades right down to line manager-level conversations on the frontline. The second thing to say, as the person who sits at the top of this mountain of accountability surveying the landscape below, is that this is a far too centralised system. We need to provide more devolution of power closer to communities, closer to the frontline, and, crucially, closer to patients themselves, because that is how we will do the performance improvement that we need. It is a combination of accountability from above. It is a combination of setting senior leaders, who are paid significant sums of money, free to lead their organisations well.

Q19 **Chair:** Free how? What will they not have? If they are shackled in some way, what are you going to remove from them that empowers them?

Wes Streeting: What I want to see over the course of the 10-year plan implementation is earned autonomy for our best performers, where we are not looking over their shoulders so much and dictating—

Q20 **Chair:** What does that mean? Fewer targets for them?

Wes Streeting: I think we can let go of some of the control, yes.

I am up for a debate throughout the NHS about which targets are useful and which ones are not, because if you are measuring everything you are actually measuring nothing. So, I am up for that debate. There will be more freedom in terms of how to spend their budgets and how to allocate their capital, with financial flows and incentives that support those financial flows.

One of my ambitions around the GP red tape challenge, for example, is to lessen the burden of regulation on general practice. I think we can give more power away from the centre and set people free to lead their organisations well. You have to do that in a managed way. I would not feel confident letting go of control for poorly performing providers and poorly performing systems; that is where you need more performance management, not less. That is why it is different courses for different horses.

If I think back to new Labour's experience, when we were last in government and delivering the shortest waiting times and the highest patient satisfaction levels in history, and some of the things that have worked and indeed some of the things that have not worked since, that is

the central conclusion for me. It is more choice and more power for patients to create that demand within the system; it is more freedom and autonomy for the top performers; and it is more active performance managers of the poorest performers and the middle as well.

That is why, in my speech to NHS Providers, I was very clear about support for leaders, more freedom and autonomy for the best performers, and support through the new college of leadership to support good leadership and management in our health and care services.

However, I am also very clear about failure regimes as well, and holding senior managers to account to deliver, because that is the final thing I would say. I think that political decisions have made the job of NHS leaders and social care leaders really tough over the last 14 years. That does not mean that in all cases of poor performance and failure, they can just look upwards and blame politicians. We also have to hold leaders to account to deliver good-quality health and care services, and that is the approach we will take. XXX

Q21 **Jen Craft:** Good morning, Secretary of State. I am very interested to hear your thoughts on how releasing control to local areas chimes with making sure that services that are often overlooked and seen as low-hanging fruit when there are budgetary decisions marry up.

In particular, you will be aware that over the last week there has been some concern about the mental health investment standard, with 17 national charities writing to the Prime Minister to ask for it to be preserved. Do you have plans to make sure that the mental health investment standard stays in place?

Wes Streeting: That is where planning guidance is very important in the NHS, and we will publish the Government's mandate to the NHS shortly and the planning guidance in the new year.

I am committed to the mental health investment standard. I think it is really important. It is one of the better decisions that my predecessors made and I pay particular tribute to Simon Stevens, who, as effectively the head of the NHS, is the architect of the mental health investment standard.

This is only a gentle point in relation to stakeholders—in fact, I would say partners rather than stakeholders, because we expect people to lobby Government and fight their corner for things they particularly care about. In recent weeks, it has been a common experience for me that everyone, whatever part of the health and care sector they sit in, is going hell for leather in saying, "This is really important, we need this and we need this sorted now." We have only been in government for five months. We have not yet set the financial allocations for the year ahead. And on a number of fronts, I think that people have slightly jumped the gun and gone into battle mode straight away—

Q22 **Chair:** You are reassuring us, Secretary of State. You will know that yesterday we launched our community mental health services inquiry—

Wes Streeting: That is great; I am really pleased about that.

Q23 **Chair:** So the Committee has a particular interest in this issue. We have heard over and over again how the mental health investment standard has really helped. In fact, a panel we saw suggested that it would be something that you might want to consider best practice to spread to other parts of investment in the NHS.

Wes Streeting: To reassure people specifically on mental health, because I know there is lots of interest in it, bear in mind that in the first five months we have introduced the Mental Health Bill in Parliament, and not as a draft Bill or pre-legislative scrutiny; we have actually introduced the Bill. This will be the first time the Mental Health Act has been reformed since 1983; it is as old as me, believe it or not.

Our manifesto committed us to recruiting an extra 8,500 staff across children and adult mental health services to cut waiting times, and we will deliver that, and to rolling out mental health support in every school, which we will deliver. And the Budget delivered £26 million in capital investment to open new mental health crisis centres. That does not mean we have solved everything in the first five months, but it is not a bad start. I think it tells the public where we are in terms of the parity and priority that we attach to mental health. I just say to people: give us a bit of time. We have only been in government five months; we still have quite a road to go.

Q24 **Chair:** Understood. I am keen to maximise the time we have with you this morning, Secretary of State. I have one final question, which arises from the line of questioning so far, and it is about the approach to the plan. We are unsure what this plan looks like. Is it a visions and values document? Is it full of targets? Is it somewhere in between? When we finally see it, what will it look like?

Wes Streeting: This is definitely by way of reassurance: what you will not get from the 10-year plan is just a set of vision and values statements. We have done quite a lot of that, actually, and we have come into government with a clear sense of direction. We identified the three big shifts. Those three shifts—hospital to community, analogue to digital, sickness to prevention—are not new ideas. In fact, there is overwhelming consensus on them, but delivering them really would be radical. That is why what people should expect from the 10-year plan when it is published in May is, yes, a sense of where we want to be in 10 years' time—to an extent, the further you get towards the 10-year horizon, the more you are into predictions and ambitions territory—but also a clear plan of action and delivery over this term in Parliament. We came into government with a clear set of commitments that we will deliver that will make a real impact on people's lives.

Q25 **Chair:** So what will it look like? It is not visions and values, so is it a set of targets? How is it going to look?

Wes Streeting: We are consulting on that at the moment. It is a genuine consultation. I do not want to pre-empt a live consultation and disrespect

people who are giving up their time to input, but it will be about delivery, not simply about objectives and targets. It will be about the how, not just the what. So how do we shift from—

Chair: Outcomes, not just activities.

Wes Streeting: Yes, and, crucially, how do we shift from hospital to community, how do we shift from analogue to digital, how do we shift from sickness to prevention, and what are the priorities we are choosing as a Government to deliver those shifts?

Q26 **Chair:** What is your big bet? If you cannot do all three of those shifts—

Wes Streeting: Oh, we've got to make progress on all three shifts, otherwise we're stuffed.

Chair: You have got to make progress, but which is the one that is closest to your heart, if you had to pick one? I know it is like—

Wes Streeting: Choosing between children.

Chair: Like trying to pick between the children—I know.

Wes Streeting: Oh, you knew where I was going with that!

Chair: But I am going to press you. If something happens and you just have less money and you have to prioritise, which is the one?

Wes Streeting: I am torn on this one. I would say that if there is one thing that would make a demonstrable improvement in the patient experience, the level of personalised care and the extent to which we can run and lead this system more effectively and efficiently, it is around the shift from analogue to digital. When I talk about how we can use AI, machine learning, genomics and big data not only to intervene earlier, with earlier diagnosis and earlier treatment, but to predict and prevent illness, which is the game-changing paradigm shift in healthcare in this century, what I get from a lot of NHS staff is, "Look, that sounds brilliant—that sounds really visionary—but I'd just like it if the machine turned on reliably in the morning. I'd really like it if I didn't have to use seven passwords and log in to deal with the one patient sat behind me because I'm glued to my screen when I'm trying to do a consultation." We have got to get the basics right, we have got to deliver and be a world leader in that life sciences and med tech agenda, and that is where I think the health mission and the growth mission of this Government are perfectly aligned.

I will end with a typical politician's answer. Just because I prioritise that one thing—I genuinely think we will have really failed if we get to the end of this Parliament and we are not delivering meaningful, demonstrable shifts from hospital to community and from sickness to prevention. On hospital to community, this is urgent. If we do not fix the front door to the NHS, we will continue to see unmanageable levels of demand on our

hospitals, which will be worse for the patient but also more expensive for the taxpayer. *[Interruption.]* I appreciate that we will come back to that.

Finally—this always gets de-prioritised—on the sickness to prevention bit, the short-termism and sticking-plaster politics that characterise our political system is the thing that will do for the NHS in the longer term. Unless we reduce the burden of preventable illness and chronic disease, chronic disease—plus a growing, ageing society and rising cost pressures—threatens to overwhelm and bankrupt the NHS over the longer term. We are already seeing some of those morbid symptoms.

That is why I am really proud that, in our first months, we have introduced the Tobacco and Vapes Bill to Parliament, in a stronger form than before. We have already introduced legislation to ban the targeting of junk-food ads at our kids, and planning reforms will give more powers to local authorities on things like junk-food takeaways near schools. But we have more to do on the prevention piece.

We really need to build a national consensus on prevention. In the run-up to and since the general election, it has not been uncommon for Conservative colleagues to sidle up to me and say, "If anyone can reform the NHS, it is Labour, because we are not trusted—you guys have to do that". But I think some of the most powerful advocates for public health reform and intervention have actually been traditionally right-wing and libertarian voices. That is why, in the Second Reading debate, I gave credit to Rishi Sunak for the leadership that he showed on tobacco and vapes. I appreciate that that is not a conventional Conservative position: it took political leadership, and he went against the grain of lots of people in his party.

We really need to build a national consensus on this point if we are going to bend the curve of cost and demand, make our healthcare system more sustainable and alleviate the pressure on people's pockets. If you are a libertarian Tory, you are going to pay either higher taxes or higher charges for healthcare unless we do this.

