HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Department's White Paper on Health and Social Care, HC 1274

Tuesday 16 March 2021

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 131 - 195

Witnesses

I: Rt Hon Matt Hancock MP, Secretary of State, Department of Health and Social Care; and Jason Yiannikkou, Director, NHS Legislation Programme, Department of Health and Social Care.

Examination of witnesses

Witnesses: Rt Hon Matt Hancock MP and Jason Yiannikkou.

Q131 **Chair:** Welcome to the House of Commons Health and Social Care Committee's final evidence session on the Government's White Paper for NHS reform. Today, we are very grateful to have with us the Secretary of State for Health and Social Care, Matt Hancock, and his trusty official, Jason Yiannikkou, with whom I had the pleasure of working for many years. Thank you for joining us. Please, as ever, pass on our thanks to your team for their incredible work during the pandemic.

Before we move on to the reform proposals, I want to ask you, Secretary of State, a couple of questions about the Budget and the nurses' pay award. As you know, the NHS 10-year plan made a 2.1% provision for annual pay increases for NHS workers. How did your Department come to recommend just 1%, given the incredible pressures that staff have been under during the pandemic?

Matt Hancock: As you know, Chair, I am a huge fan of and supporter of the workforce right across the NHS, who have, as you say, done an incredible job during the pandemic. It is absolutely extraordinary. The NHS was carved out of the pay freeze that, due to the enormous pressure on the public finances, has been applied to everybody else in the public sector. We put in place evidence reflecting what is affordable. Of course, we will study what the pay review body says.

Q132 **Chair:** Could I ask you to clarify one thing, over which there has been some uncertainty? Does it constitute a real-terms pay cut or not? Is there an extra 0.7% on top of the 1%? Could you just explain that one?

Matt Hancock: Inflation is below 1%, and therefore a proposed 1% pay rise is indeed a pay rise. That is simply a matter of fact.

Q133 **Chair:** I have one other question on the Budget. The next financial year starts in just 16 days, but the extra £7 billion or so that the NHS is asking for, for Covid-related costs in the first half of the next financial year, from April to September, has not yet been agreed. Why is it taking so long?

Matt Hancock: It is really important to understand which parts of the Budget we are talking about. The NHS underlying budget has been agreed as part of the long-term plan settlement. In addition, in the spending review, we put in another £3 billion. Around half of that goes to paying for the problem of infection prevention and control, essentially making it harder to deliver services. Around half of it, £1.5 billion, goes to the elective recovery for people whose operations and diagnostics were inevitably delayed due to the pandemic. You will have seen the latest figures last week showing that over 300,000 people have now been waiting for more than a year for treatment. That is clearly far too many. In fact, we had got the number down close to zero this time last year, just before the pandemic hit, but unfortunately it has risen very sharply.

There is the long-term plan budget, plus the £3 billion extra allocated in the spending review, and then we have been clear that we will fund the Covid costs. Working out exactly what they are is complicated, not least because you have to see where we are in the pandemic. Thankfully, we are in a far better place in the pandemic than we were either in November, when the spending review was being settled, or indeed in January and February. Thankfully, there are now under 10,000 people in hospital across the UK with Covid. There are even fewer in England, of course. We will be publishing the exact operational costs shortly, but what all parts of the NHS know, and we have made very clear to them, is that the direct operational costs of Covid will be covered, so people can plan with confidence.

Q134 **Chair:** I wonder whether you think that we are cutting it rather fine because there are just 16 days to go. A lot of people would say it is the primary responsibility of the Government to give some budgetary certainty to people in a pandemic. Are you expecting this to be resolved very soon?

Matt Hancock: Yes, very shortly. The central point is that to make an estimate of the costs, which is effectively what we will be doing, you need to know the state of the pandemic. For the system, for anybody running a trust or a system, the message has been very clear, which is that we will cover the operational costs of Covid.

