

Health and Social Care Committee

Oral evidence: The Work of NHS England, HC 563

Wednesday 17 December 2025

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Watch the meeting

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

Questions 115-209

Witnesses

[I](#): Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care; Samantha Jones, Permanent Secretary, Department of Health and Social Care; and Sir Jim Mackey, Chief Executive Officer, NHS England.

Examination of witnesses

Witnesses: Wes Streeting MP, Samantha Jones and Sir Jim Mackey

Q115 Chair: Welcome to this special Christmas edition of the Health and Social Care Committee. We are delighted to be joined by the Secretary of State for Health and Social Care, Wes Streeting. Thank you so much for coming. He is accompanied by his two most senior colleagues: Samantha Jones, who is the relatively new permanent secretary at the Department—thank you for coming, Samantha. This is your first session with us, I think.

Samantha Jones: Yes.

Chair: Welcome. And Sir Jim Mackey—not quite as new, but equally important to this conversation. Thank you, all three.

It is an auspicious day, being the first day of industrial action by resident doctors at a time of significant concern and pressures across the system. We will, of course, come to these points later, but I will start by talking about something very close to our hearts, which is mental health.

You will all be aware that we recently published a report into community mental health services with a particular focus on severe mental illness. It of course surprises no one that we found many holes in the system and too many people being failed, but we also identified some solutions. I will start with the funding. The NHS constitution makes it clear that physical and mental health problems should be treated with equal regard, but the medium-term planning framework seems to suggest that the mental health investment standard is changing. No longer will it incrementally increase the proportion of spend at ICB level, but instead it will hold firm with inflation. Secretary of State, is that you addressing parity of esteem? Why have you changed the definition?

Wes Streeting: Since coming into office, we have increased mental health investment. In fact, investment in mental health care has increased by an extra £688 million this year, which has enabled us to hire 8,500 more mental health workers, deliver more talking therapies and roll out more mental health support in schools, as we set out in our manifesto.

There is a challenge with the mental health investment standard because of the investment we are putting in particularly around clearing the elective backlog. I think you heard in my previous evidence to the Committee that I am somewhat sceptical about input targets, which micromanage frontline leaders. We are trying to move away from that era of command and control across all areas of health. In mental health we have been too focused on inputs, without properly monitoring outputs and outcomes.

The Darzi investigation found that 109,000 children and young people were waiting more than a year for their first appointment with a mental health specialist, despite spending on mental health services increasing by over 50% since 2019. It will be the job of the new mental health director



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to reverse that dynamic, but that does not mean that we are cutting mental health spending—far from it. In 2025-26, all systems are forecast to deliver the investment standard as currently defined, and real-terms mental health spending is forecast to increase by £320 million. From '26-27, we have set out that over the next three years, ICBs will be required to meet the mental health investment standard by protecting mental health in real terms—in other words, rising in line with inflation. In addition to that—

Q116 Chair: Hold on. May I just stop you there with that definition? That is a different definition. I also point out that in that same session when you spoke about inputs, in the same breath, you also said that you were committed to maintaining the mental health investment standard—but the mental health investment standard was understood to mean that the proportion would rise in line with, if not higher than, overall spend. The spending review makes it clear that spending on the NHS is inflation plus 3%. Your new definition for the mental health investment standard is inflation plus 0%, because it is being held in real terms. That is what that means, right? Jim: have I got that right? In accounting terms, is that correct?

Sir Jim Mackey: I think the source of the confusion is that the spending review—in the medium-term planning and the allocations that flow through all that—just takes a baseline and moves it forward from a simple pro-rata percentage point of view on every line. That does not mean—

Q117 Chair: So it is inflation plus—every line—3%.

Sir Jim Mackey: Yes. You are right in that it has not reflected the pure mental health investment standard moving up through the spending period on every line, but in substance we are still maintaining the standard in next year.

The key is what we get from trusts and ICBs when they return their medium-term planning returns. We expect the shape of spend to have changed. It won't be exactly in line with the allocations in the medium-term planning framework. Then we work with people over the next couple of months to make sure that things are running properly.

Q118 Chair: Your definition of the standard is that you are holding spending steady.

Sir Jim Mackey: We have not changed the standard. You are interpreting from those allocations that that means something in terms of the standard. As I said, we have not changed the standard.

We are concerned about an overfocus on input measures and spending more being a proxy for better outcomes, because we don't think that is actually the case. I think it is generally not the case, in the way that we have been looking at things over the last few years. But we have not retired the standard, if that is the point.

Q119 Chair: Would you at least admit that the way it is being interpreted is a shift—maybe within its parameters, but it is a shift compared with last



year?

Sir Jim Mackey: In an ideal world, the spending review and allocations would have been in accordance with every specific standard on every line. It is just not the way it was done and agreed with Treasury. So allocations have gone out, but they are indicative. It basically says, "Here is the spending power. Here is what we want you to deliver alongside it." We expect, when everybody comes back on this and on neighbourhood care and other things, the pattern of spend to have started to change.

I have had a similar challenge on neighbourhood care in that in medium-term allocations we have not reflected our expectation of big shifts in spending line by line. That is what we expect, but we did not want to be as explicit as that in the allocations, because it is simply a formulaic, "Here is your spending plan."

Q120 **Chair:** The overall issue here, which we saw in the Darzi review and we see over and over again, is that—I hate the word "burden", but NHS activity spent on mental health is 20%, yet we know that the input of funding is, at the moment, decreasing, over the last couple of years, with overall spend. Now with this change, it looks like that is a possibility as well at ICB level. Am I wrong to think that the overall spend at ICB level will be, as a proportion, less next year than it is currently?

Sir Jim Mackey: No.

Q121 **Chair:** You are expecting the proportion will hold, at ICB level.

Sir Jim Mackey: Yes. As Wes has said, we are expecting to deliver the standard in '25-26. There has in recent years been a very significant increase in mental health spend, but we are all concerned about quality of services in mental health and public confidence, with some of the really big catastrophic events that we have all seen. We have been over-reliant on the input metric—

Q122 **Chair:** What are the new output metrics that you are planning to put in? From what we have seen, you have removed the accounting mechanism, so no longer do they have to account for the spend in the same way. We have also seen a reduction of mental health output measures. So what new output measures are you going to introduce?

Sir Jim Mackey: The new mental health leader, who was appointed last week, is going through clearance processes so has not yet been announced. They will lead a process where we refresh our view over time. The data in mental health is not as strong as it is in acute services. It is about how we get more of a focus on outcomes. I think what is really important in this—

Q123 **Chair:** Is waiting time standards one of the things they will consider?

Sir Jim Mackey: It will be.

Q124 **Chair:** That was a major recommendation in our report. There is a huge disparity between mental and physical.



Wes Streeting: We will respond to your report and keep it in mind as we are modernising our approach to mental health services. I do think it is somewhat of an indictment of how the money has been used that although we have put more money into mental health services, we have not seen an improvement in outcomes.

You are right as a Committee to scrutinise, and I think this is increasingly where we will find ourselves as Parliament, in NHS spending, as we devolve more power, resources and responsibility to ICBs and to providers, and effectively say, "We are going to judge you on outcomes." Parliament has a really important role, as will the Secretary of State and the Department of Health and Social Care and the NHS executive, for making sure that as they use those freedoms, that they use them well—so where is the money going? What are the outcomes for patients?

The final thing I would say on the measures is that although, as Jim said, we are not proposing to abandon the mental health investment standard or to change the definition, and you can compare what we are doing to that measure, there are some important elements of mental health spending that are not included. There is £473 million in capital funding available nationally over '26-27 to '29-30; that will support the establishment of 24/7 neighbourhood mental health centres and mental health emergency departments, known as crisis assessment centres. We are expanding neighbourhood health services, eliminating inappropriate out-of-area placements, and increasing crisis accommodation for people with learning disabilities and autism. Lots of that spending is not counted in the mental health investment standard. As we integrate more mental health and physical health services together in neighbourhood health centres and services, hopefully we will see a bit of a blurring of the boundaries between physical and mental health.

Q125 **Chair:** That is very important. You will have seen from the report that we are really inspired by the neighbourhood mental health centre pilots we saw. There are six of them, and we recommend that you increase the funding for the pilots, because we need that data. We need to work out what excellent looks like in all the different settings they are in. Our concern is that, because the election interrupted the funding cycle, they will not have the full 12 months, so I urge you to look at that seriously. We go as far as saying that we think they could be transformational across the country. We would love to see one in every community, but are you saying that if something like that happens, it would not come from the mental health investment standard money? Are the two not linked? I am confused by what you said.

Wes Streeting: The capital investment isn't. That is the distinction. We want to make sure that, from a patient point of view, there is increasingly less of a distinction between your physical health services and your mental health services where the two interact and relate together. I am always struck when meeting patients who may have received a really challenging physical health diagnosis or experienced a degree of trauma the distinction between how physical health services treat and see them and how mental



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and therapeutic services see and treat them. It feels quite separate, whereas they need to be joined up.

There are things like the Child House model to support child survivors of sexual abuse and provide joined-up care around the patient, which we are rolling out and announcing today. We also think about some of the experience that we have had with maternity services—families who have gone through some of the worst ordeals—

Chair: We will come back to that.

Wes Streeting: Yes. If you are a mother who has suffered birth trauma and injury, it is quite likely that as well as treatment for the physical scars you bear, you need therapeutic support. It shouldn't feel like you are accessing different NHSs, or different parts of the NHS. We have to join up services.

Q126 Jen Craft: I would like to continue on the theme of mental health for a minute. Turning to the review into mental health conditions, ADHD and autism, what was the thinking behind collating those three almost separate conditions into the one report? They are quite wide areas. I note that you are looking to cover children, young people and adults in the review. What was the thinking behind combining mental health conditions, ADHD and autism in the one report? Is the timeframe given—three to six months—enough to carry out the work needed?

Wes Streeting: You are absolutely right to draw a distinction—and we do—between mental illness, autism and ADHD. They are different sets of conditions, although we are increasingly seeing a relationship between them, not least because of unmet need or late diagnosis. It is not uncommon, for example, for people who have struggled to access their ADHD medication or have received a late diagnosis to experience a real deterioration in their mental health.

The reason to look at these three things together under the umbrella of a prevalence review is that we have seen rising demand for the different services. This is just a supposition—it is why we need a stronger evidence base and to pull the existing evidence together—but I think that we are seeing not just increased demand because of awareness about these conditions, but increasing prevalence of the conditions too.

Before we got into all sorts of political debates and wider public policy questions ranging from how we best meet the needs of these different patients, to what meeting those needs means for the education system, to how DWP responds to rising demand and what that support looks like, I felt it was the responsibility of the Department of Health and Social Care to provide an evidence base for understanding prevalence.

Q127 Jen Craft: Is the idea to understand what is driving a potential increase in prevalence or to understand if there is an increase in prevalence in the first place?