Chair: We are one Committee and speak with one voice, regardless of party. On that national conversation point, I call Danny Beales.

Q27 **Danny Beales:** When launching the consultation, you said that the 10-year plan "will transform the NHS to make it fit for the future, and it will have patients' and staff's fingerprints all over it." With the consultation so far, are you confident that that commitment will be kept?

Wes Streeting: I really am. Since we launched change.nhs.uk back in October, we have had 1.2 million visits to the website. Over 100,000 people have registered, 70,000 have sent survey responses and over 10,000 have contributed ideas. Yes, some of the ideas involve firing me out of a cannon, or putting a Wetherspoons in every hospital—actually, I found that one quite attractive, but the Chancellor has vetoed it. But for all the Boaty McBoatface-type suggestions, we have actually seen more reach and engagement through the publicity generated.

Through the online engagement, the more than 700 members of the public joining our deliberative events, the 3,000 staff already taking part in online workshops, the 1,000 partner organisations involved in the online call for evidence and the more than 800 integrated care system leaders, I have seen two things that make this whole process worth every bit of the time and investment we have put into it. First, the patient voice in this process is so much louder than it is in most meetings on any given day of the week. Most people who come to see me have big system views, provider interests or producer interests. They knock on my door and, even with the best of intentions, patients can get overlooked. We have a strong patient voice coming through.

Secondly, we are finally nailing this myth that the challenge I will have as Secretary of State is trying to battle a load of people on the frontline who do not want to see reform of the NHS. Actually, it is the opposite. There are lots of producer interests. To be honest, there are lots of days when I go into work and feel like I am going into battle with something or someone, and I doubt that that will change over the next four years—that is fine; I quite enjoy that. But over and above everything else, the thing that I see from frontline staff is a real demand for change, and good, practical, deliverable ideas for change. We are taking those ideas really seriously as part of this process.

I am genuinely excited. I think that it has been a meaningful consultation, and a great use of the time that we have spent so far. We have more to do, particularly in terms of under-represented groups.

Q28 **Danny Beales:** Let me turn to that specifically, Secretary of State. For that statement to be true, the under-represented groups will have to be addressed in a meaningful way. We have heard from, for instance, the RCPCH a concern about under-representation of children and young people. The portal is only available if you are 16-plus. I do not know how many of the 600 or 700 in deliberative groups have been children and young people. Darzi highlighted specifically that children's care is a major concern. How have children and young people's voices been heard in the development of the plan?

Wes Streeting: That is a fair challenge, and in the spirit of transparency I will give you some other anxieties I have about participation, not least because it might help us to get the word out and drive up engagement. On children and young people, for very good safeguarding reasons, we have to tread carefully in how we engage with them, but in the new year we will be holding some engagement events specifically with children and young people. Lots of our partner organisations have very active children and young people's participation elements, and there are charities specifically focused on children and young people. Through partners, we will get engagement. We are directly engaging with children and young people, and that is very important to me and the things I care about.

Thinking a bit more broadly, I can draw out some of the disparities and inequalities that I want to nail in the rest of this consultation period. You mentioned under-16s. Going to the slightly older cohort of younger

people, 16 to 24-year-olds account for 3% of the responses we have had online but 11% of the population, and 25 to 34-year-olds are also lagging behind slightly in terms of proportion of the population. Asian respondents are 10% of the population but account for only 3% of the responses. Black African, Caribbean and black British groups account for less than 1% of the responses but 4% of the population.

Danny Beales: I think this has been outlined in a response to the Committee.

Wes Streeting: Fine. Finally, men—that classically under-represented group in our society, but men's health is a serious issue—accounted for only 34% of the responses. In all of those areas we will be going further with our partners, and we are thinking about how we do our social media outreach to try to drive up participation.

Q29 **Danny Beales:** I am conscious of time and that colleagues will want to get in. I think this is an important point. The Committee heard from a group of lesser-heard or seldom-heard voices—traditionally one would have said "hard to reach", but they were not hard to reach and they were incredibly engaged and passionate about contributing to their care. As I think they described it, they were banging at the door of the NHS to be heard. For this to be a meaningful process, how are we going to reach disabled people, people with disabled children, and disabled children and young people? The methods described so far do not seem to be adequate and do not seem to be reaching those groups. We have heard a concern from them that the plan might already be being written and in draft form. To co-produce the future of the NHS is what they are rightly calling for. How will they be involved in a meaningful way?

Wes Streeting: I will say two things. First—to deal with the cynicism—the plan is not already finalised or written and drafted. I do not have a secret draft in my drawer. We took some flak for that, by the way. We came into government and when we launched the 10-year plan engagement, people said, "Why don't you already have your 10-year plan? You were in opposition for 14 years. What have you been doing?" I had to gently remind people that the last shadow Health Secretary to come into Government with a fully formed plan to impose on the system was Andrew Lansley, and that did not turn out so well. We came in with a clear set of promises that we will deliver and a clear reform agenda overall, but I think it is right that this is produced with people rather than done to people. That is a better way of doing policy and driving reform.

It is my job, but I do not have a saviour complex; I alone cannot save the NHS or the social care system and turn it around. I have to mobilise all the people who work in it and use those services to help me drive the performance we need. We are specifically working with local health systems and partner organisations to ensure that we include people who are traditionally under-represented. They include disabled people, the under-represented groups I have always mentioned and people who otherwise would never have real engagement or a voice, such as the homeless or sex workers. It is really important that we engage people who

rely very heavily on health services but often do not have a voice, let alone power and agency. We are definitely going harder on this, and you will no doubt hold me to account when I next come in front of you to see how those numbers have improved. But I am on it, as is Tom.

Tom Riordan: We have met the Children's Commissioner, and she did a big consultation with children that included feedback about health. We are going to take that into account and work with DFE colleagues on that agenda. We have also engaged with local authorities, which often, as the Secretary of State said, have those relationships with groups of children, such as those in care or with disabilities. We are keen to tap into that as well, and that is another route to try to get the right representation of those voices.

Q30 **Jen Craft:** Sorry to press you, but I am looking for more information about how you will involve those groups. The feedback we received was that groups were unable to access the consultation in the most basic of ways. Alternative formats were not available when the consultation was first launched, and then when they became available, they felt a little bit like an afterthought. BSL first-language speakers often cannot access healthcare, which seemed to be echoed in how the consultation went out. How are you going to ensure that those groups are involved in a meaningful way? I understand that the intent is there—and it is a laudable intent—but which groups are you going to be talking to and how are you going to be driving the culture shift to ensure that those people are included at the very start of the process?

Wes Streeting: First of all, we designed in accessibility with how we commissioned the partner agencies that we have involved in the consultation process. We did give it that consideration at the design phase, but I take your criticism on the chin in terms of people still feeling that when we launched it was not as accessible as it should have been from day one. We are absolutely open to further feedback on how we can improve accessibility.

Secondly, I really do not want to underestimate the importance of partner organisations in all of this. If I can be slightly critical of the Department I lead and the NHS—

Chair: Please do.

***Wes Streeting*:** I do not feel that the organisations I walked into in July, which I now lead, had the degree of openness and partnership with, in particular, the voluntary and community sector, or—and Tom might want to speak to this with his previous local government hat on. Look, I come from local government, and the situation is definitely better now than it was when I was a councillor and cabinet member for health and wellbeing in a London borough. But honestly, is the NHS as good a partner as it can be to people who work with it to both shape policy and deliver services? No. Does local government feel like an equitable partner around the table with the NHS? No. Is my Department one that instinctively looks outwards to bring people in at the policymaking phase? No.

To the Chair's point on culture, that is the culture change that I have tried to bring in the first five months, having come from local government as an elected member, and having spent my career outside of Parliament working in the voluntary and community sector. I was willing to take the knocks over why I was consulting on the plan, and I was willing to say, "We are going to publish it not in March, ahead of the local elections, but in May, after them, so that it can be a genuine engagement exercise," because I genuinely think as a point of principle that working with partners and involving more people in the design of public policy means you will get better delivery and better outcomes. I feel that very strongly.

We absolutely take the criticism and challenge on the chin. People were not an afterthought, but I also accept from the criticism that, even having thought about it properly, we still did not get it entirely right. Feedback is the breakfast of champions. We will learn from that and try to do better in the future.

Tom Riordan: To support that, and linked to the point about culture that the Secretary of State was talking about, I think those parts of the country that are working best have characteristics such as trying to work in a way that is very patient or citizen centred and trying to put the system, not the organisation, first. When things are getting tough, they tend not to default back into the organisation and look for blame, but to try to look for solutions together. That is at the heart of it. When you are in local government, you are closer to what is happening on the ground. You cannot avoid the voices of individuals. You feel very accountable. I feel pretty accountable today. We have to look at the distance between the patient voice and the centre, and make sure that we are hardwiring it into the way the systems are working—not just the NHS, but social care and others as well. A lot of the solutions to this lie in citizens and the voluntary sector.

Wes Streeting: Absolutely.

Tom Riordan: The fine grain you have to have about individuals and their lived experience is another thing we are trying to tap into. We have tried to address the challenge that was identified at the start, so there are multiple formats and ways to respond to the consultation now, including language translations, British Sign Language and an easy-read format. People can respond by email, post, telephone or BSL video. But even then, we have to do extra engagement with people, and we accept that we have to try as hard as we possibly can if we are going to live up to that "with" rather than "to".

Q31 **Andrew George:** I suppose the shift from hospital to community is the holy grail question. For the 30 years or more that I have been involved in the politics of health, it has been a mantra or objective. The language may well have changed but, if anything, things have moved in the opposite direction. It is a laudable aim; everyone, other than the most malevolent tribalists, wants you to succeed. What can you say to us that will persuade us that you will succeed where others have failed?