Q135 **Chair:** Thank you. Let's move on to the White Paper. We have had a lot of discussion on this Committee about the need for accountability in the new integrated care systems and for the public to be able to know how well their local ICS, their local NHS, is doing. Thank you for responding to those concerns in a letter that you sent me yesterday. Could you outline what that letter says to the Committee so that everyone understands?

Matt Hancock: Yes. Would I be able to take a moment to set out the big picture of what the reforms are intended to achieve, and then come on to the letter?

Chair: Of course.

Matt Hancock: The purpose of the reforms is to strengthen integration, reduce bureaucracy, and strengthen accountability in the NHS. The goal of them is to build on the best practice that is already out there when systems work together. That has been significantly strengthened by the crisis, where systems across not just the NHS but local government and others working together has been critical.

Perhaps the best example is the vaccine roll-out, which is being done at a system level. The systems are broadly often the same geography as a county council or sometimes a little bit bigger; for instance, the whole of Greater Manchester is one health system. The goal is to have greater integration and remove a load of bureaucracy. They are the first two goals.

The third goal is to have stronger accountability. That means stronger accountability to Parliament, but you can only have stronger accountability if you also have high-quality analysis and public understanding of how well each system is doing.

In response to suggestions from the Select Committee—I am very grateful for your work so far on this—we will ensure, as part of the Bill, that the CQC will be able to inspect how well systems are doing and publish on that basis, including setting out the high-level, four-part report—Outstanding, Good, Requires Improvement and Inadequate—that everybody knows and understands, to make sure that we can have proper public accountability for how well systems are operating, including how well the different parts of the system integrate. Obviously, the goal of integration is one that has been long sought, and that I hope the Bill will help to deliver.

Q136 **Chair:** Thank you. We welcome that. Will the same thing apply to local authorities with respect to their social care responsibilities?

Matt Hancock: We have to work that through very clearly. I am sure that will be something that is discussed during the passage of the Bill. The challenge is how to ensure that there is proper transparency and accountability, not whether to have it. Of course, local government is first of all accountable to local voters and local taxpayers in terms of their formal responsibilities, but has its own inspection and accountability framework. We do not want to overburden them with non-co-ordinated accountability. We have to make sure that we get the details of that right.

Q137 **Chair:** But you accept that a local electorate cannot actually hold their local council to account on the social care system unless they have some expert understanding of how well social care is working in their area.

Matt Hancock: Yes, I do, and that that expert understanding is communicated in terms that people with lay rather than expert experience can understand. It is like the four-rank rating, which I think has served us well.

Q138 **Chair:** Thank you. Lots of colleagues want to come in, but, finally, I want to ask you about your powers of direction that you are asking for in this Bill.

You have been very clear that the NHS will retain clinical and operational independence. Can I ask you about a few real-life examples to understand how the power of direction would work? Will you have the power, for example, to direct an appointment in the NHS—say, the chair or chief executive of a hospital?

Matt Hancock: The proposed approach on appointments is that NHSE would make appointments, but they would need to be signed off by the Secretary of State. It is effectively moving appointments to joint appointments in which the Secretary of State would have to be content

that an appointment was appropriate, rather than the Secretary of State appointing directly.

Q139 **Chair:** It is joint rather than direction. Let me move on. As you know, there has been a lot of controversy in the pandemic over procurement. Under these powers, will you have the power to direct the purchasing of equipment, medicine or supplies from a particular supplier?

Matt Hancock: No, not by any individual trust, in the same way that I cannot now.

Q140 **Chair:** Another thing that happens at arm's length from you at the moment is that NHS England uses a formula to allocate NHS resources to different parts of the country based on need. Will you have the power to override that, perhaps in support of the levelling-up agenda or something like that?

Matt Hancock: That formula, which has stood the test of time, currently has to fulfil requirements set out by the Secretary of State, so there is already an interaction on its definition. Of course, the Secretary of State should be able to define the approach that is taken to such an allocative formula because, ultimately, the Government are accountable to the citizens we serve and—

Q141 **Chair:** I am sorry to interrupt. I think everybody would understand that you set the approach, but having set the approach that this part of the country gets X and that part of the country gets Y, the individual decision is not something you would be involved in.