Wes Streeting: I think it is a bit of both; it is to understand what is going on, and the trends and the drivers. From a broader health perspective and how we think about our 10-year plan, first and foremost, prevention is better than cure. If we can understand the drivers of different physical or mental conditions and there are steps that we can take to prevent people from becoming unwell, we should do that—that is the first thing. Secondly, we are seeing lots of examples of unmet need across all three categories of patient.

Thinking back to my interview with Laura Kuenssberg, and being taken down the over-diagnosis rabbit hole, afterward I was flooded with correspondence from people saying: "Over-diagnosis? I can't even get a diagnosis." Clinical views range from, "There is certainly a degree of over-pathologisation"—which I think is probably the better term to use in this context and debate—to clinicians who strongly refute that assumption and assertion. The views are similar from patient and family perspectives as well. Then you get to the wider issues around the stigma surrounding these conditions. After my own experience with foot-in-mouth syndrome on Laura Kuenssberg, I felt that the best thing I could do, and my responsibility as the Health Secretary, was to establish better evidence so we can have a better informed debate, and to make sure from a policy point of view that we meet these needs.

Q128 Jen Craft: Is three to six months enough time to build that evidence base? This is a discussion that has been taking place for a number of years as to why demand is increasing. If you visit a primary school anywhere in the country, they will tell you that the uptick in the high needs base and SEND in general is quite significant. Is three to six months really enough time to grasp what is driving this and to get the idea behind it?

Wes Streeting: I think so. The approach I have taken with a number of these sorts of review is, "Let's go as fast as we can so that we can make progress as quickly as possible, recognising that so much of what needs to be done in terms of the public policy response relies on good evidence." But as I have also shown in other contexts, if I have set people a deadline that is challenging to meet, to the extent that it would impact the quality of the work, I am always open-minded and responsive. For example, on the NHS workforce plan, which we intended to get out this side of Christmas, the overwhelming view I had from trade unions, royal colleges and NHS leadership was, "If we take a little bit more time, we can actually produce something better." I would much rather get a bit of challenge at the Dispatch Box for taking a bit longer than we had intended than rush something. That is the assurance I would give you.

Q129 Jen Craft: Can we expect this to maybe drag on for longer than three to six months?

Wes Streeting: No, that is not the expectation I am setting. I definitely do not want the review team to think, "Oh great, we can kick back," but to be fair, the team behind this—not just our formal reviewers but the team of officials sitting behind this—are really keen to get stuck in, because we

recognise just how widespread public concern is about this and the degree to which families are really suffering.

As ever with so many things, it is not just about the person at the centre of mental illness or mental health crisis, or someone who is struggling to get the support that they need with autism and ADHD; it is about the whole family and the wider friendship group. I think this is something that touches a lot of people, and there is a clearly a lot of public concern. The Department's responsibility and mine is to ensure that we are informing public debate, so that we can start from a somewhat stronger evidence base than maybe I had when I answered Laura's question.

Q130 Jen Craft: I will briefly turn to something completely different—just to throw everyone for a loop. In the 10-year plan there is key messaging around poor performance carrying consequences in NHS trusts, which is something quite close to my heart. My local acute trust, Mid and South Essex NHS Foundation Trust, consistently scores “inadequate” on CQC ratings, including its latest well-led review, where it again scored “inadequate” and was downgraded from “requires improvement” to “inadequate” in A&E and paediatric care. Some of the findings from the CQC inspectors, including having to flag that someone was deteriorating in A&E, were truly shocking. It feels as though the impetus for change is placed in the hands of those who have potentially led the trust to receiving that rating in the first place. What kind of interventionist measures are available and what can be done for trusts such as this so that poor performance carries consequences?

Sir Jim Mackey: That is a good point and there are a few ways that we are going at this. First, we have refreshed the oversight framework to try and make it more rules-based and clear and make those performance and governance issues more transparent and consistent between organisations. That allows us to better differentiate who is in trouble and who is not. That is developing over time so that we can see when an organisation might look fine, but things are starting to go off in a certain area and we can get upstream and respond to that.

The organisation that you mentioned is one of a group of organisations that, if I am honest, over the last 20 or 25 years has been a cause for concern for various reasons. We have a bit of work going on to say that, if we are honest, our interventions have not really worked in those places. There are sometimes systemic or structural issues that we are not fully understanding. We will be having a discussion with Wes and the team in the new year about that.

Q131 Jen Craft: What does future intervention look like in this space? You are quite right, I have lived there my whole life, and I know that it is a couple of decades' worth of this being a failing NHS trust that does not deliver for people in the area. What does intervention look like to turn that around?

Sir Jim Mackey: I am not going to tell you specifically today because we are in the process of working this out and I do not want to jump to conclusions and do what we have been doing for the last 20 to 25 years.



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We have been relying on mechanisms that mobilise support teams and we escalate the organisation into different levels of oversight, they get improvement directors, and we send them people from the GIRFT team and that sort of thing. That works for a lot of organisations, but the evidence tells us that for 20 or 25, it just does not. That tells me that there is something else going on that we have not fully acknowledged. We need to be able to really nail that before we then start tailoring support and interventions for those organisations, which is what we want to try and do in January. There is a bit of a pattern for this group of organisations in that they are generally a bit more remote, often coastal, do not have the workforce supply that others do and so on—but it is not as simple as that.

Chair: A work in progress. Keep us updated. Thank you very much.

Q132 **Alex McIntyre:** I will turn to the maternity review being undertaken by Baroness Amos. Sadly, her initial findings will be all too familiar for Gloucester residents. The ones I have met told me about mothers being sat in bloody bed sheets without being changed and often not being listened to by their doctors, and sadly we have lost babies to avoidable deaths. That review will come in the new year. I appreciate you have not seen the findings yet, but will you give a commitment to implementing the findings in full? Also, what planning is now being undertaken by the Department to make sure that ICBs and local trusts have the capacity and resources needed to implement those findings at pace?

Wes Streeting: First, while we would never commit to something before seeing it, it is always my presumption in favour of implementing recommendations from reviews that we commission from expert people and teams. Otherwise, if you start with an assumption that you are not going to, then there is no point having the review in the first place. I will be up front, this investigation has drawn criticism, particularly from lots of maternity families that I have worked really closely with. The objective here was to establish, as rapidly as possible at the same time as producing a high-quality output, an evidence base for understanding the quality of maternity services across the country, because while there are certain services that have hit the headlines for all the wrong reasons and those worst cases, my concern is that maternity failures and poor standards are widespread. We have got to establish that evidence base.

Secondly, as Baroness Amos's initial impressions report highlights, we have been drowning the NHS in recommendations from a series of reviews. Having spoken to maternity leaders, frontline staff and families, one of the services that we can do as a Government is to help the whole maternity service see the wood for the trees, to give people clear and consistent direction about what the first-order priorities are to ensure safe care, and then to work through those issues methodically.

I have seen examples, including in Nottingham, which has been one of the most high-profile trusts, where frontline staff are being told to do one set of actions by the Ockenden review and were then given contradictory instructions by the CQC. That puts staff in a really difficult position. Which



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way do they look? Do they look to the Ockenden review? Do they look to the CQC? And then it causes real concern among families and the wider community because they are thinking, "Well, hang on a minute. Does this system know its"—I was about to use unparliamentary language—"backside from its elbow if people are being told to do contradictory things by experts in this area?". We have a responsibility to set out honestly to the public where the system is, and we have a responsibility to the system to direct it as to the key actions it can take and then to drive improvement.

One of the reasons why I am establishing the maternity and neonatal taskforce, chairing it myself and including everyone from staff representatives and the professional views right through to families and other experts is to make sure that we are keeping a focus on the recommendations and the progress. I have no doubt that the Committee will do that. Parliament should also do that, because—to be honest, we have seen this fairly widespread across the public sector—there is no point having lots of recommendations gathering dust on shelves and then just adding to them with more recommendations or more regulation. We have got to provide clarity and consistency, and then enforce progress and hold people to account if they do not deliver.

Q133 Alex McIntyre: On that taskforce, can I make a request? I recently met one of the brave whistleblowers who spoke out in the BBC "Panorama" documentary about Gloucestershire Royal hospital and the maternity failings there. To be quite honest, they were shut out from the internal investigations into what has gone wrong, and they were not listened to by the NHS. We know that the NHS unfortunately still is not where it should be in terms of listening to whistleblowers. When we have staff representatives, can we make sure that those who have taken the brave step of blowing the whistle are listened to as well as those who are currently in the system? Quite often, the people who have spoken out, or have left the service because they did not feel the service they were providing was safe, are then not listened to because they have taken that decision to step away.

Wes Streeting: That is a very good suggestion, and I will take that away.

Alex McIntyre: Thank you. I am going to hand over to Paulette because she has a question on maternity before I come back in.

Q134 Paulette Hamilton: Good morning, Wes. My question relates to the black maternal health report that was published yesterday. I want to start by thanking you because one of our objectives regarding morbidity was accepted and will be dealt with in the first quarter of next year.

My issue is around some of the others, but we have not got time for all of them now. The issue is, many of those recommendations were quite easy recommendations, such as the one relating to cultural competency training. To be honest, that should be mandated and should be quite easy to implement. Could you explain why that was not accepted in the report?



Wes Streeting: There are two things. Around 20,500 maternity staff have completed the e-learning module to date on cultural competency training. Work is under way to draft a new statutory and mandatory training competency framework for all NHS staff that will replace the core skills training framework. That will go live in April 2026. The reluctance to commit now to mandating that particular module for maternity is about considering it in the context of that wider work being undertaken. I wouldn't read that as a hard "no".

Q135 Paulette Hamilton: The only reason why I have questioned that one is because—and I will shut up soon because we are really tight on time—in October you introduced some training that is predominantly for consultants and other groupings. That training seems very bitty and very varied, it isn't co-produced and people don't know whether they are coming or going.

For me, if something is mandatory, it is then co-produced through yourselves at the Department, with the midwives and, as we have recommended, with families who are going through the trauma. Surely that would lead to a more inclusive piece of training; at the moment, everything that is there is all over the place, and you are adding yet another thing.

Wes Streeting: Without getting ahead of ourselves, the intention is to make sure because, to be honest, the issues around racial inequalities and discrimination are actually quite endemic across the NHS. When you look at the experience of our black and Asian patients and staff, as I have said before, we have a widespread cultural problem.

I would expect cultural competency to be included in the mandatory training competency framework for all NHS staff, and that is why there has been a reluctance to commit to something just for maternity, but I am very happy for us to continue this conversation and to get this right.

It may be that it is your view and the view of others that, regardless of what is being offered to all NHS staff, we have such an issue with maternity that we should have something that is maternity-specific. I am happy to look at that with you and then report back to the Committee.

Q136 Alex McIntyre: Let's move on to industrial action. Before we come to the BMA, I will start with the longest ongoing strike in NHS history now—the phlebotomists in Gloucestershire. What steps are you and the Department taking to resolve that dispute so we can get the phlebotomists back into work, where they want to be.