Wes Streeting: I would say a few things. First, one of the first things I did, within weeks of coming in, was find the money to deal with the issue of GP unemployment so that we could deploy 1,000 more GPs to the frontline within this financial year. I was really clear up front—not least because I did not want GPs to think, "I really hope he doesn't think that's it"—that that was an immediate response and a practical thing we could do, rather than the solution to the challenge.

As well as making a practical difference to something that really matters to patients, I wanted to show very early on that primary care was at the forefront of my thinking. The 9.35% investment in general practice in 2017-18 fell to '21-22. Core practice funding has fallen in real terms from £175 to £165 per registered patient. In September '24, there were 1,399 fewer fully qualified GPs than in September 2015. Public satisfaction has fallen, yet GPs are delivering more appointments now than before the pandemic with fewer GPs available. I wanted to send a message very early on that when we talk about shifting out of hospital into community, we mean it. My first visit as the new Secretary of State was to a general practice. People might say, "Well, that's optics; it's superficial," but it was also about showing very early on that we get it. Without preannouncing decisions that are still in the final stages of being taken, people will see in the choices I am making about how to invest over the coming year that I will be walking the talk on hospital to community.

Of course, it will take time to deliver the real shift, and it is not just about where the money goes. In terms of quantum, it is also about what we are funding and where, the financial flows and incentives, and activity. I want to see more activity taking place out of hospital in the community, with care close to people's homes and, indeed, in people's homes. We are already seeing some brilliant things in terms of hospital at home that we need to scale up, which will allow better monitoring of patients and care for people in their home. We have to rebuild community care—the role that district nursing plays, for example. I have shadowed district nurses and they are an absolutely vital part of the NHS, but if you talk to people in the nursing profession, they will say it has been undervalued and understaffed.

On hospital to community more generally, with things like diagnostics and minor injuries, there is much more that we can do close to people's homes. That will not only be a better experience and impact for patients, but it will be better value for taxpayers' money. If people cannot get a GP appointment that costs 40 quid, they might well end up in A&E, which costs 400 quid. That is worse for them and more expensive for the taxpayer. That is the shift we need to see.

Matthew Style: Is it helpful to talk about some ways in which we are bringing to life those shifts and that reform agenda in how we are approaching the immediate challenges that face the NHS this year?

Chair: We are very keen on specific examples.

Matthew Style: I will give you some examples, then. In the plans that we have set out for responding to winter pressures and delivering urgent and emergency care improvement this year, we have placed particular emphasis on asking ICBs to ensure that they are proactively identifying those patients with the most complex needs who, in other circumstances, would be most at risk of emergency admission. We are asking ICBs specifically to have plans in place to avoid an escalation for those patients, to ensure that there is provision in place out of hospital to meet the needs of those patients.

In elective care, one of the most important parts of our plan to recover performance against 18 weeks is not only maintaining the level of activity that we are delivering in acute hospitals, but making sure that GPs can more easily access advice and guidance to support patients in the community, without an unnecessary referral into acute care. As I say, in the short-term actions that we are taking to drive recovery in acute services, we are embodying the very shift that the Secretary of State has set out.

Q32 **Chair:** What information do they not have now?

Matthew Style: There are some increasingly well-established processes in place across the NHS so that primary care clinicians can access specialist advice to support them in managing individual patients without what would otherwise have been a referral, which is inconvenient for patients as well as placing pressure on the services.

Q33 **Andrew George:** I am not aware that those things have not already been rolled out. It is certainly a mantra that has been expressed by those on the frontline of the NHS, so I am not sure there is anything new as far as that is concerned.

Wes Streeting: This is one of the things that I have a sharp eye on, and there is definitely inconsistency across the country in coverage and impact. Going back to one of my earlier points, if we can take the best and leading practice and make sure that it is consistently delivered across the country, that will be better use of taxpayers’ money and there will be better impact for patients.

Q34 **Andrew George:** And you will be able to balance that with your view that you do not want an overly centralised system. You want to let go but at the same time hold on.

Wes Streeting: If I think about some of the examples that I have seen, it is not just about top-down direction; it is also about horizontal leadership across different parts of the NHS. For example, I recently went up to the Redcar constituency with Anna Turley and Amanda Pritchard, the chief exec of NHS England, and I saw how the community-based team were actually working very closely with the ambulance service. North East Ambulance Service is one of the most challenged services, and it too often ends up in the headlines for the wrong reasons because of its responses. That community-based team is able to work with the ambulance service to identify people who have called in, and it can deploy community-based

teams to people faster than an ambulance would get there, which often frees up the ambulance response because it is not needed, and the community-based team can help.

If I think about some of the ambulance ride-outs that I have done over the last few years, I have often been to the homes of people who did not need an ambulance at all; what they needed was some community care or social care. Those are the sorts of differences that we can make if we are able to shift the focus out of hospital and into the community. Yes, our hospitals are under enormous pressure. One of the things that I have been struck by, when talking to CEOs and CFOs of hospitals over the last couple of years, is that they recognise that so many of the solutions to their problems, whether it is demand coming through the front door or delays out of the exit door, lie outside of the hospital and in the community, with primary, community and social care.

Q35 **Andrew George:** But that is not what, for example, the president of the Royal College of Emergency Medicine is saying. Dr Adrian Boyle is saying that, if every acute hospital had an additional ward for the admission of patients who are clogging up the emergency departments, that would relieve a lot of pressure. That requires more investment in the acute sector, which you are suggesting needs to be channelled to primary care. How are you going to do that, when there is a very compelling case to double-run—if you like—investment both at the acute end and the primary care end?

Wes Streeting: I have a lot of respect for Adrian. If we just took that statement as literally the thing we would do to deal with UEC pressures, we would end up deepening and worsening the diagnosis that Darzi provided, where we concentrate more staff in hospitals, thinking that is the way to deal with the pressures, either in UEC, electives or elsewhere. That would be the wrong thing to do. This winter, at present, we have more beds open than we had last winter. Those numbers will flex and vary as we scale up and down, dependent on pressures.

I am not pretending for a moment that things are easy in emergency departments today, or that they were easy yesterday or will be easy tomorrow. If we are serious about alleviating the sort of pressures we see in hospitals, whether we are talking about ED waiting times, ambulance response times to get people conveyed to hospital or elective waiting times, the solutions to the better performance of the NHS lie in primary, community and social care.

Q36 **Andrew George:** There has been a reduction from 8% six years ago to 5.5% of the NHS pot going into community services. If you are going to reverse that, you can use the mental health investment standard, perhaps, as a means to achieve that. Can you now set us an indication as to what level you think that proportion should be? Can you give us a target date by which you intend to achieve that? If you are going to shift from hospital to community—

Chair: Higher? Lower?

Wes Streeting: You really are in a Christmas special now. Thank you for the temptation, Andrew. I am not going to set out financial allocations at this stage. When we do shortly, I think people will see that we are already beginning to walk the talk in the shift that we want to see. That is the right thing to do, both in terms of current pressures and putting the NHS on the path to deliver better care for patients and better value for taxpayers' money. It is going to take time, and the public are realistic about that. We will see demonstrable improvement over the course of this Parliament.

Chair: We look forward to holding you to account over that in future sessions.

Wes Streeting: Do you want to come in on that, Tom?

Chair: Quickly, because I do mean to move on.

Tom Riordan: We tried the extra ward in Leeds, and it did not work. We changed tack with the hospital. Going back to the digital point, we got frontline staff to have shared casework on a real-time basis, put integrated teams of social workers and clinicians into the hospital and revamped our reablement service. That took pressure off the hospital and worked.

The best of the NHS to the rest of the NHS is real. The collaboration between neighbouring hospitals is important, as well, on who does what, to take the strain when needed. There is the virtual ward idea: beds that are in people's homes but with wraparound support through the virtual ward. Hertfordshire has done that really well, and other places are doing that. It is that combination.

Q37 **Dr Cooper:** Thanks so much for being here this morning. I am gently going to move you from the hospital to the community and along to prevention. Staying with the community, I want to pick up on a point that Andrew and Danny made about capital investment. As we all know, hospitals are very large buildings and house a lot of people and do a lot of good things.

If we are moving from hospital to community, could you talk a little bit about the capital investment that you think is going to be necessary? I hear what you say, Tom, about virtual wards. They are great and I've worked in them myself. I am also aware of the need for community infrastructure to deliver a hospital to community shift. I would be grateful if you could talk about that for a couple of minutes.

Wes Streeting: The consequence of the under-capitalisation of the system that Darzi described in his report is that right across the NHS estate we see real challenges. Hospitals have been put in the spotlight because of the new hospitals programme and the promises made by previous Governments. If I think about the primary care estate and mental health estate, I am worried, to put it mildly, about where we are. That is why I was delighted, because of the choices made by the Chancellor in the Budget, that we will have over £100 million next year for around 200

upgrades for existing GP surgeries, which will both create additional space and boost productivity.

This is the first national capital fund for primary care since 2020. I am not pretending that one year's capital allocation of £100 million will have solved all of the problems, but I think, again, it is showing, through action, not words, that we are serious about the shift from hospital to community, and that we are recognising the pressures in primary care, specifically in that context, as well. I hope that that will start to make a real difference and provide some light at the end of the tunnel to a part of the profession, in general practice, who I think have been extremely demoralised, to put it mildly, given their experience over recent years.