Matt Hancock: I would expect it to follow a formula that fits criteria that are set out and agreed with the Secretary of State.

Q142 **Chair:** If you direct that a merger should or should not go ahead in a particular part of the NHS, will that be subject to a public interest test so that people could challenge the decision in the courts if they wanted to?

Matt Hancock: Yes. As Sir Simon Stevens set out to the Committee last week, the principle is that, if and when a power of direction is exercised, it should be done transparently and subject to a public interest test. That is very similar to a direction over the civil service by a Minister. Almost every decision in ministerial life is taken on the basis of advice. Very occasionally, a decision is taken overriding advice, and if that is what happens it is entirely within a Minister's right to do it, but they always then need to be transparent about it and set out reasons, and it should be in the public interest. Essentially, we are taking the same approach.

Q143 **Chair:** Will the clinical and operational independence of the NHS be enshrined in any legislation that you put forward?

Matt Hancock: That will be absolutely integral to the framing of the power of direction clauses in the Bill. The wording is slightly different from that which you have used a couple of times. It is clinical and day-to-

day operational independence, and that will be enshrined in the approach that we take, which will be set out in primary legislation.

At the same time as saying that, I do not want to constrain that process through primary legislation, not least because there are unforeseen events. One of the problems with the existing legislative framework around the health service is that it is too prescriptive. It tries to anticipate events or assume that events will always be as they are now, and I do not think that is the case. The Bill is being framed in order to allow more flexibility about how the system, especially at the local level, can respond to circumstances and can work together according to the needs of local areas.

I will make a principled argument throughout the passage of the Bill that we have to give the service, and indeed the wider health and care system, with integration with local government and others like the third sector, community interest companies, voluntary organisations and what have you, the flexibility to respond to circumstances on the ground.

Q144 **Laura Trott:** Secretary of State, we heard at a previous evidence session from the King's Fund, who said that the most successful NHS reorganisations have been around improvements in patient outcomes. The examples they gave were cardio and cancer. Can you explain to us how patient outcomes are going to improve as a result of the changes?

Matt Hancock: Yes. I think patient outcomes will be improved through all three of the principles that underline the Bill. They will be improved by integration. We already know that problems in terms of patient outcomes are generated especially when different parts of the system do not talk to each other. There is legion evidence about that. It is when you go to your GP and then go to hospital and have to spend precious time, sometimes when you are in significant discomfort or pain, explaining everything again because there isn't integration of information in the system.

There is the lack of integration, long bemoaned, between the NHS and social care, which, over the last year, we have managed to improve very significantly, but still there are barriers in law between them working together as best they could, despite the fact that many parts of the country have good integration despite the legal framework rather than because of it. Those are just two examples.

On busting bureaucracy, there are currently barriers to giving high-quality patient care. I would point to information barriers and the inability to share data properly and appropriately because of legislative barriers that are in place, as well as clinicians spending too much time on bureaucratic requirements rather than patient care.

On accountability, it is harder to depict the direct link from accountability through to improved patient care, but there is no doubt in my mind that systems that are highly accountable, and properly accountable, tend to have more focus on improving what matters to the people they are being

held accountable by. I want people to be held accountable ultimately by the citizens we serve, through the democratic process. One example is giving the Secretary of State more powers of intervention in reconfigurations. If a reconfiguration is directly against the interests of a local area, the Secretary of State should be able to intervene.

There are currently intervention powers, but they are incredibly difficult and complicated to use. I have only used them once, and that was to stop the permanent closure of Chorley A&E, which was not justified by the clinical evidence. I am very glad that I was able to do that, but I had to stop the whole local reorganisation process in order to do it. I hope that the power of direction will help to ensure that, when reorganisations have to occur on the ground, they are both clinically led and supported by the local population, rather than the two being at loggerheads, as they have been too often in the past.

Q145 **Laura Trott:** Measuring the impact, as you referenced, is going to be the key thing. It is absolutely welcome, as you set out in your letter to us yesterday, that the CQC will be involved in inspecting the ICSs. Will the CQC look at the patient outcomes that have been fostered as a result of these changes? Will they make sure that the ICSs are assessed on those?