Wes Streeting: First, it is completely unacceptable that this strike has rumbled on for so long and this dispute has rumbled on for so long. As you say, it is the longest running in the NHS. I don't think anyone has really covered themselves in glory in this dispute.

When you look at the change that the trust was proposing to make versus the impact this dispute has had, one clearly outweighs the other. I won't say any more at this stage because my understanding is that the trust and



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Unison are in a very constructive phase of dialogue, and I hope that, in this season of good will, the dispute will end shortly.

I am very happy to pick this up with you in the new year if that is not the case, but my sense is that both the trust leaders and Unison desperately want to see an end to this. I don't think we are that far off. I should declare that I am a Unison member, by the way.

Q137 Alex McIntyre: Thank you. Moving on to the subject of the day, we have heard a lot about the strikes in the media and the decision by the BMA to go on strike. To push you on a slightly different angle, what steps are you taking to try to resolve the strikes even at this late stage? Also, what steps are you taking as a Department to protect patients, including those in my constituency of Gloucester?

Wes Streeting: I am not going to waste valuable time this morning relitigating what I have said very publicly and regularly on the BMA and my views on the timing of this industrial action, because they are well known. Jim, I and other senior NHS leaders met with the BMA yesterday morning—even at that late stage—to try and see off strike action this week.

Obviously those talks, which went on for about five hours, were unsuccessful. From where we are sat, we have two disputes: there is one on pay, one on jobs and the strike action that sits beneath them. On pay, our view as a Government is that we came in, we recognised the deterioration in resident doctors' pay over more than a decade and we felt that a 28.9% pay rise, covering the first three years, was real progress in the right direction for resident doctors. We were clear with the BMA that, with resident doctors having had two years in a row of the highest pay rise in the public sector, we could not afford to go further but of course we are willing to talk about future years. Those doctors have not done badly out of the DDRB's recommendations.

On multi-year deals, the problem that we have, which I think was reiterated yesterday, is that what the BMA is really angling for—and fundamentally, even though we put forward a really good jobs package, this is ultimately a pay dispute for the BMA—is a 26% rise in addition to the 28.9% that they have already had. When I challenged the BMA on the time period over which that could be delivered, there was a gap—a very wide gap—between BMA expectations and affordability.

There is also a fairness thing: I am responsible for 1.5 million staff in the NHS, not just doctors. We are in constructive discussions with Agenda for Change with a view to putting together a package that will include pay structure reform for Agenda for Change—Unison and RCN have been crying out for us to look at how we improve their members' pay, which has not improved as well as that of doctors, and whether we could do that in a multi-year deal. I cannot go higher with the BMA on resident doctors than I do with Agenda for Change staff; I do not think that would be fair, so we are kind of at an impasse on this for the moment. My frustration is that even now there will be doctors saying, and there have been doctors online



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who have said, "Look, the Government have done nothing on pay. They have not moved on pay." I do not think that seriously recognises how much we have done.

My disappointment is that we are obviously in violent agreement with the BMA on jobs, in terms of poor workforce planning and the bottlenecks. The package that we put forward was really strong, on not just making sure that we have more specialty training places—bringing forward 1,000 of those to the current round and 4,000 over the next few years—but the emergency legislation that we plan to introduce, which would deal with UK prioritisation of graduates for those training places, would have reduced the competition ratio from 4:1, where it is today, to less than 2:1. I thought that was a really good thing. I do not think that that message landed in the last week but, listening to the BMA reps yesterday, there is agreement between us and the BMA that that is a good thing to do.

Where does that leave us? For the moment, we are entirely focused on getting the NHS through the next five days of industrial action. In fact, I am probably just as, if not more, worried about the weeks that follow, frankly. The consultants who are getting us through the next five days are the same consultants who we would normally ask to put in extra shifts and extra effort to get us through what are normally peak pressures around Christmas and new year. As a result they are going to be more knackered. We have asked a lot of our consultants and I feel the weight of responsibility to and for them and other NHS staff.

It is dicey. I was at the operations centre this morning with Jim. We are off to a decent start but this is going to be a challenging five days and a really challenging few weeks. We are doing everything that we can to keep the show on the road. The most important message that I want us to convey collectively, as Parliament and the NHS, is to the public. I do not want people who need to access healthcare to think, "Strikes are on; I better not try." If it's an accident or an emergency, people should access A&E. If it's not an accident or an emergency but people require healthcare, 111, over the phone or online, will be there for people and direct people to local services so that they get the right care in the right place without adding to A&E pressures.

I hope that has given you a helpful overview of where we are with the BMA. On jobs, we are broadly in agreement but pay is too far apart. The sadness I feel—especially when I meet with Jack Fletcher, who is a decent person who cares about his profession—is that we are in agreement on so many things. If we were not locked in what is an increasingly difficult dispute, we would be making more progress together. These strikes are going to come at a cost of around £0.25 billion, with impacts on operational pressures, patients and the whole NHS workforce. I deeply regret that we are in this situation.

Q138 Gregory Stafford: To continue on strikes, the cost of July's industrial action was funded from existing NHS budgets. When Sir Jim was in front of us in September on strikes, he said, "but bearing the cost of that"—"that" being the strikes—"would be beyond our ability to cope with...It



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would be unreasonable for the NHS to do that, and it would have consequences on what we are able to provide.”

How much central funding has been given to the NHS to cover the strikes, both in November and now?

Wes Streeting: So far, not least thanks to the way that Jim and Elizabeth O’Mahony, the chief financial officer of the NHS, have managed the system to keep costs under control this year, we have been able to absorb the pressures and costs of strikes without directly impacting on frontline services.

Q139 Gregory Stafford: Is that correct, Sir Jim?

Sir Jim Mackey: Yes, so far. As of this stage of the year, financially, we are still broadly on plan. Elizabeth is in discussion with finance directors around the country about how we get some funding out into the system to recognise pressures—one of them being industrial action—without also doing what has happened in previous years, where whatever the cost is gets settled.

As Wes has said, there is no new money coming into the service from the Treasury or anywhere else, for understandable reasons. We have had to absorb it internally, and we have managed that so far. However, as I said last time, there will come a point where it becomes unreasonable to expect that to happen, but the services have managed it really well so far.

Q140 Gregory Stafford: But if money has been rightly saved in the NHS, that money has been spent on strike action rather than on improving services. Essentially, it has had an impact on frontline services, because that money could have been spent on improving x, y or z.

Wes Streeting: There is an opportunity cost—absolutely. That is why I think the strikes are ultimately self-defeating for the BMA and its members. I know that the sense from BMA members, reflected in the ballot—both in terms of turnout and the margin of the ballot response—is to give the Government a good kicking.

Gregory Stafford: I do understand that.

Wes Streeting: So it does have an impact on the opportunity cost, as you suggest.

Q141 Gregory Stafford: Therefore, going forward, given that there will probably be more strikes—I hope there are not—are you, Secretary of State, going to give a guarantee that in future the NHS will not have to find internal savings to cover these strikes?

Wes Streeting: We will have to keep the costs under careful review. I obviously talk to the Chancellor and the Prime Minister all the time about how we are managing the pressures in the NHS and the impact on services, so those will be ongoing discussions.

As we can see across the board, and this is one of the points that needs to be considered in terms of the choices and trade-offs we make as a



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Government, we are not awash with cash as a country. I cannot simply knock on the Chancellor's door and ask to access the reserve, because it is not in abundance. There is such a wide range of pressures on the public purse at the moment, on everything—from the defence of the nation to crumbling public infrastructure, through to the unavoidable and unexpected, let alone something like this.

That is the context in which I have asked resident doctors, as well as the wider NHS workforce, to understand that as a Government we are going as hard and as fast as we can to improve pay, terms and conditions and quality of services. Our job is made harder if we are locked in disputes and strike action that cost all of us, including doctors. As you have rightly pointed out, there is an opportunity cost of around half a billion pounds that has gone on funding strikes, which could have gone into funding a whole number of things that we and the BMA would agree on as areas to make progress.

Q142 Josh Fenton-Glynn: I am going to move to a different area; I am sure you will be pleased not to talk about industrial action for a bit. I am going to talk about palliative care. You will be aware that this Committee commissioned an independent expert panel to look into palliative care, and the report wasn't good news. The panel found that as a result of the reliance on charity funding and because there are no minimum service standards in ICBs, there is a postcode lottery in provision, with poorer and more marginalised communities often losing out. Is that a picture you recognise?

Wes Streeting: Absolutely. I want to be up front about the fact that one of the things I am worried about, particularly in relation to the hospice sector, is that in common with the wider voluntary sector we are seeing real pressure not only in terms of costs, but in the ability to raise money through regular individual giving, which is the bread and butter of so much of the voluntary sector. Particularly this part of the voluntary sector is seeing a real impact from regular direct debits going down and that sort of thing.

Even with the money that we have put into the hospice sector—£100 million already for the sector as a whole in capital funding, and £80 million in revenue funding for the next three years for children's hospices—it is really important that we as the public continue to support our hospices. The Government is developing a palliative care and end of life—

Q143 Josh Fenton-Glynn: Can I just pause you there? Your line there was that the public need to do more to support palliative care. That does not feel like a sustainable model for the funding of palliative care.

Wes Streeting: I will come back to that in a second. I am about to set out what we want to do with the modern service framework, which is linked to that. I think I have said this before: I am personally uncomfortable with the extent to which the hospice sector is reliant on voluntary donations as opposed to statutory funding. We understand historically why that has been the case and where the hospice movement



has grown from. But as someone who has benefited from the hospice sector in terms of end-of-life care for two of my grandparents—both of my grandmothers in the last 30 years—and the service that I saw at first hand, with the wider support provided by organisations such as Marie Curie with the hospice at home and palliative care nurses and teams that go into people's homes, when I look at that, that does not feel to me like a "nice to have". It does not feel like the extra boost that you would expect the charity sector to try to provide to help in the health and care space; it feels like an essential part of a modern health service.

But in common with some of the other things we are addressing this morning, there is some distance to travel between where we are and where we want to be. In loads of those areas, there is a cost attached and we have to manage our resources well. It is in that context that I say to the public that I want to be able to do more to help the hospice sector financially.

Believe me, if ever I spot a capital budget or a capital programme that is underspending towards the end of the financial year, or if there is an opportunity to invest more in hospices, I am like a magpie on this issue—I will swoop in and seize any opportunity I can to put more money into hospices. That was one of the reasons we put the £100 million in last year. On the £80 million for children's hospices over the next three years, the reason we did that was because Stephen Kinnock and I were determined to provide certainty for the children's hospice sector and get away from, "If the money is available, we will give it to children's hospices."

In terms of where we want to be and as part of the journey towards a better funded hospice sector, we are developing a palliative and end-of-life care modern service framework for England. That will be aligned with the ambitions set out in the 10-year plan. I can assure you that, as and when I am able to provide more resources for this part of the health and care system and family, I absolutely will do that.