Q38 **Dr Cooper:** Interesting; thank you. I am aware of time and the fact that other colleagues want to get in, but I just wanted to shift you ever so slightly—in a happy, cultural shift—over to prevention, while still looking at primary care. A recent King's Fund report highlighted the emerging consensus that a health system based on a strong primary care infrastructure and a strong public health sector is essential to maximising the health of the population but, despite the fact that public health and primary care are mutually reinforcing, they are organised and funded as two separate entities. Secretary of State, do you see value in bringing the funding for these two areas together? If so, what do you see the role of the public health grants continuing to be in local authorities?

Wes Streeting: That is an interesting question, and exactly the sort of debate we should get into through the 10-year-plan process as well. I have a particular perspective to bring to bear on this, as a former cabinet member for public health, and I will probably bring in Tom, if he wants to, as a very recent chief executive of a city council, in Leeds.

I think we definitely need to see better joint system working. I am not sure that the solution would be to take public health out of local government and put it into the NHS. I am open to the arguments, and, in the spirit of the 10-year plan, I think these are the sorts of debates we ought to be having, and I think it would be a good kind of discussion to have, including in Parliament, in the fora we have available to us in different places around the place.

I think the public health delivery of local government is important. It is amazing what local government is still able to do despite its experience over the last 14 years, and I experienced some of that during my time in cabinet in local government. I actually think the pandemic showed us that, when the NHS was reaching the limits of its engagement with communities on things like the vaccine roll-out—it had motored really well and then bumped its head against the ceiling on the roll-out, and started to struggle to go further. Local government has much better relationships into communities, including the ones that Danny described earlier—those places that are not hard to reach but are under-represented and underserved by the NHS—and local government was the route in. I think there is a lot to say about the effectiveness and the reach of local government, which the NHS could partner with effectively.

We will be making the public health grant allocations shortly—in fact, I am happy to say that we will be doing that in January, which is earlier than it normally comes, so that will give people the chance to plan ahead. I do think there is a role for GPs to play in population health management.

Going back to Matt's point a short while ago about the hospital-to-community pressures and how we are managing them, one of the reasons why advice and guidance is so important in relation to general practice is that people are seeing patients now with increasingly complex multiple comorbidities, so, actually, I think the role of the general practitioner becomes more important, not less, over the coming years and the coming decades. We can continue to treat those symptoms of chronic disease, but we have really got to shift to the prevention as well, and I think general practice has a powerful role to play in that. Tom, I don't know if you wanted to say anything on local government as well?

Tom Riordan: Thank you, Secretary of State. I just want to agree with that and say that the role of the third sector is also critical in this space and local government holds the main relationship, at local level, with the VCS. If you think about those connections that you can make to older people who want to stay in their home and live independently for longer, it is often the third sector, the local charities, that can really connect to them better. The same is true for people with addiction problems. The collaborations that work best involve GPs, the NHS, local government and the VCS. The funding will always come in a slightly different way to each of them, but what we are really interested in is this: how do we make it easier for people to collaborate once that money is there, and how do you make sure that you have got all those partners working together? That is where the neighbourhood health service idea is really exciting, because it could be the vehicle that we use to drive the sort of reform that the Secretary of State has articulated.

Matthew Style: That is also why ICBs are so important in all this and why that structure, which brings together those partners, is critical.

Chair: That is a theme close to the heart of the Committee, for sure.

Q39 **Josh Fenton-Glynn:** Thank you, Secretary of State: it is really good to hear that local government's voice is going to be stronger. I say that as a former council cabinet member for social care, and I am going to bring us on to social care. Lord Darzi has said that 13% of patients in NHS beds are there because there isn't appropriate social care. I was at my local trust last week. They said that the number is about 20% in Calderdale and Huddersfield NHS Foundation Trust, and they are quite well run. Andrew Dilnot's report was first released in 2011. Is this going to be the Government to sort out social care?

Wes Streeting: Yes. I am the Secretary of State for social care, not just the Secretary of State for health, and I would say first, just in overall terms, there is no solution to the crisis in the NHS that does not also involve a solution in social care. The second thing is that social care is important in and of itself, whether it is supporting disabled people of all

ages or supporting people in later life, which is particularly relevant in a growing ageing society. There will be overlapping needs between those two groups, but they are distinct, separate, and important.

I hope people have seen, in the first five months, that we have taken a number of significant and important steps specifically on social care, whether that is fair pay agreements in the Employment Rights Bill—within the first 100 days—which will deliver not just better pay for care workers, but better career progression and recognition so that we value people as care professionals.

Secondly, the Budget delivered the biggest expansion of the carer's allowance since the 1970s. We delivered, thirdly, an extra £86 million in the disabled facilities grant and also, through the spending power of local authorities, an extra £3.5 billion—through the Budget—with £680 million ringfenced for social care.

Do all those things represent the solution to the care crisis? No. However, to my earlier point in relation to mental health, we have been in government for five months. I don't think those four things are a bad start, but there is more to do. In particular, on the 10-year plan I think we need for social care—alongside the 10-year plan for health—we will be setting out in the new year how we will build that plan. Particularly in the context of this Committee, one of the best things this side of the election, in terms of the political discussion we have been having—I have been struck by the level of cross-party ambition on social care. We have had people in the Conservative party, the Liberal Democrats and Reform all saying effectively the same thing: "There is plenty of blame to go around. Let's work together to fix the care crisis." And that is what we want to do.

Q40 **Josh Fenton-Glynn:** Can I pause you for a second? It is good to hear those words, and I do appreciate that the Government have been in place for only five months, but this is obviously a long-term project and we should have a clear idea of what our social care system is going to look like. I am not sure, despite having run a local social care service and having a lot of interest, that I am clear what our social care service is going to look like in five years and 10 years. Do you think you are clear?

Wes Streeting: First, I really welcome this Committee's inquiry because it will speak directly to the anxiety I feel about what it is going to look like if we don't do anything. It will be continued mismanaged decline and rising demand. Demand for publicly funded social care is estimated to rise by 43% between 2018 and 2038, just on demographic pressures. We are seeing a decline in access to publicly funded adult social care, despite there being over 2 million requests for social care support in 2022-23, which are the latest figures I could get my hands on. Vacancy rates in the social care workforce remain more than twice the national average for other sectors.

Q41 **Josh Fenton-Glynn:** Can I come in on that point? We can't talk about social care without talking about the workforce. Skills for Care released its report, "The state of the adult social care sector and workforce in

England", in October, which made for pretty grim reading. A few stats from that: the vacancy rate is 8.3%, which is more than twice the national average, compared with the NHS vacancy rate of 2.3%, which is a good story to tell because the NHS has more sustainable careers. The vacancy rate for social care is unsurprising because those with five or more years' experience in the sector earn only 10p more than people who have just started; in 2016, that was 33p. Meanwhile, 18% of those in the sector earn 10p less than the real living wage. Those numbers all worry me, and they are all things that have happened since the Dilnot report. That report opened up a lot of answers to the social care problems in 2011, but what worries me when we are looking at the future of social care, is that there are a whole new load of problems that have come about as a result of inaction. How are we going to get a sustainable workforce in social care?

Wes Streeting: I would say two things in response. First, on what we walked into on Dilnot, even if the money had been there, which it wasn't in common with many of things, the system wasn't even operationally ready for the timetable set out by the previous Government. Even if it was just a case of spending the money that was there in the pot, it wouldn't have been rolled out in time, so we have taken the decision to pause and roll it into the wider social care reform agenda. What Dilnot would have dealt with is care costs, not necessarily overall care provision. To be fair to Andrew Dilnot, he put a huge amount of time and expertise into the report. He came up with a very well thought through and workable solution to a component of the care crisis, but he wasn't tasked with, and therefore didn't set out, the overall strategy for social care.

On workforce, that is where fair pay agreements will be so important. We all reach for the example of the care worker who goes to work for Asda or Aldi, because they can get better pay and a lot less stress and physically demanding work—I say that with respect to shop workers—but we are losing quite a lot of our care staff to the NHS, which is a caring profession with better pay.

Q42 **Josh Fenton-Glynn:** That was what happened in my authority—it was from retail, through caring into the NHS.

Wes Streeting: Exactly, into the NHS. That will make a real difference and we have to build a proper career progression. Not every care professional is going to end their career being the Deputy Prime Minister, like Angela Rayner, but I would like every care professional in this country to have the same status and regard that the Deputy Prime Minister, or indeed the Prime Minister, have. That is part of it, but in common with the NHS, we need a 10-year plan for social care. We will be setting out how we want to approach building that plan in the new year. I would like all parties in Parliament to be as engaged and involved in that as they can, so we can start to build consensus.

Q43 **Josh Fenton-Glynn:** You have said that we will be setting out how we do that in the new year twice now. Does that mean we are setting out a new commission to look at it? Or does it mean that we are setting out the

comprehensive plan as to what it looks like?

Wes Streeting: It means we are setting out how we will go about building the 10-year plan in the new year.

Josh Fenton-Glynn: Thank you. I know time is short, so let's move on to other people.

Q44 **Joe Robertson:** Good morning, Secretary of State. It is good to see you. I have some questions on the national insurance contributions levied on employers in the Budget. At the beginning of this session, you said health and social care is facing the worst crisis in history. In hindsight, do you think it is probably the wrong time to take £125 million from GPs, £50 million from pharmacists, £30 million from hospices and £1 billion from social care providers?