Matt Hancock: Yes. The point of the ICSs is to be able to get the budget into the hands of local leaders, who can then spend it according to the best interests of the long-term health of the population. That, of course, can be measured.

There will be a challenge, which is that the long-term outcomes are harder to measure than ticket-at-the-turnstile outputs. The problem of focusing too much on the outputs is that you essentially incentivise medicinalising a problem, rather than trying to solve it before it requires a stay in hospital. That problem is at the root of what we are trying to solve with a population and health-based approach. The purpose of getting the CQC in, which I think the Select Committee has championed and articulated very well, is to try to hold systems to account for that population and health-based approach, where the goal should be how healthy your local population is. That is the goal of an ICS. All of the services of the NHS locally, and the work of the council, are means in delivering that big-picture goal.

Q146 **Laura Trott:** What is the key data that you would like to see, Secretary of State? As you sit there looking at the new ICSs and trying to assess how well they are doing, what will you be looking at to make sure that they are working effectively?

Matt Hancock: The biggest one is healthy life expectancy. That is ultimately what health services are about, but that obviously takes years to change and improve. You have to then look at proximate indicators for that, and whether they are on things that are currently regarded as entirely within the public health space but are very important for improving healthy life expectancy—like smoking rates or smoking in

pregnancy rates—all the way through to how effective the providers of health services are, for instance hospitals, within that system.

To take cancer, it is absolutely vital that we continue the work of a generation or more in driving up cancer survival rates. I am very excited about the prospect of some of the new technologies that we have learnt about in the vaccines programme—we have learnt so much more about RNA technologies—and being able to apply them to cancer.

What really matters in the here and now, alongside the research on cancer, is early diagnosis. We know that early diagnosis saves lives, as well as the services. That is a matter for the whole health system. You cannot individually hold a hospital to account for early diagnosis because it is about the hospital, GPs, community services and public health communication to the population: "If you find a lump, please present." You need a system-based approach to drive early diagnosis of cancer.

While in this country we have been very good at improving the outcomes for cancer recovery once diagnosed—because you are then into one bit of the system, which is essentially oncology—the bit we have not driven as much as many other parts of the world is the early diagnosis, because that is more diffuse across the system. In insurance-based models, the insurer has a financial incentive to do that. We do not want an insurance-based model here, but we want a system having a responsibility, and indeed an incentive, to pull together, and, for instance, diagnose cancer.

Laura Trott: Thank you, Secretary of State.

Q147 **Taiwo Owatemi:** Secretary of State, are you able to elaborate on the role that you envision local authorities will play in partnership bodies?

Matt Hancock: Yes. Local authorities have a mission-critical role to play in the delivery of improved health outcomes locally, alongside the NHS. The goal will be that local authorities will have a statutory role to play in the ICS partnership bodies. Currently, in most parts of the country, they play a strong role in a non-statutory and collaborative way with either ICSs or their predecessors, the STPs. We wanted to make that a statutory role so that the strategic goal of the local ICS is a combination of the work of the NHS and local authorities.

Q148 **Taiwo Owatemi:** How confident are you that local authorities are happy with the current proposal?

Matt Hancock: We have had some very good feedback. We designed a lot of these governance processes alongside the LGA. I put on record my thanks to James Jamieson at the LGA, who had an integral part in the design of the paper.

The very large majority of the proposals in the White Paper come from the NHS long-term plan. However, we have taken those proposals and worked with the LGA and others to turn them into a health and care system plan because it is a health and care Bill that we are proposing

about the integration of the two, building on the work of the NHS but also the work of the LGA.

Q149 **Taiwo Owatemi:** In our previous evidence sessions we heard from both the King's Trust and the Health Foundation that in order for collaborations between different bodies to be successful there has to be a cultural and behavioural change, in addition to the current legislative change being made. How has that been considered?