Q144 Josh Fenton-Glynn: Okay. We will now move on to the workforce within that. There are currently 78 vacancies for palliative care consultants, or there were when the report was published, and that is on top of the 132 clinicians who are expected to leave the profession in the next five years. There have also been pretty bad training bottlenecks in palliative care—although they are getting better—but certainly for the last couple of years. We have a workforce crisis here. How close are we to solving it?

Wes Streeting: We are working on our workforce plan at the moment. As I said earlier, we are taking a bit more time with that because we want to get it right. This is consistent with the shift we want to see from hospital to community. We want to see more community-based teams. I want people aspiring to a career in the NHS, whether as doctors, nurses or other healthcare professionals, and to see the future of the NHS—where the action and excitement is—as being in the community, closer to people's homes and in people's homes. I think that particularly applies to palliative and end-of-life care.



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Sir Jim Mackey: Going back to the discussion with the BMA, this is part of what we want to try to do with the training system, which, again, we are in heated agreement on. We are trying to shift away from a system that prescribes nationally how many slots there are in certain specialties in specific locations. We are trying to make it more local, as well as trying to expand and make it more community-orientated.

Q145 **Josh Fenton-Glynn:** Just to pick you up on that, the problem with the postcode lottery, particularly because there are no minimum service standards in ICBs, means that we might have to have some form of direction on this to make sure that we are fixing that problem.

Sir Jim Mackey: The MSF will give us more structure to be able to direct more consistency of provision. I had a session with a hospice chief exec yesterday, and heard very clearly from them how hard it is to continue to function in the current world. She was working with two ICBs that had very different approaches as well, which is not unusual. We want to bring that consistency, as Wes has said, against which we can then hold people to account, and we can start seeing people commission a consistent model. Specifically, on the workforce model, if we can reach agreement with the BMA, this would be a specialty you would expect to see grow over time.

Wes Streeting: There is going to be a cultural challenge there. One BMA representative I spoke to in the context of the additional specialty places said, "Look, we want to know where these places are. What we don't want is loads more geriatricians in north Wales." Notwithstanding the fact that I am responsible for the NHS in England, I think that demonstrates to an extent where some of the thinking and culture is around future career ambitions. We will need more geriatricians; community is a good place to be; and—I declare an interest, as I have family in north Wales—I would quite like more geriatricians in north Wales, but I would like them to be all across the country as well.

Q146 **Josh Fenton-Glynn:** I will move you away from geriatricians in north Wales, because I want to get to the broader point. We have a workforce crisis. We have experienced staff leaving. We have what looks to be a postcode lottery in provision. We also have the Terminally Ill Adults (End of Life) Bill coming down the pipe, which has an auto-commencement clause after four years, whatever the state of social care. As Health Secretary, do you think it is safe to pass legislation with an auto-commencement after four years against this backdrop?

Wes Streeting: That is a decision for Parliament.

Q147 **Josh Fenton-Glynn:** As Health Secretary, do you think it is safe?

Wes Streeting: The Government is neutral on this.

Q148 **Josh Fenton-Glynn:** I appreciate that the Government is neutral. I am not asking you what you think we should do. Do you have safety concerns?



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Wes Streeting: I would like to make sure that, were Parliament minded to proceed with the Bill and see it through to completion and on to the statute book, we have high-quality palliative and end-of-life care services, so that there is a real choice and no one feels compelled to take up an assisted death through the absence of palliative and end-of-life care services. That is not where we are as a country at present.

Q149 **Josh Fenton-Glynn:** Do you think that auto-commencement puts that at risk?

Samantha Jones: Shall I come in?

Wes Streeting: Yes please, permanent secretary, save me from this line of questioning.

Samantha Jones: As you will be aware, the Bill is going through and we have 34 amendments from the Lords sponsor in the Committee stage. It would not be appropriate for us to pre-empt what is happening in Parliament for obvious reasons. However, we will, with the Ministry of Justice, ensure that Ministers are appropriately briefed on every aspect and every workability aspect of the Bill as we proceed. I do not think it would be appropriate at this stage to comment any further.

Q150 **Andrew George:** To continue on workforce, I will take you back to the statement you made to Parliament prior to the strikes. I raised this question with you: "If there was an agreement on training places and jobs, would you really withdraw that if the strike went ahead?", and you said yes. Is this not cutting off your nose to spite your face? If everyone is agreeing that that is the right thing—it is going to benefit the NHS; it is going to benefit patients—surely you can at least proceed with that while you continue your dispute over pay.

Wes Streeting: Well, there is both a jobs dispute and a pay dispute with the BMA. While we are in agreement about the need for emergency legislation and UK prioritisation of graduate places, it is a challenging place for a Government to be to implement an offer that has been rejected by BMA members. There have to be consequences for choices.

On my intention at this stage, recognising that once we get beyond the next five days and through what is going to be an extremely difficult few weeks, by my reckoning, between the time of the expiration of the BMA's mandate and the result of their current ballot for a fresh mandate, we have about four to six weeks to use—well, I hope—with the BMA to see if we can come to a resolution to this dispute. I think that would be in the interest of their members, patients and the NHS as a whole.

With that in mind, I think it would be my intention to continue as planned with the preparation for the Bill, to bring the Bill to Parliament, and to get it through as many of its parliamentary stages as possible with the time that the business managers have prepared for. Then, I hope, we would be in a position where we could see the Bill not just passed on to the statute book, but put into practice.



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I will want the BMA's agreement and I will want an end to the dispute for that to happen, but in the meantime, given that we know that the parliamentary timetable is packed and we know that it is not for Government Ministers to just assume that Members of both Houses will nod the Bill through and it will require scrutiny, I think it is important we let that scrutiny go through. I also think, by the way, having listened to what Jack Fletcher and his team said yesterday and having listened to some of the feedback from resident doctors, it is quite clear they have lots of questions about the detail.

The thing I have probably been most struck by, in listening to resident doctors over the past couple of weeks, is that even where they are in agreement with the Government, they still don't quite believe it is going to happen. I think that says something. There is just such cynicism about politics that actually having a Bill that is there in black and white, giving resident doctors the opportunity to see the benefits it would bring, might have a bit of a "seeing is believing" effect. When doctors realise they will actually be able to enter a new application round in the spring, and that this will make a material difference to their progression, it might just underscore again that this is a Government that genuinely wants to work with them on the many, many issues that we are in agreement on.

Q151 Andrew George: So it is not a total backtrack; it is a semi-withdrawal of the—

Wes Streeting: We are going to get the Bill ready, get it through both Houses—I hope—and if the BMA is in agreement with us and we can end this dispute, we will motor on.

Q152 Andrew George: You have said that the NHS would collapse without migrant workers, and that is certainly true throughout the NHS. How do you square the fact that the NHS would collapse without migrant workers with the Home Secretary effectively proposing to stop them coming?

Wes Streeting: Where we have been as a Government is recognising that, first, we want to attract international talent. That is certainly true in our health and care services, and I am very happy today to be going across to Unison's rally for migrant workers to personally thank people who give so much to this country and to our health and care services, and to underscore my appreciation and this Government's appreciation for what they do.

There is an over-reliance on international recruitment. I think that is reflected in the issues we have had with resident doctors on competition for places and the extent to which international medical graduates are competing on equal terms with home-grown talent. We are dealing with that. To be honest, it was reflected in the comments of the leader of the Green party. Aside from his characterisation of care work, he was effectively saying that care work is hard work and low-paid work, so it's not for us—it is for people from overseas. I really reject that. That is why this Government is improving pay and conditions and putting in place a real career structure for the care workforce.



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What I want to see is a care profession, because whether you were born in Brixton or any other part of this country, or you have come from overseas to work in our health and care services, you deserve good pay, good conditions, rewarding work, job satisfaction and the opportunity to progress in a career. I want to end the kind of culture that says, "If it's hard work and low-paid work, that's not for people like us who are born here. That's for foreign people who we can give low wages to and exploit." I don't think that is right.

Q153 Andrew George: Until that happens, and until our own workers are prepared to take on these jobs—fundamentally, we are talking about jobs involving minimum wage and very hard work, in both social care and care work—we will still be dependent on migrant workers. What are you saying to the Home Secretary to make sure that that supply is not stopped?

Wes Streeting: We are working closely with the Home Secretary. On the principle of what the Home Secretary is driving towards, there are a couple of things. First, she wants to make sure that we are controlling who goes in and who goes out and that we are recruiting the people that we need—no more and no less. Secondly, she wants to make sure, in terms of some of the illegal crossings, small boats and abuse of our asylum system, that we are reducing some of the pull factors to the UK. That is what the Home Secretary is driving towards.

Q154 Andrew George: I don't want to stray into other areas like asylum. You are talking about decent pay and decent working conditions. In order to achieve your shift from hospital to community, one of the big problems—in terms of your future workforce plan, which we look forward to seeing—is ensuring that the jobs are attractive enough to build the workforce to enable that to happen.

At present, we are really struggling in that sector. There are many district nurses and community nurses who work their socks off throughout their lives and still end up on band 5. Given the level of professionalism that you are requiring from them, as clinicians out in the community, how can you ensure that you can build a workforce on that basis?

Wes Streeting: That is a very good point. Part of the conversation we have been having with the Agenda for Change unions has been around pay structure reform. Nicola Ranger at the Royal College of Nursing, in particular, has been banging the drum really hard on the issue of the professional status of nursing, recognising the enormous contribution of nursing to the NHS and recognising the value of nurses wherever they work in the NHS. Part of what we are currently talking to the RCN and the wider Agenda for Change family about is looking at this band 5 to 6 issue.

More generally, as I said to Josh earlier, I really want people who are thinking about a career in the NHS to imagine not just working in a hospital or a GP practice, which is what lots of us who are muggles and do not work in the NHS might instinctively think about, but in community-based teams. Some of my favourite NHS staff shadowing has been with district nurses, and I really want to see that part of the nursing profession, in particular, grow and flourish. I really want people who aspire to be



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nurses to imagine themselves not just on a ward or in a practice, but out there in the community and in people's homes. I have seen it at first hand. It is remarkable work, and it impacts on such a wide range of people—often not just the patient in front of you, but the wider family, whether that is the conversation I heard one district nurse having with the wife of a husband whose mental health, as well as physical health, was really suffering, and the burden on her, right through to the district nurse who was holding the hand of loved ones in the final hours of life.

Chair: You may well find a letter on these lines might be coming your way in the new year.

Q155 **Dr Cooper:** I want to continue where Andrew left off, on the workforce. Secretary of State, it is great that you are so incredibly keen on community, so let's stick with the left shift. Can you outline how you are developing our prevention workforce, both in and out of the NHS? I am thinking specifically of that community workforce, but also our voluntary and community sector and our public health workforce, which I appreciate is in another directorate, but is still intrinsic to what we are doing.