Wes Streeting: I would say two things in response to that. First, I do not accept those figures, on the basis that I have not set out funding allocations for the year ahead, so we will not know the net impact one way or the other until I have done that. Secondly, we would not have £26 billion for the Department of Health and Social Care without the political decision the Chancellor took in the Budget. If people do not agree with raising employer national—

Q45 **Chair:** You can understand that, from the point of view of this Committee, that is taking from one hand and giving with the other. It is just going round in circles within the system. From the Committee's perspective, having taken from one pot, you are then going to give it back—

Wes Streeting: Even without having spelled out the financial allocations for different parts of health and social care, it is obviously the case that the amount of money given to the Department of Health and Social Care dwarfs employer national insurance contributions from the health and social care sectors. It is perfectly legitimate for people to say, "I don't agree with the Chancellor raising employer national insurance contributions," but then you have to say what you would cut in the NHS or social care in order to reverse that decision, or where else you would raise £26 billion to avoid cuts to health and social care.

Q46 **Joe Robertson:** Can we just be clear that the £26 billion is not for health and social care? It is for the NHS. Those two terms are not interchangeable. GPs will not benefit from the £22 billion for day-to-day spending, nor will social care, pharmacy or hospice. Unless your announcement pledges money to GPs, can you give any assurances that the money you will take from GPs, pharmacies, social care and hospices through national insurance will be returned to them?

Wes Streeting: My Department has received £26 billion thanks to the decision taken by the Chancellor on employer's national insurance contributions. I am taking into account the wide range of pressures that we inherited in health and social care when making allocations right across health and social care. You cannot on one hand say, "We love the investment," and then criticise raising employer national insurance

contributions. If you do, you have to say where you are going to cut or where you are going to raise taxes alternatively.

Q47 **Joe Robertson:** You have pledged £26 billion to the NHS and just 2.5% of that—£600 million—to social care. With respect, I think it is misleading to say "£26 billion for health and social care". The vast majority—98%—is for the NHS, which is not the same as health and social care. Can you give GPs—

Wes Streeting: So you would like to spend more on social care. Which taxes are you raising to provide more money for social care?

Q48 **Joe Robertson:** It is not for me to do your job, Secretary of State. I am asking you to justify your decisions. Can you give assurances to health and social care providers that are not the NHS—GPs, pharmacies, social care, hospices—that you will return the money you are taking from them through the Budget via national insurance contributions? Can you give them those assurances, possibly before Christmas?

Wes Streeting: I can definitely say across health and social care that we are better off thanks to the decisions the Chancellor took at the Budget to invest in health and social care. As I have said very clearly, particularly in terms of primary care, hospices and so on—I understand that people want to set their budgets for the year ahead—I will be making my allocations in a timely way so that people can plan for the year ahead, and—

Joe Robertson: When?

Wes Streeting: They should not be taking decisions ahead of seeing the allocations. As I say, we are in a much better position than we would have been had the Chancellor not done the heavy lifting that she did in the Budget to plug the black hole we walked into, stabilise public finances and start fixing the foundations of our public services. People may not agree with employer national insurance contribution rises—fair enough, but what would you cut, or which other taxes would you raise? Those are legitimate questions for Opposition parties to answer.

Q49 **Joe Robertson:** We are talking about less than £250 million to return to GPs, pharmacies and hospices. That is a drop in the ocean for the Treasury, but a huge pressure on GPs. I would suggest that they are more likely to agree with me than you.

Wes Streeting: I am definitely taking into account those pressures—

Joe Robertson: Thank you.

Wes Streeting: —but that "drop in the ocean" complacency perhaps contributed to the £22 billion black hole.

Q50 **Joe Robertson:** I think £250 million is a drop in the ocean for the Treasury, and I think GPs, pharmacists and hospices would agree with me.

Can I ask you about the Darzi report? Darzi says that to deliver hospital to community and treatment to prevention, you need to hardwire

changes in the system by adjusting financial incentives. Do you agree?

Wes Streeting: Completely.

Q51 **Joe Robertson:** So how is levying tax on community providers, but not on acute trusts, incentivising hospital to community and treatment to prevention? How is that incentivising moving from acute to community?

Wes Streeting: You are making a whole set of assumptions ahead of me setting out financial allocations for the year ahead. I come back to the central point, which I am afraid you cannot escape. You cannot say, "That £26 billion is great; I love the investment, but I really hate the way you are raising it," unless you spell out which services you would cut or which taxes you would raise as an alternative to employer national insurance contributions.

Q52 **Joe Robertson:** I am saying: return the money to healthcare providers, instead of taking with one hand and giving with the other.

Returning to hospital to community, you are giving some tantalising suggestions that there will be something coming down the road. You talk about doing it in a timely way. A timely way for you and the Department might be a little different from a timely way for healthcare providers. They need to know now. I think you have acknowledged that they need to know in order to plan for the next tax year. Can you give any assurances? You told the BBC that you might do it before Christmas—let's start with that. Are you going to make an announcement in the next four working days before Christmas Day?

Wes Streeting: I did say to hospices that we would make an announcement before Christmas. That is next week, and I intend to keep that promise. More broadly, I am mindful that people need to make decisions around their organisations for the year ahead, so I think we need to come to this early in the new year at the latest, and that is what we will do.

Q53 **Joe Robertson:** Can we take early in the new year to be January?

Wes Streeting: Early in the new year would be January.

Q54 **Ben Coleman:** Thank you, Secretary of State, and thanks to Tom and Matthew for coming. It is good to see you. I have to say that it is refreshing to find a Secretary of State who gets local authorities and local government. I have been on an ICB myself. I have worked, as many people here have, in local government, and I have also been a cabinet member for health and adult social care. When you say that the NHS does not see local government as a good or equitable partner, that bears out the experience of a lot of people here. How do we make the NHS see local government as an equitable partner? Are we just talking about social care, or are we also talking about public health, housing and other areas?

Wes Streeting: Especially on the latter point, many of the challenges that local government is grappling with are presenting themselves in GP practices, in EDs and on elective waiting lists. This relates to the whole

argument around prevention and the brilliant work that Michael Marmot has done on the social determinants of ill health.

We have to bend the curve on cost and demand to alleviate those pressures, which is one of the reasons why, around Budgets and spending reviews, I am very conscious that, often, a penny that goes into the NHS has an opportunity cost for investing in tackling the social determinants of ill health. We have to bear that in mind. That is where the need for financial rigour and the best use of taxpayers' money comes from.

On the relationship between the NHS, local government and other partners, it could definitely be better, but I would also give the NHS some credit for seeing improvement. If I think about our planning for this winter, for example—I will bring Tom in on this point to talk from direct experience over recent years, in a part of the country that has led the way on integration of health and social care and building a strong partnership—my sense is that although there is room for improvement, and some parts of the country are better than others, the relationship and interaction between health and social care is better now than it has been in previous years. Certainly, when Karin Smyth and I were at NHS England recently, in the operational control centre for winter, we had a considered and in-depth briefing on the insights that health leaders have on social care provision.

So it is getting better. I think it could be stronger still. ICBs are an opportunity in this respect. Again, there are always leaders and laggards, but I think we can characterise the relationship as an improving one, with further room for improvement.

Q55 **Ben Coleman:** That is very helpful. You talk about the relationship with social care. Even in social care, I feel that local authorities have a much better understanding of the NHS than the NHS has of local authority social care provision. But are we just talking about social care when we are talking about local—

Wes Streeting: No, definitely not.

Ben Coleman: Are we talking about public health?

Wes Streeting: One hundred per cent.

Ben Coleman: Are we talking about housing as well? And do you think that the NHS understands sufficiently how those things operate in local authorities?

Wes Streeting: I think there are varying degrees to which the NHS needs to understand. On public health, there are members of the public who walk into some sexual health services, for example, oblivious to the fact that those services come through funding from their local council rather than the NHS. As far as they are concerned, they are walking into an NHS service. Often, they are walking into an NHS setting because of co-location. That is a good thing, and we need to see more co-location of

services to deliver better impact and better value for taxpayers. We definitely do need better insight.

On housing, where this is particularly relevant is the interaction with things like mould or damp-infested homes, where we have to get homes up to decent homes standard. There is no point in taking someone into hospital with respiratory problems, getting them back to health and discharging them back to the same mouldy home. We have to work together to ensure that they are discharged into a better place.

One reason I am really pleased with what we have done with the disabled facilities grant in the Budget is that someone who has had a life-changing injury or illness that might now require handrails or ramps and other home adaptations will get them. That is not only good for faster discharge into a better setting; it is also great secondary prevention. If you have the right support at home and the right set-up, you are less likely to suffer trips and falls or, worse still, just sit there thinking, "There's no point in me getting up and about because of the risk of falls," and end up sitting there in your armchair in the living room physically deteriorating.

As I said—and this will probably be a feature of our interactions over the coming years—I do not pretend we are currently where we need to be. I think it is better than it used to be, but there is definitely room for improvement.

Tom Riordan: I think the ICB structures have helped. There is a better connection at officer level, in terms of the running of services going into winter, particularly this year. There are more tried and tested partnerships actively working on the ground. Politically, it has helped to have the integrated care partnerships, because, as those of you who have been cabinet members or leaders will know, that makes a better connection. In my experience, there was a tendency for the NHS to look more to the scrutiny function of local government than to the cabinet member in that respect.

There is definitely more we can do. Having sat on an ICB myself, I think we can do more to strengthen the voice of public health through the DPHs, who gained a reputation as a fantastic local, trusted voice in a lot of places through the pandemic. We need to think about home care, as well, and ensure that that is recognised and talked about as much.

Q56 **Ben Coleman:** When you say "we" need to do that, I presume you are talking about the NHS and the Department of Health and Social Care. What action are you specifically taking to ensure that the NHS takes the trouble to understand local authorities, how they work and what they can do better than now? At the moment, it is still very top-down and very "We say you should do…" That is not going to get the best health outcomes, is it?