Matt Hancock: I totally agree with you. It is incredibly important. The White Paper is a proposal, not just for legislation but for reform. In fact, if the legislation does what I want it to do, when it comes into law in April 2022, it will fit a modern legislative structure around the work that is already being done well by systems where they work well together. For them, it will merely be a helpful addition, and a removal of some of the legislative barriers that are currently in place.

My goal is that the enactment of the Bill we propose merely supports the much wider set of changes, including, for instance, the cultural and behavioural changes you talked about. I point back to the vaccines programme. We have effectively run the vaccines programme through the systems and through ICSs where they exist. That is the pulling together of all parts of the NHS—hospitals and primary care especially, but also community, and to a lesser extent, mental health trusts, and local authorities and volunteers, and local civil society. The vaccines programme shows us how a healthcare system as a whole can pull together to deliver for its citizens. The new approach to the NHS builds explicitly on the success of the vaccine programme.

Q150 **Taiwo Owatemi:** Previously, you said that the goal of the new changes is how healthy a local population will be. Obviously, for a population to be healthy there has to be strong public health. The current White Paper contains two public health matters—obesity and the fluoridation of water. Why was mental health and wellbeing not included? Does a duty need to be placed on ICSs with regards to mental health and wellbeing in all their service provision?

Matt Hancock: They absolutely will have a duty to look out for people's mental as well as physical health. Whether that is put into law or not, we can debate during the passage of the Bill, but it is absolutely vital, and, of course, the point of an ICS is to look out for people's mental and physical health.

Essentially, I agree with the premise of the part of your question on public health reform. You have to see the health and care White Paper that we are discussing today in the context of four different reforms that are under way in the Department post Covid. We have the mental health reforms that we set out in the White Paper in January, building on the Wessely review. We have the public health reforms on which we will be saying more very shortly, including establishing a body whose sole job is

to look out for future pandemics and to ensure we are the best prepared possible, as well as strengthening the health improvement side.

Of course, there is the need for social care reform, as we set out in our manifesto. There are four reforms going on, and they all interlink and are interlocking. The public health reforms will be enormously strengthened by a population health-based approach in ICSs, but that is not the only part of public health reform. There is a lot of non-legislative public health reform on which we will be saying more very shortly.

Q151 **Rosie Cooper:** Secretary of State, you said a little earlier that we would be held accountable by the people we serve, and that the ICS will plan and fund for whole populations. I have mentioned this before. Where would my constituents' voice be heard, when they are geographically in one ICS but their acute hospital services are provided by another? Effectively, they will be left without a voice in the provision of acute services for them. Do you see this as a problem you can resolve?

Matt Hancock: Yes, I think that is eminently resolvable. The technical answer to your question is that the allocation of where the funding for somebody's healthcare lies is determined by the location of their GP practice, or their residency if they are not a member of a GP practice. That is the technical answer to your question.

The policy answer to your question is that an ICS is responsible for the people in its area, as I have just defined.

Rosie Cooper: Secretary of State, forgive me. My constituents are all in West Lancs.

Matt Hancock: Thanks, Rosie. Of course I understand that. I represent West Suffolk. In West Suffolk, when people go into hospital, very generally, they go either to the West Suffolk hospital or to Addenbrooke's in Cambridge. The GP of my constituents in Suffolk will choose to send somebody either to Addenbrooke's or to West Suffolk, and for in-patient care the funding will obviously follow that patient, and that is how you can hold the secondary care to account, alongside CQC inspection and the system as a whole.

Of course, there has to be cross-boundary treatment, not least because of tertiary care, where you might end up in a regional centre that it is far too specialised to have in every ICS. Of course, that needs to be resolved, and the patient voice will follow the fact that, for instance, in one ICS you may well, for care, go over the boundary to another.

Q152 **Rosie Cooper:** I suggest that my constituents do not have a voice in that second ICS, unless it is mine, which is not the whole story.

How do you envisage the representation of the NHS ICS boards being made up? How do you see them being chosen? Would private companies such as Virgin in my constituency be allowed to be on them? They would then influence the services and determine by whom they are provided.