Wes Streeting: Yes, in a few ways. First, we have worked hard, particularly as a ministerial team, but also with the new leadership on the official side in the civil service in the Department and in the NHS executive, to improve and build on the relationships we have with local authorities and local government—particularly directors of public health, DASSs, DCSs, and even some of the place-based directors in local government—to make sure that we are implementing health in every policy in local government. They are part of our workforce planning and that conversation.

Dr Cooper: Are they part of your funding planning? This is absolutely a conversation that nobody disagrees with, but you will appreciate that the funding is still going into the acute sector. I very much realise why that is the case—because we have failed to prevent people getting sick for so long, and we have a massive acute problem now.

But in terms of looking at the funding, at what point are we going to be able to look at the funding and see parallel funding tracks running? For example, when I am going to be able to look at public health funding and say, "Okay, that has some teeth."? When is the community funding going to look—it will never be comparable to the acute sector, but when will we start seeing a significant difference in the funding streams?

Wes Streeting: In terms of the public health grant, we have been protecting the public health grant and increasing it to recognise the invaluable work that local authorities do.

On the prevention side, we have been pulling a whole range of levers at the centre of government, from changes to the law and regulation, whether that is getting the smoking Bill through Parliament, or action on obesity and targeting of junk food and those sorts of policy levers, right through to the Chancellor's decision to introduce a gambling levy. That



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was brilliant in terms of lifting half a million children out of poverty—there is prevention for you, right there; primary prevention—but also from a health point of view. Regardless of its role as a revenue raiser, raising that money also helps us to tackle gambling harms as well.

This is kind of in common with some of the other lines of questioning this morning. There is no shortage of things we could do with more money. We have got a finite pot; we have to manage our resources well.

Q156 Dr Cooper: Again, just to press you, I appreciate that it is very hard to reduce the spend in the acute sector—I am not naive to that—but at what point during the course of this Parliament will we be able to say, “Okay, there are significant resources going into the community sector”?

Public health is massively under-resourced, and I appreciate the increase. Is there a sort of progressive economic plan within health to say, “Okay, we are going to have to run parallel tracks, and that will mean that the acute sector is either going to have to take a hit”—I don’t know how that is going to happen—“or we are going to have to redistribute our resources somehow”?

Sir Jim Mackey: We should see this start to come back through medium-term plans. There are a few tricky elements of it. We have introduced this unbundling of the block contract that starts to allow the flow of block funds in urgent care into hospitals to start being released, so that if the care is provided somewhere else, that part of the service can get the investment.

There is always a bit of a timing thing here, where you would ideally like the investment to go in and then start to see the flow fall out. But again, I think our history of this in the NHS is not great. When we have tried this before and made up-front investments, it has often not been related to shifting flow into hospital, so we have ended up increasing costs. What we are expecting to see is ICBs, in their plans, start to set out small steps on neighbourhood care, prevention and using the unbundling of a block to start—

Q157 Dr Cooper: That is in their role as strategic commissioner—that is what you are expecting to see.

Sir Jim Mackey: Absolutely. And then to start seeing patients being treated in other settings. That reduces income into the hospital sector and fuels further investment in community services. The hard bit is going to be the first 18 months or two years of it, as we start to get things off the ground, prove the work—

Q158 Dr Cooper: I do not disagree, Jim. It is an incredibly difficult thing to do. It has been talked about a lot before and it has not happened. You will appreciate that we are going to keep asking and see if it actually works this time.

A specific area we looked at as a Committee in the world of prevention and clinical services was sexual health services. It was a pretty damning session, to be absolutely honest. The whole thing is commissioned piecemeal, and the clinicians, managers and providers that run it all said



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that it needs to be overhauled. Jim, when you have been in previously, I have expressed concerns about some public health functions at least in local authorities that essentially are clinical, to a greater or lesser extent. Sexual health services very much feel like an actual case in point here. I wondered what your thinking was around this area. I assume you have read our report.

Sir Jim Mackey: You are right. I will say what I have said before: when I have been responsible for running those services, it is very hard to work out who funds what, how the money works, who works for who, and so on. It is similar to palliative care, as a real patchwork around the country.

Q159 **Dr Cooper:** I appreciate that, Jim, but you are the people to solve this. Rather than admiring the problem, I wonder whether you would like to suggest any solutions to this issue, Wes?

Wes Streeting: There have been a few things so far: first, to appreciate and respect through actions, not just words, the role that the voluntary sector plays in the provision of sexual health services. In my early weeks and months in office, that meant, for example, making sure that when we contract, we recognise the actual cost provided by the voluntary sector and not see them as a cheap and easy option, trying to short-change them in the way that I think has happened over the years.

We have had a big focus on HIV with our HIV action plan, which I am particularly proud of. More broadly, UKHSA has been leading work to review our collective approach to sexually transmitted infections. As part of that work, it published its STI prioritisation framework in October 2024, which will allow local systems to work and identify what combination of interventions to focus on, recognising that there is different prevalence and different needs in different communities in different parts of the country. We have rolled out the world's first vaccine programme to prevent gonorrhoea, and clinical guidelines have been published by BASHH to enable doxycycline to be used as a post-exposure prophylaxis for the prevention of syphilis, or DoxyPEP. Please do not ask me to explain the science.

Dr Cooper: Wes, that is great, but we have heard all this in the session—

Wes Streeting: I think that at the heart of your question, Becky, you are asking—

Dr Cooper: I am asking about commissioning the services—it's a mess.

Wes Streeting: Is local government the right place for this sort of public health work? So far, the answer has been yes. It is a finely balanced argument, and there are some decent arguments for taking some of those services back into the NHS. I know that is where you are pushing us—

Q160 **Dr Cooper:** I am just looking for a sensible way to commission. At the moment, bits of sexual health services are commissioned here, bits commissioned there, while some clinicians can do some bits and some clinicians cannot do some other bits. It is not a sensible or holistic way of



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looking at—

Wes Streeting: I think that that is a fair challenge. We should come back to you on that in more detail. We will go away and take up the challenge.

Q161 **Dr Cooper:** Great. Have a think, read the report—lovely. In terms of alcohol, Wes—happy Christmas—will you briefly outline how, as a responsible Government who prioritises people's public health, we can protect people from harm, while supporting pubs to thrive?

Wes Streeting: That is a good challenge. The problem with alcohol is excess generally in terms of tackling things like obesity, and in terms of good health, whether liver health or otherwise. We have a particular challenge with problem drinking and people who drink to the point of dependency or addiction. We should draw a distinction between those things. Pubs are a good thing, and they are a good thing for health. That is not just my view; it is the view of the chief medical officer, no less, because pubs, like other community spaces, provide a place for people to come together and socialise, which is a good thing from a health and wellbeing point of view.

Q162 **Dr Cooper:** Great. I think we have established that the cheap alcohol in the supermarkets is the problem. Are we going to tackle that?

Wes Streeting: You are leading me towards minimum unit pricing.

Dr Cooper: Excellent. I am trying to be quick because I want to ask you about the gambling as well, so go on.

Wes Streeting: It is a debate worthy of our time and Parliament should get stuck into it.

Q163 **Dr Cooper:** Okay. Very quickly, should we ban online advertising for gambling?

Wes Streeting: That is a matter for my colleagues at DCMS.

Q164 **Dr Cooper:** But we have a health view on it.

Wes Streeting: I have a health view on everything. I make sure that they are always put across in cross-Government discussions. There are choices and trade-offs. I am not aware of any plans to take action in that area.

Chair: I urge you to keep reading our work on that issue.

Q165 **Danny Beales:** Following up on sexual health very briefly—I thank my colleague for raising it—you are right, Wes, that the tools are there now. We have PrEP for HIV, DoxyPEP and vaccines for hepatitis, gonorrhoea and Mpox. We have a range of tools. We should be winning the battle on sexual health, which is a perfect example of prevention over cure, yet rates of many STIs are still going up and there are still huge, and in some instances widening, inequalities. As you and Dr Cooper have mentioned, fundamentally the system is fragmented. In 2019, this Committee recommended a new sexual health strategy. The previous Government

never delivered it. In 2025, we have again recommended an updated sexual health strategy to bring the system together and build on the prioritisation framework that UKHSA have produced. Do you think it is time for a system-wide strategy on how to realise the potential of these prevention tools?

Wes Streeting: I certainly think we need to take up Beccy's challenge of thinking about how we are organising ourselves in the commissioning and delivery of services. You are absolutely right, Danny, to make sure that, as we are thinking about that, we are focused on outcomes, rates and effective access to treatment. We also have to do much more on the prevention side. I would be very happy to work with members of the Committee on that, not least given your experience in this area before you entered Parliament.

Samantha Jones: I would add that one of the elements behind bringing together NHSE and DHSC is to bring policy and delivery closer together. The regional directors of public health are very much part of the NHS delivery to try to bring this bit together. We should definitely come back, because it is more about it being done locally rather than from a national perspective. It is about bringing together the health and local government element.

Q166 **Joe Robertson:** Secretary of State, as you will know, the Alzheimer's Society and the *Daily Mail* are refocusing attention on dementia. Part of the fight against dementia is ensuring early diagnosis and ensuring that there is not inequality across the country in terms of diagnosis. It is a really important campaign. What can you do, and what are you doing, to improve diagnosis of dementia early and to improve dementia care generally?

Wes Streeting: That is a great question. One of the areas that I think we can be really optimistic and excited about is the science that is taking place in this country, which is helping us to better understand dementia and conditions like Alzheimer's and the brain more generally. I think we will see real breakthroughs over the next decade.

None the less, in the meantime, we should be honest about the fact that the health system has struggled to support those with complex needs, including those with dementia and their loved ones. Through the 10-year plan, people living with dementia will benefit from improved care planning and better services. By 2027, 95% of those with complex needs should have an agreed care plan.

We are also going to deliver the first ever modern service framework for frailty and dementia to deliver rapid improvements in the quality of care and in productivity. That will be informed by phase 1 of the Casey Commission, which is expected shortly, in 2026. One of the advances we are making through the NHS app, which will also have wider application, is the "My Carer" tool. That will enable those looking after their loved ones with dementia, with permission, to make sure that decisions are agreed and taken with and by those who best know the patient, where patients



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may not be able to take those decisions independently. In terms of the experience of the person who often carries so much of the load of loving and caring for someone with dementia, hopefully we will recognise the status of that person more clearly and help them to better manage the care of their loved one as a partner in their care.

Q167 Joe Robertson: Turning to something different, you are currently planning puberty blocker trials—testing on hundreds of children who will receive drugs to alter their sexual development. You have said that you are uncomfortable with that, but you are in a uniquely privileged position to do something about it. Will you ensure that no children are tested on by having drugs that alter their sexual development?