Tom Riordan: I have to watch when I say "we" because I do slip into Leeds mode, but I do genuinely mean the Department and our NHS partners. One of our directors who has been working on the 10-year plan

and I recently did a session with about 200 DPHs, leaders and chief execs. We are very keen to do that "with not to" with the sector. We will not solve that overnight but, by having more people at senior levels who understand local government and want to work with it, that is the difference we can make.

On neighbourhood health, you are right to target housing. If you think about people you need to get back into the community living independently, the disabled facilities grant that the Secretary of State mentioned is absolute gold dust locally at times, because you can get the adaptation that you need to allow people to do that. There is that connection with wider public services. We have not talked about work and skills, but the work we are doing with DWP on trying to get people with disabilities who want to work back into work can help the economy and local people. That is the bit of the neighbourhood health agenda that has most potential to drive together, rather than apart, the NHS and local government.

Wes Streeting: Similarly, one of my new year's resolutions, as well as DPHs, is to—Stephen Kinnock is on the case, as is Andrew Gwynne on the DPHs—improve my direct connections to directors of adult social services in local government. Although we are the Department of Health and Social Care, our levers and our line of sight are nowhere near as well developed as they are in the NHS. There is loads of scope for this. If I think about social care providers, they are much more tech and data-driven and enabled than I think people would characterise them. There is lots of scope for us to improve there, and I want to improve my connection to DASSs.

We have touched a lot on the local government side of things, not least given our experience. On big, bad secondary care in the context of this conversation, is there anything you want to add, Matt?

Matthew Style: Thank you, Secretary State. Mr Coleman, if I may come at your question from how we in the Department can support and drive change and improvement on the important agenda that you set out, in the new year we will set out how we are going to assess the performance, capability and maturity of ICBs, and it is really important that one of the things we put emphasis on within that framework is: "How good a partner are you as an ICB? To what extent are you really leaning into that role as a convenor, as a bringer together, as a builder of relationships?" We have talked a lot about things we are going to do in the new year, but that is another one.

Q57 **Ben Coleman:** It gives us things to look forward to. It was very encouraging to hear what you said about the disabled facilities grant. I think you are saying that occupational therapy is a good profession to go into under this Government. Is that right?

Wes Streeting: I would say so.

Q58 **Ben Coleman:** Darzi talked about damp and mould, which you touched

on. As you well know, local authority funding has been denuded over the last 14 years. There is a huge problem of damp and mould for local authorities to fix. Is there an argument for some money coming from the NHS to local authorities to fix damp and mould?

Wes Streeting: In terms of the shift that we want to see in the NHS lens out of hospital and into community, I think there is a broader question about prioritisation of Budgets and spending reviews over the course of this Parliament and beyond. That is why I probably sound—and am, to be honest, in practice—so hawkish about NHS finances. The NHS is the thing that does best at Budget time. It tugs on the heartstrings of the country, because we all care about the NHS deeply and we have all had personal experience of lifesaving care, as in my case, or of care for others—I suspect that is the case for everyone in this room and everyone watching—so the NHS always wins at Budget time. The danger is that we say, "People will always pay more for the NHS, won't they? Well, okay, now the NHS will be the way in which we fund home repairs, because that's a big determinant of our health. In fact, why not take over provision of income support and start prescribing cash on the NHS?" Before you know it, the NHS has become the state. In the longer term, we will not have a country with an NHS; we will have an NHS with a country attached to it.

Q59 **Ben Coleman:** So when you are at the Cabinet table—

Wes Streeting: Around the Cabinet table, I do feel a degree of discomfort, which I described in my NHS Providers speech, knowing that every penny I got for the NHS is a penny that could have gone to places that are often social determinants of ill health. That is why we have a moral duty as the national health service to spend the money that is already going in better than we currently do, and to try to bend the curve of cost and demand so that the NHS is not always the big pull on public finances and we are able to invest in areas that also contribute to the common good, the social good and the economic good of the country. If we can deliver that shift from treating sickness to prevention, not only will that be better for healthy life expectancy and all the things that make life worth living; it will also reduce cost and demand on the NHS.

Q60 **Jen Craft:** I will be brief because we are pressed for time. An area where we would like to see more intervention from DH, as opposed to DHSC pushing control out, is the Government's strategy to halve violence against women and girls over the course of this Parliament. I am very interested in the role that you see DHSC playing in that, whether that is NHS prevention or support for victims and their families. How will you play your part in delivering that very important mission?

Wes Streeting: I think that is really important. There are some very obvious things that we can do on the victim support side of things, in helping victims of domestic violence—not exclusively, but predominantly women and children—and providing them with the support they need. Recovering from violent relationships or from a violent attack is itself a

trauma. Your earlier questions on mental health investment standards and mental health services are highly relevant to that.

The other thing I would say about health and care services is that we have lots of eyes on people at various points. The eyes on patients that we have in the NHS can identify signs of physical and sexual violence and abuse. Identifying victims at the right time and, crucially, assisting the police to collect evidence are a key part of successful prosecution. We have to have the right diagnostic and lab capacity to ensure that our forensics and police forensics are as good as possible, from a wider system infrastructure point of view.

Obviously, for the worst possible reasons, child abuse is in the media at the moment. The NHS can be the difference between identifying victims and making sure social services are intervening, and accepting a borderline plausible or implausible explanation and giving people the benefit of the doubt when we might later regret it in the serious case review. All those things are really important.

The final thing I would say is something that I think about a lot in the context of the Employment Rights Bill, for example, and other contexts. I lead one of the largest employers in the world in the national health service. One of the things that employers can do is be there for their staff when they are victims of violence. That might be just being compassionate and giving people a bit of leeway, but often it might be noticing patterns of behaviour, bruises or changes in someone’s demeanour and behaviour, asking the right question, giving them the confidence to confide in someone, and then, as an employer, supporting them as they go through what can be a really difficult criminal justice process.

There is plenty of scope here. One of the things that I am genuinely excited about—it can sometimes sound a bit technocratic, but actually it is so powerful—is the mission-driven approach to government that the Prime Minister set out. This is how we are joining the dots across different missions. We are thinking about the contribution that my Department can make to the Home Secretary’s mission on violence against women and girls, and about the contribution we can make to the Education Secretary’s mission on opportunities.

Chair: We will certainly come back to that.

Q61 **Jen Craft:** I have one very quick follow-up question. I really appreciate your answer. On the sexual violence and rape side of the violence against women and girls strategy, the feedback from the sector is often that the NHS and local ICBs, rather than being a help, are quite often a hindrance in referring victims to support services without the funding that follows. That obviously has a huge knock-on effect on growth and wider health impacts. The outcome for a victim of sexual violence or assault is often not a criminal justice outcome. We can talk about a cultural shift. Are there any levers that you intend to use to ensure that ICBs are providing support for victims and not just pushing it on to the third sector?

Wes Streeting: That is a very good challenge, and we need to think quite deeply about it.

Q62 **Chair:** We would be very happy if you wanted to write to us.

Wes Streeting: Yes, we will come back to you. I will bring in Tom, who will obviously have a perspective on this.

Chair: We do want to move on.

Wes Streeting: I will bring in Tom very quickly in that case, but the final thing I will say is that I have spent a lot of time, in recent weeks and months, with victims of the NHS—whether they are victims of maternity scandals, of poor care at the wrong time or of mental health scandals—and it is a very sobering experience. If victims do not get that follow-through—particularly women who do not receive a level of follow-on care, having been victims of domestic violence, sexual violence or other violence in other spaces—we are adding further injury. I would consider those victims in the same category.

A big part of my focus on patient safety is continuing to put the voices of people who have been failed by the NHS at the heart of our thinking and planning on improvement. I will make sure we do some follow-up work on this and come back to you.

Chair: Please do.

Tom Riordan: The lever that is very important in this space is the children's safeguarding partnership, where you have the three statutory partners. That is one of the ways that we can try to make sure there is a health voice and engagement around case conferences, in particular.

Q63 **Paulette Hamilton:** Good morning, Secretary of State. My question is around underserved and more deprived communities. The previous Government talked about the creation of 40 new diagnostic centres to help to tackle health inequalities, reduce waiting lists and bring care closer to the home. What role do you see the community diagnostic centres playing in achieving the Government's ambitions on health inequality?

Wes Streeting: That is a great question. First, in overall terms, one of the reasons why our outcomes are so poor relative to other countries' is that we do not diagnose fast enough, so earlier access to diagnostics will lead to faster diagnosis and better outcomes. That is not just good in terms of patients, their life chances and their life expectancy, but better value for taxpayers because faster diagnosis and faster treatment often mean access to cheaper treatment.

On your specific point about health inequalities, we absolutely have to apply this lens. I will go toe to toe with anyone who thinks that thinking about equality, diversity and inclusion is a waste of time. Black women are four times more likely to die in childbirth than white women, and black men are twice as likely to die of prostate cancer than white men. Women

in this country—not even a minority—get sent round the houses on things like endometriosis; even with common conditions like polycystic ovary syndrome, which are much easier to diagnose, they are often treated like alien species with a rare condition. That has to change.

That is why we have to make sure that, when thinking about diagnostics, we are thinking about people who are more at risk, and making sure that we are doing much more targeted screening based on risk. We have to make sure that the messages that aim to get people in sooner are aimed at the right people, at the right time and in the right way. I think that that will become even easier over time, as we take a more data-driven and personalised approach to patient care, and as diagnostics and genomics improve. Hopefully, we will get to a point in our lifetimes when we can say, "You, Wes, will come in for this screening on this date, because you are more at risk than Danny," for example.