Wes Streeting: As Health and Social Care Secretary, as a general principle, I follow clinical advice, and wherever possible I try to resist pressure—wherever it comes from and whatever the issue—to overrule clinicians who are better qualified than I am to make clinical judgments about the provision of health services. That is not to say that I cannot or would never, but there has to be an extremely high bar for me wading in in that way, because I think that would set something of a precedent.

On this issue—probably more than on any other issue that I have had to make decisions on as Health Secretary—I have thought long, hard and carefully, and continue to do so, about what the right thing to do is. That started when we were in opposition; we supported Sajid Javid commissioning the Cass review. I think that is one of a number of things that he did in terms of asking the right questions and being prepared to get into this area, which I think has led to a positive legacy and impact after his term in office.

The Cass review recommended a ban on puberty blockers. My predecessor, Victoria Atkins, put in place a temporary ban. I not only upheld that temporary ban; on clinical advice, I made it a permanent ban. The Cass review also recommended that clinical research be carried out because of a lack of evidence. Part of the pathways trial, which will involve around 3,000 young people, looks at a whole range of therapeutic support and interventions that are not at all related to puberty blockers.

In the case of puberty blockers, Cass recommended research in this area. Approval came only after extremely rigorous safety checks and with multiple safeguards in place to protect young people's wellbeing, including clinical approval and oversight, and parent approval as well. There are strict eligibility criteria in place along those lines. Through the decision-making process, the decision to put a young person on the trial must then be ratified by a national multidisciplinary team and there will be close observation. As part of the trial approval process, it went through extremely extensive ethical approval processes. That is the base upon which NHS England has commissioned the trial and authorised it to go ahead.

Q168 Joe Robertson: I understand, and of course it is right, that you upheld the ban on it originally, so if this trial is to go ahead, it is on your watch



and with your consent. There is an alternative. The primary outcome measure of these tests, we learn, is a survey of children, some of whom have had body-altering drugs. There are already thousands of children who have had those. Why can they not receive the survey—the primary outcome measure of these new tests—and form part of the research?

Wes Streeting: Joe, part of what Cass recommended and what will be undertaken is exactly that sort of research into people who are older and have undergone that kind of medical treatment or other sorts of support, from therapy through to other support from the NHS, to understand their outcomes. At the heart of the decisions I have made to date, I have had two things in mind first and foremost: first, the safety and wellbeing of an extremely vulnerable group of children and young people; and, secondly, ensuring I am following clinical and expert advice and evidence.

On the decision to uphold the ban and then turn it into a permanent ban—

Q169 **Joe Robertson:** It is not a permanent ban, because you are allowing a test so that children who have not received drugs so far will do so on your watch.

Wes Streeting: A permanent ban on the prescription of these drugs outside a clinical trial. I have been challenged, because I have said, in both instances, that I was uncomfortable about the ban and I am uncomfortable about the clinical trial. Both those statements are true and consistent. When I put in place the permanent ban on puberty blockers, I was confronted with a whole group of young people and their parents who looked me in the eye and told me that I was doing real harm to them, their lives, and their mental health and wellbeing. Those are not comfortable conversations. At all times, I have had to weigh up whether withdrawing access to this drug or enabling access to it is likely to do more or less harm, depending on the choice that I have made. That is the sort of consideration I have had to make.

Q170 **Joe Robertson:** I get that it is tough. Can I ask you a question about a subject that is about public policy—the potential for a lower age limit, under which no child can consent? In law, no child under the age of 13 can consent to sexual activity because they do not have capacity and do not understand what it means. How can children under 13 consent to body-altering drugs that will change or even block their sexual development, potentially forever? How can they possibly have capacity to understand what that means? Will you consider a lower age limit, by which no child can receive those drugs because they cannot consent?

Wes Streeting: Two things. First, no child in this study is able to give consent and therefore be a participant in the trial and receive puberty blockers. In order to participate in a trial, a young person would need to give informed assent by repeating back to the clinician what the risks are and why they would want to go through them. It is the child's parent or guardian who would need to provide informed consent. Absent that, a young person would not be eligible to participate in the trial. I absolutely agree with your assertion that a young person cannot give consent. What they would be required to do is give informed assent, and it is for the



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parent or guardian to provide consent. Absent that, they cannot participate in the trial.

By the way, I am also very happy for Parliament to continue to scrutinise, debate and discuss. These are finely balanced judgments, and all the way through I have had to weigh up the risk of harm to children and young people. That is why it is not straightforward, and why I have lent on clinical advice from people far more qualified than us to make these decisions. This is not easy, and it is not a comfortable decision. It is one that I wrestle with daily.

Q171 Chair: Thank you very much. I need to move on to scandals. It is linked, of course, to the merger that we are seeing between NHSE and the Department. My first question is very simple: are we ever going to get an answer to the Hughes report, Secretary of State? It has been two years.

Wes Streeting: Yes, you are.

Q172 Chair: When?

Wes Streeting: We are working with our colleagues at the Cabinet Office to address a whole number of issues from the Hughes report. Obviously, work on infected blood is now well under way, but we have other issues, particularly about the vaccine-injured community. There are a whole bunch of patient groups who have been failed by the NHS historically.

Q173 Chair: Yes, that is what I am trying to come to, but the Hughes report was meant to be a blueprint, particularly for the redress part of this. As you know, there are many suffering from Primodos, which is a historical injustice that is not yet recognised, I think, by the Department as being the injustice that the victims describe it as, and there are many others. The reason I am asking specifically about the Hughes report is because that was the beginning of the process.

Wes Streeting: Yes, I appreciate that. We have committed to progress on initiatives to improve clinical service provision before the second anniversary. We are beginning to see progress already on both sodium valproate and pelvic mesh, but in terms of broader redress I would put this under the same category as a number of other patient groups that we are dealing with where there is a cost attached to it and there are choices to be made across Government. We are working with colleagues in the Cabinet Office in particular to make sure we have a consistent approach to remedying these sorts of injustices.

Q174 Chair: They do have a lot in common, don't they? There are three broad areas. The first is that patients feel unheard, which is often where the problems begin. They also want it never to happen again, and they want investigations to happen in a timely way where recommendations are actually implemented. The third part is the redress scheme. Once those investigations have been established, which they often are, patients then have to fight all over again to get any kind of compensation beyond a mealy mouthed apology, which, frankly, does not do it for them.

Wes Streeting: I couldn't agree more.



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Q175 **Chair:** Would you agree that those are the three main areas, and is the idea to link those up? At the moment, they are just not linked up.

Wes Streeting: Yes, and to be honest, it is the third issue of redress that so often causes the hold-up. The reasons for hold-up are, more often than not, financial. The reasons for hold-up are because responsibility sits across different Government Departments. I say this by way of explanation rather than an excuse, as you can probably—

Q176 **Chair:** We spent £3.1 billion on clinical negligence claims in a single year. Some of that money could be diverted if the other three parts of the system were working well.

I have a question for Samantha. One of the Dash review's recommendations is that Healthwatch should sit under you. That has raised concerns. You have been written to by 138 local Healthwatch providers, which pointed out that at the moment Healthwatch is completely independent. That is one of its strengths, because people who do not trust the Government and people who do not trust the NHS, quite often because they have been failed, feel that there is somewhere completely separate that they can go where their voices will be heard. You did answer their letter, Secretary of State, and much of what you have said they agree with, such as saying that it should be closer and the patient voice needs to be embedded. I do not think anyone disagrees with those principles, but you did not at all address the point about independence.

My question to Samantha, given that you are the one who is going to be running this as part of your Department, is: how are you going to ensure, if that is the way you are going to go, that it will maintain its independence? That is the point I do not feel has been bottomed out yet.

Samantha Jones: I think Dr Dash's review was very clear that the landscape around patient safety is cluttered. The review said that we must be very clear about who is accountable for patient safety and who is accountable for regulation, and that we must ensure that an independent mirror is held up. Of course, the CQC is an example of that.

As we design the future Department of Health and Social Care, which we are starting to do now, we have a very clear requirement to ensure that the patient voice and the independence of the patient voice is incorporated in our approach to patient safety as we move forward. I am very happy to come back to the Committee as we progress over the next year with more details to demonstrate how that independence is happening in practice.

Q177 **Chair:** It is a work in progress. However, there is another area where independence is also being questioned, and that is investigations. You will be aware that the HSSIB was set up following the aviation model. It is relatively nascent; it has only just started. Again, as part of that review, the plan is for it to sit under the governance of the CQC.

You will understand people are concerned, and I share that concern personally. If it is sitting under the same governance, how can we be assured that it is completely independent? In the aviation industry it is

completely independent and, by way of example, the HSIB, its predecessor, which was not on a statutory footing, did criticise the CQC as part of its investigations.

Investigation is not regulation; the two are not the same. Regulation is meant to stop things from happening in the first place, while investigation is what happens after there has been an issue. How can you be completely assured that, by having the HSSIB sitting under the CQC, there will not be inadvertent conflicts of interest?

Wes Streeting: The first thing to say is that we are not going to incorporate HSSIB into the CQC until the CQC is in a fit state to receive it. Secondly, we will make sure, through the governance arrangements and accountabilities, that we do not lose that sharp focus on investigation and the expertise that HSSIB has, which I am determined to protect.

Chair: Do you understand the issue about independence? You did not actually answer that.

Wes Streeting: The CQC is independent and is the independent regulator.

Chair: But it needs to be independent of all parts of the system, because if the CQC itself is the problem—which you have pointed out that it has been at points—how can we be assured that the investigative arm is not in conflict with one of the arms that it should be investigating?

Samantha Jones: We are very well versed within the Department of Health and Social Care, as you will appreciate, in having inquiries and independent inquiries that are part of, but separate to, the delivery and oversight of care. Your point is absolutely well and truly understood. As the Secretary of State has said, the CQC is independent, and we will ensure that how we run inquiries—for example, within the Department—is also done in terms of the lessons that the CQC have learned, making sure that there is independence, which is the point that you are making.

Q178 **Chair:** But HSSIB is not the same as the inquiries made under the 2005 Act.

Samantha Jones: No. I was using it more as an example of how we can do both things at the moment in the Department, and we will ensure that that is the case within the CQC. It was an example.

Wes Streeting: The principle here is that there are tons of checkers in the system. We need a few more doers, and we want to streamline to make sure that we have the right people doing the right jobs and diverting as much resource to the frontline as possible.

Q179 **Ben Coleman:** I would like to move on to a different area, which is mostly going to involve questions for Sir Jim and Samantha, to give Wes a break. It will be about PFI and public-private partnerships. The plan is to build 250 neighbourhood health centres, with 120 operational by 2030, the vast majority via a new PPP model and costing around £1 billion. Of course, a lot of money was spent on buildings for health and other services with the



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private sector under the old PFI model, and I am very interested in understanding what we have learned from what went wrong before.

My question is this: can you set out what you, in the Department and in NHSE, have learnt from what went wrong with PFI? If you can reassure me on that point, I will feel much better about the next stage as you take things forward with the PPPs.

Sir Jim Mackey: We are all keen to avoid repeating the problems of the past, so the model that is being developed through discussions with the Treasury—

Ben Coleman: I am going to stop you right there, because I thought you would say that. I am not going to ask you about the model; I would like to go one step back. What were the problems that you found with PFI that the new model is trying to address? If you could start with the problems, and then we could talk about how the new model would address those, would that be okay?

Sir Jim Mackey: Yes—if you don't interrupt me again, I will try to explain it. In the old model, there were problems with the overall cost of borrowing, the way risk was managed and the way swaps worked in all of that, the actual risk transfer versus perceived risk transfer and how that was conducted in the model, and then the cost of variations—how hard it was to change anything. For some schemes, because the model changed over time, there was a problem with the way the asset came back into NHS ownership at the point of termination. All those things are being addressed in that model.

Q180 **Ben Coleman:** Are there other problems that you have come across? I think you have left something significant out, but I do not want to lead you. I just want to get your view on what else has been a big problem. Samantha, I can see that you want to come in.

Samantha Jones: Jim and I are as one on this. The important point around this is that it is not bringing back PFI—

Ben Coleman: No, I am just focusing on the problems that you—

Samantha Jones: I understand. We both had experience of that in practice. The new PPP model is being led by NISTA, which is independent, and co-designed by us, for the reasons—

Ben Coleman: I am going to stop you. Forgive me.

Samantha Jones: May I finish? For the reasons of more transparent payment mechanisms, greater contract flexibility to accommodate the change, and stronger monitoring in terms of robust maintenance of the actual asset condition. The reason I say that in answer to your question is that those refer to what we would like to do differently in the future, rather than the past.

Q181 **Ben Coleman:** You have both read the White Fraiser report, I presume. Have you read it?

Samantha Jones indicated dissent.

Ben Coleman: No? Okay, well that is possibly the most comprehensive report on what went wrong with PFI. It is only two years old; it was published in July 2023. I do not see how anybody can take forward what is going on without learning properly from the past. It identifies the problems that you have identified, but the No. 1 problem it identifies, which was obvious from the beginning, is civil servants' skills. The skills that civil servants needed to negotiate contracts were lacking, and the skills that the public service needed to manage the contracts were woefully lacking. It is partly to do with a completely different mindset between the public sector and the commercial sector. I have seen it in local councils—they talk about partnership, and you have recognised the fact that the risk balance is often wrong, because partnership means when both sides take risk. But it is not just that; there is the ability to have negotiating skills to understand negotiating incentives and leverage. Have you recognised the need to change the skillset of the public sector if we are going to do £1 billion-worth of PPP deals?

Samantha Jones: My reference to NISTA was for precisely that point, which is that developing and negotiating these schemes requires, as you rightly say, a different skillset. That is why private sector expertise is being harnessed through the NISTA programme—the development in the future—to ensure that those people who are designing those schemes and responsible for the negotiation of them take skillsets from lots of different places. That is why I was referencing NISTA. It is taking that into account; it is a very different skillset.

Q182 **Ben Coleman:** Are you saying that we are getting private sector people in to train up the civil servants in negotiating, or are we going to be doing what we did previously, which was effectively taking advice from the private sector all the time while we negotiated? Inevitably, they will be acting in different fora from the very people we are negotiating with. Are you raising the skills of the civil servants so that they are able to do this on their own, or are you going to be using lots of lawyers and people from outside to be alongside them?

Samantha Jones: The model that is being developed by NISTA, supported by us, will actually build on lessons from the past, including a mixture of people from outside the civil service—outside the NHS—working alongside commercial. I am very happy to come back, as it is developed over the next year or so, on what it looks like, what the skillset is and how it works together as we go through.

Wes Streeting: My other observation is that, in the time that has passed since PFI was introduced, the skills and capability of the system have changed. We can go back and check, but there will probably be more people in commercial functions now in the Department and in NHS England than there were before. Obviously, I want to bring those together. You are right, Ben, to make sure that we do not repeat past mistakes. At the same time, even today and in recent years, we have seen private investment models—whether that is LIFT schemes in England or the



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mutual investment model in Wales—that have passed without controversy, have not hit the headlines and have not seen people with placards outside saying, “No to LIFT!” or “No to MIM!”, because it has gone well.

Q183 Ben Coleman: That is a very important point, and I appreciate you making it—I felt that you might—but isn’t there a big difference between building something on time, which is meeting a political imperative, and seeing what happens over years to come: whether there are problems, how they are dealt with, whether civil servants have actually contracted effectively, whether we end up paying 100% more than we expected to pay? Isn’t it too soon? We can judge MIMs and LIFT and say, “Yes, they delivered the projects on time,” but we cannot judge whether they will be a success over decades, in the way that we have now been able to with PFI.

Wes Streeting: In terms of how we are thinking about the PPPs on neighbourhood health, in particular, there are definitely things at the forefront of our mind. One is making sure that you have simple and transparent payment mechanisms. Another is making sure that contract flexibility is built in to make sure that we have accommodation changes. Another is the monitoring to make sure that we have robust maintenance of asset conditions, and to make sure that, unlike some other models, the state has the asset.

The other good thing—this is the nicest thing I will say about the Treasury today—about the way the Treasury have set up the approach we are taking to the financing of neighbourhood health is that they have chosen to do public investment in this project, alongside the private investment model, so that we can look in real time, with a like-for-like comparison, at what has been most effective. Has one been more cost-effective than the other? Has one developed better quality than the other? Has one been better maintained the other?

Q184 Ben Coleman: That requires quite a lot of time, and the pressure on building 120 and getting them operational by 2030—

Wes Streeting: That is why you do it in real time, Ben. I think having that kind of approach is the right way of thinking about it.

Q185 Ben Coleman: I think there is great strength in somebody starting to negotiate and just saying, “No, we can’t negotiate. You’re asking too much,” and walking away from it. Is there a danger that civil servants would feel under so much time pressure that they might not be prepared to walk away or close down projects?

Sir Jim Mackey: Absolutely not. It may be worth having a separate session on this. We are, in substance in the project—

Chair: We are doing an entire inquiry on NHS estates, which we launched on Friday.

Sir Jim Mackey: So we are dealing with all those issues. I have signed off PFIs and bought one back, so I have learned a lot over the years through those processes. The evidence does suggest, though, that PFI schemes in

the NHS generally produce better maintained assets in the long term. They have generally outperformed the NHS in the main.

Q186 Ben Coleman: Forgive me for coming back on that, but if you had spent the same amount of money as a PFI scheme costs to maintain—

Sir Jim Mackey: There is a long answer to that—

Ben Coleman: Simply within the public sector, if you had been able to make the money available to keep hospitals properly maintained over a number of years, that would be the comparator that you would need to use. I think it is a wholly unjustifiable statement to make.

I have one last, very quick question. Are ICBs going to be negotiating and managing these contracts?

Chair: Yes or no.

Ben Coleman: Are the PPPs going to be negotiated and managed by ICBs? If so, will they be trained?

Sir Jim Mackey: Not in my view, no. There will be—

Chair: Thank you. Sorry, we need to move on.

Q187 Danny Beales: Secretary of State, in our 1,000 critical days inquiry earlier this year, one aspect of what we looked at was vaccinations in infancy. These remain below national coverage goals: there are significant disparities by region and demographic group, which do not seem to be closing; coverage of pre-school immunisations has been declining since 2012; and rates in the UK are lower than in Japan, France, Australia, Germany and Denmark. We found that in 2023-24, coverage had decreased on 14 vaccine coverage measures, and no measures met the WHO's 95% target, which used to be an NHS target but was removed from planning guidance in 2025-26. What is going wrong?

Wes Streeting: Well, it is a mixed picture on vaccination.

Danny Beales: It does not sound very mixed; it sounds quite poor.

Wes Streeting: If we take where we have been ahead of this winter, we have delivered over 17 million flu vaccines for this season, which is 170,000 more than this time last year; 60,000 more NHS staff than last year are getting their jab; and we are on track to deliver the 5 percentage point increase in flu vaccine uptake in healthcare workers, which was set out in our urgent and emergency care plan.

On school immunisation, the levels are broadly the same as last year and slightly better in some cases. Schools with low uptake will be followed up by second visits this week before schools break for Christmas. On the RSV vaccine, almost 68% of 75 to 79-year-olds have been protected, and we are on track to deliver the 70% target by the end of March, as set out in the UEC plan. The 2,500 more GPs and the modernised GP appointment bookings are helping with that. But there is more to do.



Q188 **Danny Beales:** You describe some positives, but some of those statistics are quite low metrics and well below the 95% WHO target.

Wes Streeting: On that, Danny, to put all those positive numbers in context, we are not back to where we were in terms of pre-pandemic levels. That is the initial bar we have to set ourselves. I report progress without wanting to sound defensive or complacent, because your central challenge is absolutely the right one.

Q189 **Danny Beales:** Should the Government restate the 95% vaccine uptake rate in planning guidance? Was it right to remove that target, bearing in mind where we are and where we have slipped to?

Wes Streeting: Regardless of whether it is in the medium-term planning framework, we need to give this the specific focus it requires and make sure that we have got resourcing. For example, we have seen a 45% decrease in health visiting numbers over the best part of a decade. Those sorts of things do have an impact. To make sure that we are improving, we are starting in those areas and with those patient groups where we have the biggest challenge. The 12 pilots that we are running with health visitors from mid-January will be with families who have the most barriers, including everything from ability to travel, to language difficulties and vaccine hesitancy.

Q190 **Danny Beales:** The pilots are very positive, and we heard about the role of health visiting. We also heard that those pilots are quite slow and in very few areas, and will potentially take another 12 months, if not longer, to reach national-level impact.

You rightly mentioned resourcing. A response yesterday to a parliamentary question about NHS England's spend on vaccine and immunisation programmes suggested that, in 2021, NHS England spent 1% of its budget on immunisation; that fell to 0.64% in 2022 and 0.5% in 2023. If the overall budget has gone up—and maybe one might challenge the percentages—in real terms it fell from almost £1.5 billion on vaccinations in 2021 to £989 million and £850 million in 2023. That is lower in percentage and real terms than 2020-21. Do those drops in spending on vaccination programmes concern you?

Wes Streeting: Let me go away with Ashley Dalton and kick the tyres on all of that. On one hand, particularly when you spell it out not in percentage terms but in actual spend terms, that says to me that we need to take a good look. I would expect that across a whole range of areas, with the emphasis we are putting on productivity and modernisation, we would want to see greater efficiency and therefore not always higher spending. The tragedy of the NHS is that it has had higher spending and delivered poorer outcomes.

Q191 **Danny Beales:** We are seeing more and more vaccines through scientific advances.

Wes Streeting: And we have got the new MMRV vaccine, which means that from January the MMR vaccine will include chicken pox for the first time. There are lots of positive developments, and that could also point to



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why there are savings if, for example, you have more conditions confined to a single dose. I will go and kick the tyres on that, because it is a fair question and a fair challenge.