Q64 **Paulette Hamilton:** Can I push you on that, Secretary of State? When you talked about the 10-year plan, you said that Asian communities and black communities were not engaging with that plan. I absolutely support what you are saying about the diagnostic centres. The trust of the different communities, disabled communities and others has broken down over the years. What you are saying is absolutely correct, but how are you going to get them there, to actually engage with what you are saying? We are even getting that breakdown in rural communities, because rural communities are also saying that they are treated as second-class citizens. You see that in the dental health and pharmaceutical stuff, which others will talk about.

Wes Streeting: We could do a lot worse than taking the NHS to people. One of the things I was really encouraged by was actually in your neck of the woods—in Birmingham. I went and saw one of the diagnostic vans that is out and about doing screening, specifically because the NHS concluded that they were more likely to find the right people out in a busy shopping centre than they were by asking people to come to the NHS. On the particular day I was there, they had partnered with a local mosque, because they had recognised a real under-representation of the local Muslim community in accessing those services. So, as well as the people with the NHS there and the nice branded van, they had people from the local mosque there.

It is an irony of the NHS, having been built in no small part by the Windrush generation and having always had a pretty diverse workforce by average standards across the economy, that we none the less are not good enough at reaching into all communities. There is also a disservice based on poverty and deprivation.

So one of the things that I will be looking at very carefully, in terms of things like resource allocation—where services go and where funding flows go—is making sure we are doing a lot more on a needs-based approach, looking at health inequalities data and at deprivation data and making sure we have a focus on the right people, in the right places, to deliver

better health outcomes and to get rid of some of those baked-in inequalities.

Q65 **Chair:** My vice-Chair's question was also about rural communities. Could you comment on those briefly?

Wes Streeting: That goes back to my conviction on devolution, actually. I genuinely think that we will see better service coverage in all communities, but especially in rural communities, if those decisions are taken close to communities and close to people.

Q66 **Chair:** Many of the best-practice examples that you collectively have been giving in this session are primarily urban, primarily based on cities and towns. There is a general concern that the rural part of the country is less understood by your Department. Is that a fair challenge?

Wes Streeting: It is the right concern. I have been emphasising something in relation to the poorest performers in the country and the most challenged areas of the country; I can think about the south-west and Cornwall as an example. The areas at the bottom of the league tables today were also at the bottom of the league tables back when we were last in government and the NHS was performing at its best, with the shortest waiting times and highest patient satisfaction.

Okay, the service performance was better relatively than where it is today, but even in the context of a high-performing system, with really good outcomes and satisfaction, those communities were still challenged. That says to me that it is not a case of some bad chief exec we need to fire but that the way in which we are designing and delivering services needs to change.

That is why, much as I believe very strongly in a national health service—one of the things I need to unlock as Secretary of State is the untapped potential of the single-payer system on things like procurement, tech adoption and roll-out and that strategic leadership nationally—different services will necessarily look different in different parts of the country to meet different needs.

We must not overlook rural communities. If I may say so—this is not a tribally political point—one of the great things for me since the general election is that we have lots of Labour MPs who now represent rural communities. Within the governing party, we have those strong voices that remind us that even though those rural communities have some very lovely picture-postcard towns and villages, they often also have very significant levels of deprivation and health inequality. That exercises me, in terms of my values and your values on social justice.

Q67 **Paulette Hamilton:** I am going to stop you there because we are almost out of time. I have one more question, and I want to make it a good one. As you work towards establishing neighbourhood health centres, how will you ensure that having shared services at a local level, whether they be in the neighbourhood health centres or out, delivers on the needs of all health and social care partners?

As you know, and as I keep harping on about, the health part of the system tends to take priority. What tends to happen when you have shared services is that health tends to be the dominant partner. Going back to what Ben said, I am fed up—because I come from local government—of being the second cousin once removed.

Wes Streeting: I think that, between us on this side of the table and the representation around that side of the table, there is a lot of possibility in terms of how we can redress that imbalance between health and social care and health and local government. By conviction, we will definitely do that and see the sort of improvements that we want to see.

On neighbourhood health centres—services and centres are two slightly different things—we are really open to working on those. With our frontrunners across the country, we are going to be testing different approaches to the design and delivery of those services and trying to build on some existing core strengths and seeing what works. Down the line, by the way, we might decide that, over the next decade, we will have different horses for different courses anyway; I think that is fairly likely.

In terms of neighbourhood health services, the sorts of services available across health and social care should be consistent in quality, standards and reach across the country, and that is what we will be working towards. Tom, is there anything you want to add?

Tom Riordan: The Department not understanding rural areas as much as urban ones is not something that I have come across. There are really good practices in places—Hertfordshire, Surrey, Warwickshire and other rural areas—with really good integrated working, particularly with GPs and mental health services, at times.

However, I served all of Yorkshire for a large part of my career, and I am used to trying to balance that thing about rural versus urban, and smaller towns and coastal areas. The CMO's report on coastal towns is really important in that respect as well. However, I do think that the role of market towns is going to be really important in how we think about moving forward, in the context of what has just been said about driving people together, between health and social care. That is something that people can understand, and that is how people live their lives in those areas. Therefore, how we bring that together in a way that makes access to services easier for people in those rural areas is definitely something that we are looking at.

Paulette Hamilton: I am going to stop there and hand back to the Chair.

Chair: We will go to Gregory Stafford next.

Q68 **Gregory Stafford:** I am very pleased to see your commitment to Pharmacy First and to potentially expanding the role of pharmacy going forward. However, when I speak to national pharmacy leaders, and indeed pharmacies in my own constituency of Farnham and Bordon, they tell me that they are essentially under great financial pressure. Part of that, as Mr Robertson mentioned, is around national insurance

contributions, but part is down to the fact that negotiations on the contractual framework have not started. When is the Department going to start the contractual framework, and when will we see the terms of reference for that?

Wes Streeting: Stephen Kinnock will be starting that shortly in the new year. I do recognise, by the way, the fundamental point you are making: pharmacy is under enormous pressure.

I have been balancing things up when thinking about financial allocations. Before I even get to where I want to be on community pharmacy, which is even more ambitious—how we can get them to do even more prescribing, as they do in Wales; how we can expand Pharmacy First; and how we can alleviate pressure on general practice and reduce A&E attendance through better service from pharmacy—my No. 1 focus is first stabilising the system.

We have lost over 1,250 pharmacies since 2017, and we have seen a real-terms cut in funding for community pharmacy of 28% since 2015-16, so I absolutely recognise those pressures. I am taking that into account when thinking about allocations for the year ahead, and I definitely see, as does Stephen Kinnock, a bigger role for community pharmacy as part of the shift from hospital to community. I am carefully working through, with Stephen, the package that we will need to initially stabilise the system and create a more stable foundation from which to build a better future for pharmacy.

Gregory Stafford: I accept what you have said, and it is reassuring to hear that, but I think we need—well, I need—a little bit more clarity on exactly when that is going to come, because Community Pharmacy England has said that there will not be a community pharmacy sector left to deliver the contractual framework if your Government doesn’t get on with negotiations. Likewise, the National Pharmacy Association has voted in favour of collective action for the first time in its history. Clearly, the people you want to be delivering all this, who I agree should be delivering all this, are really concerned about their future, so can you reassure them now that they will get the funding they need, and on when they are going to get it?

Wes Streeting: As I say, now that we’ve got the budget set, we will be consulting with Community Pharmacy England shortly, in the new year. I do want to reassure pharmacists across the country that we are taking into account the enormous pressures they are under when we think about allocations, so that we can stabilise the system and create the foundations from which to recover.

Q69 **Gregory Stafford:** Expanding pharmacy and what pharmacies can do is the right thing to do. Where do you see the tensions with general practice? We had a meeting of the all-party group on pharmacy yesterday, and the BMA representative there, a GP, seemed relatively sceptical about not just your future ambitions but, indeed, Pharmacy First. How will you bring GPs on board with this?

Wes Streeting: The first thing I would say is there is plenty of work to go around. There really is.

What I am picking up—I have done for some time now—is, effectively, a competition between general practice and pharmacy, because people are worried about their own bottom line and their own financial sustainability. Whereas I see more activity in community pharmacy as an opportunity to reduce some of the pressure on general practice, GPs see it as a threat to their bottom line. Against the backdrop of under-investment in primary care and real pressures in both general practice and community pharmacy, that is rational, and we need to help them to address that.

I would also cite this as a really good example of producer interest. What has to come first is what is in the interests of the patient. How can we get them the right care, in the right place, at the right time, in the most convenient and accessible way and, for the taxpayer, in the most affordable and financially efficient way? I think I can help to take some of the tension off the boil by delivering on the shift from hospital to community and putting general practice and pharmacy on a more financially sustainable footing.

This is actually a very good characterisation of lots of the conversations I have had in the last few days in particular, and certainly since the Budget. At the same time as I am trying to manage the competing choices and trade-offs between GP and pharmacy, I also have the pressures in secondary care and the workforce, and I have the nurses, who are, totally rightly, concerned about the pressures in the nursing profession in particular. Every single part of health and social care is under enormous pressure at the moment. I am not going to try to boil the ocean with this budget, because it can't be done; if we try to do everything for everyone, everywhere, all at once, we will fail. But we will make the right strategic choices now that provide some stability and solid foundations from which we can help to recover the whole health and care service.

Q70 **Gregory Stafford:** I agree with you that the health and care system is under pressure. On that point, back in 2017 the Labour party said that 4,000 people were going to die if the winter fuel allowance was removed. What assessment has your Department done of how many people are going to die?

Wes Streeting: Because of the choices that the Chancellor has made, particularly on protecting the state pension through the triple lock, and even taking into account the decision she has taken on winter fuel allowance, pensioners will still be better off this winter than they were last winter and will be better off next winter further still. Of course, one thing that gives me the confidence to stand by that assertion is that she has protected winter fuel allowance for the poorest pensioners and put in place financial support, which I think will make a real difference to people.

Q71 **Gregory Stafford:** Sorry, Secretary of State—are you saying that not a single pensioner will die because of this?

Wes Streeting: I can stand by very strongly the sense that, because the state pension is rising in the way that it is, and because of the decisions the Chancellor has taken to protect the poorest pensioners, she has taken a decision that, I admit, is unpopular with people who have lost the winter fuel allowance, but it is not one that will lead to that fatalistic outcome that you just described.

Q72 **Gregory Stafford:** Putting deaths aside, do you feel it will lead to any extra pressure on the health and social care system?

Wes Streeting: I am not sure how you would disaggregate those pressures from all the other winter pressures we are seeing at the moment, but as I say, because of the protection the Chancellor put in for the poorest pensioners, including the maintenance of the winter fuel allowance for those pensioners, and because of our Government's commitment to the triple lock, which will see the state pension continue to rise, I think she has made a decision that is ultimately fair.

Q73 **Chair:** And that is for her to answer for.

Wes Streeting: Absolutely. It is hard enough being the Health and Social Care Secretary without being the Chancellor as well.

Q74 **Deirdre Costigan:** You will be glad to know, Secretary of State, that I am the last questioner today. Lord Darzi's report set out very clearly how, in their running of the NHS, the previous Government totally failed on the most fundamental requirement for the NHS, which is timely access to care. I think we had 7.6 million people on waiting lists, with more than 3 million of them waiting 18 weeks or longer.

You have set out a clear milestone in the plan for change: that you are going to put in place 40,000 more appointments every week—2 million a year—to cut down those waiting lists. You have now got the money—congratulations on getting that £26 billion from the Chancellor— for the NHS, but do you have the detailed plan that we need to actually make those 40,000 appointments happen? I am particularly thinking of constituents of mine work in Ealing hospital or up the road in Northwick Park hospital; what changes will they see in their hospitals that will mean that we can deliver these 40,000 extra appointments?

Wes Streeting: Yes, we came in with a clear plan to deliver those 40,000 more appointments. We are delivering. I said that we would deliver 40,000 more appointments every week—2 million extra appointments a year. I will commit now to coming back to this Committee after the first anniversary—well, I will be back here anyway. It's not a big deal that I am coming back next year—at least, I hope I'm coming back next year, otherwise that would be bad news—but I will be back after the one-year anniversary of this Labour Government, and I will confidently tell you that we have delivered 2 million more appointments over the course of our first year.

We are able to do that for a couple of reasons. First, when we came in—this is why the "there wasn't a black hole" thing really gets my goat—I came into the Department and one of the first things I was told by officials

was that, rather than delivering 40,000 more appointments every week, I would have to instruct the NHS to slow down and deliver 20,000 fewer appointments every week because of the black hole. Fortunately, the Chancellor and I put our heads together, and, thanks to the additional £1.8 billion that she provided to support elective capacity within this year, we were able to ramp up elective activity so that we can deliver on the first step that we promised the public. I am looking forward to being able to go back to my constituents, and yours, and say, "We said, and we did."

Then, on elective recovery more generally, investment is important—that is why the Budget was important—but so is reform. I talked about productivity at the start of the of the session. There are some brilliant places, like Guy's and Saint Thomas's, that are delivering as many procedures on a single Saturday as they would normally do in a working week, through reformed ways of working. That productivity improvement is really important. We are sending our Further Faster teams into the 20 trusts with long waits in areas with high levels of economic unemployment so that we can get people not just back to health but back to work, and that is taking that experience in.

Also, the £1.5 billion-worth of capital funding for additional capacity and new surgical hubs and diagnostic scanners will build capacity for over 30,000 additional procedures and over 1 million diagnostic tests. When you think about how 1.6 million on that waiting list are people waiting for tests and scans, that is a big dent.

It is not going to be easy over the course of this Parliament, and I would just gently remind everyone that, on the plan for change and the 18-week target, we are pledging to do something faster than new Labour did at the height of our success, and without the economic backdrop that new Labour had. That is why investment matters but so does reform. We will deliver on our commitment.

Q75 **Deirdre Costigan:** I have a quick question on that. You mentioned diagnostic tests at the weekend; how will you incentivise NHS staff to get involved in that kind of out-of-normal-hours working, particularly considering the levels of burnout that we see in the NHS?

Wes Streeting: Financial flows and incentives are really important in this system. First, for the extra evening and weekend working, we will pay staff overtime and we will make provisions for employers to be able to do that. Secondly, in terms of performance improvement across the NHS, we will build in some capital incentive for NHS leaders to drive up their performance, so there is some carrot there. That goes back to the point the Chair was making right at the top of the session. This is about incentives and freedoms for the top performers and support to improve for people who are lagging behind; and where we see failure, not because of contextual, systemic pressures but because we don't have the right leaders, we will take action to make sure we get the best leaders.

The final thing I will say—this will be something that I visibly lead on as the Secretary of State—is this: I want our best chief execs and our best

ED consultants in some of the hardest areas. When I talk about getting rid of rotten apples in senior management, I do not want our friends in the media who are watching—this is as much a message for them as for others—to go round beating up the best leaders who have been sent into the most troubled areas because after six months or 12 months they are still at the wrong end of the league table. Change takes time, and we have to change the culture so we encourage the best leaders to go to the hardest places, knowing that that will be a career enhancer rather than a career risk that sets them back, which is what happens too often. If you are an ambitious or aspiring chief exec, or a consultant, you might be thinking careerwise, "You know what? I'll go to one of our top-performing trusts. They've got the best kit and the best performance data. I will look really good, relatively, and my career will soar." We have to make sure, in terms of career incentives, that we also incentivise people to go to the hardest-hit areas, the lowest performers, so that we are genuinely taking the best people in the NHS to the worst parts of the system, to drive up performance and standards.

Q76 **Deirdre Costigan:** You mentioned overtime. I recognise that you are on unpaid overtime at the moment, because we have slightly overrun.

Wes Streeting: I'll send you the bill!

Deirdre Costigan: I have two final questions. We have an ageing population. It is great that there will be 2 million extra appointments a year, but how are you taking into account the ageing population and how will we keep pace with the level of appointments that will be needed, because of course that will go up over the years?

Wes Streeting: Demand management is really important. I cannot say this enough. The shift from hospital to community is so important because alongside the extra capacity to meet demand on the elective waiting list now, we need to manage demand. That is the variable that I am keeping my eye on in terms of getting to the 18-week target. It is one thing to say I am going to clear the current backlog, but I also have more people being added to the waiting list all the time, so the faster we can get to those people to make sure they get the right care, in the right place, at the right time, to divert them away from the elective waiting list, where clinically appropriate—that is where we have to get to. Too often we get people being sent into secondary care because primary care wasn't there for them when they needed it. That is why I genuinely see primary, community and social care as part of the answer to secondary care pressures, and the elective waiting list specifically.

Q77 **Deirdre Costigan:** This is my final question. We know that, after the last 14 years of Conservative government, we have 2.8 million people long-term sick and not in work. The IPPR report said that about 900,000 of them could work and would want to work, probably, if they got the support they needed. We published recently the plan to "Get Britain Working". How will your Department work with the Department for Work and Pensions to try to help some of those—potentially—1 million people to get back into work if they want to?

Wes Streeting: We were really pleased to work with our friends at the DWP on the "Get Britain Working" White Paper. They did the lion's share of the work and we played our part, helping them out, which is how I see this relationship. The NHS does have a contribution to make. As you mentioned, we have 2.8 million people who are economically inactive and have long-term sickness as their main reason. ONS analysis shows that from October last year to January 2024, 33% of working-age people who were economically inactive were on NHS waiting lists, in comparison with 19% of those who were either employed or self-employed.

There are two parts of this—this is the mutual relationship. Integrating health and employment pathways is shown to work. The Maudsley in south London provides one of the best examples of this. Integration of the work pathway and the mental health pathway means that they are supporting back to work people who otherwise would not have been able to cope and who frankly, if it had been a pure DWP pathway, might have risked making their anxiety and their mental health worse, because let's be honest—the DWP would say this— at the moment, that brown envelope through the letterbox sends shivers down people's spines. Being from a family that experienced that kind of thing with the old DSS, I understand how that feels.

There is a real benefit to us working together, and our new WorkWell centres are making a real difference. Liz and I saw this recently in Archway. That was a really good example of, not just health and the DWP, but local government and the VCS all working in a totally seamless way, to the extent that when I was looking round the table, I not only could not tell who was from which organisation, which as far as I am concerned is proof of real joint working, but I could not even tell which of the people sitting there had benefited from the service, because there were people who had received real support to go back to work. Some of them were already successfully back in work; others were trying. Looking round the table, I would not have known who was who, and I think that is a sign of success.

There is more to do. I do not pretend that health is the entire solution to unemployment, but it is a big contributor. Similarly, the work that Liz does on supporting people back to work through the DWP makes it less likely they will end up on an NHS waiting list.

Chair: On that note, we say thank you to all three of you for coming today. It is much appreciated. It is the first of many appearances, I am sure. We have been quietly keeping track of how many new year commitments you have been making, Secretary of State. We have them all written down, and we are certainly planning to be following up in the new year.

Wes Streeting: I would be happy to send Ministers along to answer any further questions!

Chair: Absolutely. It simply remains for me to say merry Christmas and happy new year, and thank you to all who are watching.

Wes Streeting: Merry Christmas and happy new year. I will see you in the new year.