Q192 Danny Beales: I welcome that, Secretary of State. Thank you. As part of kicking the tyres, the Committee would like to outline that we have seen falling spend, falling rates in many categories of vaccination and more outbreaks among children reported in the press. One might say that that suggests that the 2023 NHS England vaccination strategy has not worked—unless it predicted this and that was the strategy, which I hope it was not. As part of kicking the tyres, I hope that we might consider updating the national strategy for vaccinations.

Wes Streeting: I think you ask a fair set of questions and we will go away, look at that in detail and come back to you.

Q193 Danny Beales: Another issue that the Committee looked at this year is dentistry. There were big announcements yesterday about overhauling the dentistry system—they were described as a major overhaul. Certainly, there were very welcome changes about prioritising the patients most in need.

Those in the sector, particularly when we spoke to them earlier this year, want the UDA to be looked at and the cap on the amount of activity that dentists can do to be changed. It does not seem that those issues were addressed in the announcements yesterday. Regarding what these announcements mean, is your sense that this is the end of dentistry reform in this Parliament, or is there more to come?

Wes Streeting: No, it is definitely not the end. This is part of it. What I want to see is consistent improvement in the quality and availability of NHS dentistry over time. We are starting from such a low bar. On our manifesto commitment to deliver 700,000 urgent emergency dentistry appointments, money has been available. ICBs have been making extra appointments available since 1 April this year; they are available across the country. But the roll-out of that has not been going as fast as either Stephen Kinnock or I would like and we will give that a real push into the new year.

The system we inherited in dentistry is, of all the parts of the NHS, the one that starts from the worst starting-point we would have wanted. Even by the usual standards of, “Well, I wouldn’t have started from here,” we are stretching.

However, what I was really struck by yesterday with Stephen’s announcement was the welcome that it got from the British Dental Association as well. To be fair to the BDA, I have to say that they have had the patience of saints. They have worked with us really constructively. They understand the pressures we are under and when they have challenged us, privately as well as publicly, they have always done so constructively, and I really appreciate that.

Danny Beales: I would certainly associate myself with that comment



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about the BDA. It is welcome that there will be further opportunities to reform dentistry and you are right about the terrible state of dentistry that this Government inherited. Has the final financial envelope for dentistry now been set following the spending reviews? When we saw the Minister previously, it was still under discussion. If it has been set, is the spending allocation on dentistry bigger, the same, or smaller?

Wes Streeting: We are currently doing financial planning with the system, as we speak, as part of the medium-term planning framework. We are getting returns from across the system back now, which will help to inform where we are on investment in dentistry. And when Jim next comes back to the Committee—because Sam and I did not make that commitment—you can ask him.

Q194 **Paulette Hamilton:** I just want to ask one small question about dentistry. The contract has always been the main issue. What is being done to address the contract, which has been the problem from day one?

Wes Streeting: Part of what Stephen announced yesterday is embedding urgent care into the contract. However, I think we are realistic that contract reform will be an ongoing process. You have heard me say before that there are lots of problems in the NHS that are not about money, and that are about modernisation, getting more bang for the buck that is going in, and changing the way we do things. In dentistry, I accept that there is a money challenge as well.

We are going as hard and fast as we can with the resources that we have, recognising that we have done relatively well out of the Treasury compared with other Government Departments, and that the Treasury is doing as much as they can, given the personal priority that the Chancellor attaches to the NHS. However, even within that constraint we are not able to spend our way out of the challenge as quickly as we would like.

Q195 **Paulette Hamilton:** Thank you, Wes. Now, my substantive question is about winter pressures. I always ask about this, so I might bring Jim in to give you time to get some water, Wes.

This year, the NHS has been preparing for winter pressures even earlier than last year; we had reports come to the Committee about that. How have your plans for this year been changed based on your experience from previous years? Even though we have prepared earlier, with the plans that you have looked at and the things that you have tried to change, what has actually changed? We still have this major problem at this time of the year.

Sir Jim Mackey: First, there is a point about what the future of urgent care is, and how the NHS can manage winters routinely without having this big pressure every year. We are going to take some time, early in the new year, as soon as we can after peak winter, to get our plans together about what that should look like in the future. We will get out of the habit of accepting that it is a terrible drama for a couple of months over winter and it is baked into how we work. We will come back at a point in time when we are able to talk about that more fully.



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This year it has been much more locally driven, with less central control, submissions, and so on. The national team worked with local colleagues in the summer to start thinking about what the plans look like and materially—to your point—anticipate where there will be problems and get ahead of them. What do you do then? What happens when place A falls over, when ambulance handovers stretch out to a certain point, when cat 2 response runs out to a certain point? What actually happens? Who is going to do what when? Rather than trying to work it out at the time, when everybody is stretched and under pressure, we are anticipating it and getting the plans more robustly in place.

We have also been working on trying to make the service more consistent, using models that work in certain places. We have a bit of work going with the Royal College of Emergency Medicine, some chief exec colleagues and the Society for Acute Medicine to create a model for the front door to help everybody to understand what works and, over time, make sure that every system has what normally works.

Q196 Paulette Hamilton: Are you hoping to learn from the mistakes that were made—though I am not saying that mistakes have been made—or some of the issues that you faced last year and this year? Could it be that working just on a local basis is not enough, and it has to be driven more centrally?

Sir Jim Mackey: Absolutely. We have a lot of work to do to make sure that people understand what works in place x, which is a long way from place y, and to make sure that that is adopted more. How does everybody understand what a standard model should be? There are some judgments in that, from our point of view about where we should allow people to work out a local nuance versus where we say, "This is just how it has to happen everywhere. It works; we know it works; everybody just do it. Commissioners need to commission on that basis."

You will have seen all the stuff in recent weeks about flu and the pressure. We have actually had our first contact with winter in a pretty nasty way over the last month. Two weeks ago, I was really worried about the way flu was accelerating the pressure on certain systems. It is still early days, but it looks as though that might be starting to settle in some parts of the country. The way the service has held on to handover performance and especially cat 2 performance, which has been the focus for the NHS over recent years, gives us heart that we have been able to learn from last year and make some adjustments—

Q197 Paulette Hamilton: I am going to have to stop you—I have one minute and I need to get this question in; it is about vaccine hesitancy. I was a nurse for many years, as everybody knows, but the big issue is around the health professionals, allied professionals and others who are not taking the vaccines. Has the time come when everybody needs to wear masks to protect patients?

Wes Streeting: No, the time has not yet come for everyone to wear masks, but we are absolutely supporting frontline leaders to determine whether, given the pressures that they are under, it is right to ask visitors



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to hospitals, or other NHS and care settings, to wear masks to protect themselves and others. There will be places where that is happening. It will be done in an informed way on the basis of the conditions that the setting is operating under and most people will happily comply with it. But at this stage, there is no need to mandate mask wearing, or to ask everyone around the country to do the same.

Chair: Thank you. Greg Stafford has the last questions.

Q198 **Gregory Stafford:** Thank you, Chair. I have three, hopefully brief, questions with hopefully brief answers. First, as far as I am aware the Government are yet to publish any timescale or scope for the health Bill; when will the Bill be published?

Wes Streeting: In 2026, certainly.

Q199 **Gregory Stafford:** Can you be a little bit more specific, Secretary of State?

Wes Streeting: Yes and no—because this is not just my decision; it is subject to the agreement of business managers. Suffice to say we are working at pace to make sure that the Bill is ready, and certainly to make sure that we can complete the abolition of NHS England within the timetable set out by the Prime Minister.

Q200 **Gregory Stafford:** Okay, so in spring?

Wes Streeting: In 2026.

Q201 **Gregory Stafford:** That is not massively helpful. In which case, let us move on to funding. Is the Department on track to eliminate deficit support funding in '26-27, given that 92 trusts are still in deficit?

Sir Jim Mackey: The medium-term plans will tell us how far apart we are when we get them, and how we develop over recent weeks. We will not have eliminated deficit support funding, but we have set up the system so that everybody knows what the rules are. We want to wean off it over time. I think it is unreasonable to expect to get to nil next year or even in the year after, but we should see material reductions. We have seen material improvements in this year so far.

Q202 **Gregory Stafford:** So essentially that target has been scrapped.

Sir Jim Mackey: It hasn't been scrapped, no.

Q203 **Gregory Stafford:** We are not going to make it in the timetable that you mentioned.

Sir Jim Mackey: We set out an objective and we are making progress against that.

Q204 **Gregory Stafford:** This is my final question. Secretary of State, you stated very recently—I think it was earlier this month—that you will not cut NHS budgets to fund the pharma deal. Can you set out how you are going to fund that?



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Wes Streeting: Well, the bill is not clear. It is extremely complicated. On the way that VPAG works and the way in which the rebate is calculated, companies have to pay the Government a rebate, which is a proportion of their sales with the revenue distributed to the NHS across the UK. With the newer medicines, the rebate rate is set each year at a level calculated on sales to an allowed rate of growth. Under the US deal, the rebate rate for newer medicines will be capped at 15%--

Q205 **Gregory Stafford:** Forgive me; we don't have much time. Where is the money going to come from?

Wes Streeting: Well, we don't know what the cost is going to be.

Q206 **Gregory Stafford:** But you must have some idea, Secretary of State, and you must have some idea of where that money is going to come from when you have to spend it.

Wes Streeting: When the Treasury made their allocation to my Department in the spending review, they took into account VPAG costs. So if the costs arrive within that envelope, we are absolutely fine. If we are without that envelope, both within my Department and across Government, we manage that in the usual way.

Q207 **Gregory Stafford:** So you will cut NHS budgets?

Wes Streeting: Nope. We are not going to cut—

Q208 **Gregory Stafford:** Where is it going to come from, then?

Wes Streeting: The Department has budgets for a wide range of things, including contingencies. We have also been funded to a degree on VPAG as well. I am not trying to be difficult in answering your question, but there is such a wide range of variables to what the number will be, and when that number and the highest plausible number would materialise, which may even be outside of the spending review period. That is why, first, I am absolutely confident in saying we will not cut NHS budgets to fund this. Secondly, we have been funded by the Treasury taking into account these costs. Thirdly, should the cost materialise at a scale and pace that is unexpected, then we manage those pressures in the usual way, which is within the Department's budget, if we are able to absorb those costs. Where we are not able to absorb costs, of course we talk to our good friends at the Treasury.

Q209 **Gregory Stafford:** Just one final point of clarification. You said you would not cut NHS budgets. Can you confirm you would not cut social care budgets as well?

Wes Streeting: Yes. We are not interested in cutting frontline services to fund the US pharma deal, which I have to say, by the way, is a deal that also delivered a 0% tariff for pharma exports for three years, and I think has achieved a really good outcome, given the pressures and constraints that the negotiating team were operating under.

Chair: Thank you very much. We also thank you for your extra time; we have enjoyed this session.