That would not represent the views of my constituents. They would be very unhappy to hear private companies anywhere near decision making in the NHS.

Matt Hancock: That is not the intention. The intention is that the NHS board of the ICS will, essentially, hold the budget, and, therefore, be responsible for the allocation of that public money. Of course, most GP practices are private businesses. We want the voice of primary care to be heard, and, as part of the ICS partnership board, that will be important.

As you know, there is a false dichotomy between public and private. We have learnt over the last year that arguments that are based on public is good and private is bad are completely wrong. Again, I want to learn from the vaccine roll-out, which we could not have done without the amazing work of private companies. Obviously, I put at the top of the list the pharmaceutical companies, but GPs and pharmacists are at the core of the roll-out. The Bill will be designed according to the needs of patients, and making sure that there is accountability, but it will not acknowledge the false dichotomy that some people run with for ideological reasons that argue that public sector is good and private sector is bad, because that would be bad for patients.

Q153 **Rosie Cooper:** Secretary of State, nobody is saying that. People are saying that GPs have the Hippocratic oath and their clinical judgment to uphold, whereas the view of private companies such as Virgin Care is to look after their stakeholders. I do not accept any of that at all. Private companies should not be in a position where they can influence health and the type of our services and to whom and by whom they are delivered. Can I ask you one final thing to do with—

Matt Hancock: What do you mean by private businesses? GPs? They are private businesses. What about pharmacists?

Q154 **Rosie Cooper:** Hang on, Secretary of State, that is a false thing as well. They are private companies, but they have the Hippocratic oath and they can be struck off if they misbehave. People like Virgin Care can deliver poor services and they get away with it because CCGs are not regulated properly at the minute. They are supposed to be dealt with by NHS England and there is hardly any regulation. I will come to that now.

The proof of that is in the pudding. Liverpool CCG paid its non-exec directors £106,000 and £55,000, and they were not regulated. It took an MP to point that out, and for the CCG chief exec and finance director to be required to resign, only to find that the fit-and-proper-persons test does not work either because they popped up in Dudley.

Don't give me all that rubbish. We need a system that is regulated properly, and people need to be accountable. What you do here is you keep pushing the dice further along the line. These people are getting away with it, as would any of those private companies.

Matt Hancock: Rosie, I am going to stop you there because the thing is that I fundamentally agree with you about the need for accountability,

and the need for those who are exercising the use of local NHS money to be held properly to account. In fact, the Bill will strengthen that. The question I was asking and the point I was making is that you cannot in law say there must be no private voice if you also want to allow for the voice of GPs, because they are private sector.

I also accept that you are making an argument that there are different types of private organisations in the provision of care, and I respect your view that there is a distinction. The point I was trying to make was not to disagree with the vital need for accountability, of both public and private institutions by the way; it was simply to say that a straightforward public good/private bad argument does not work because GPs and of course pharmacists are private businesses.

Chair: Thank you. I am going to have to move on, Secretary of State. Rosie, I am so sorry, I will try to bring you back later if I can. James Davies wants to ask a question on the same topic—the whole question of the fit-and-proper-persons test.

Q155 **Dr Davies:** First, Secretary of State, in terms of choice for patients in the forthcoming legislation, can you confirm that the existing choices for treatment outside area and inside existing ICSs will be retained?

Matt Hancock: Yes, it is very important. The fundamental split between commissioning and provision of services remains. The goal is that that commissioning will be done with more flexibility to be able to spend money according to what improves local health outcomes, rather than in a highly bureaucratic way, as now.

Q156 **Dr Davies:** Very good. Thank you. Moving back to the fit-and-proper-persons issue, can you confirm that you are considering a reformed UK-wide register of persons appropriate to be appointed to boards?

Matt Hancock: I am open to that. In fact, may I bring in Jason to explain where we are up to?

Jason Yiannikkou: Thank you, Secretary of State. As you know, the Kark review made some recommendations in this area, which NHS England is looking at in the context of the People plan. We will be bringing forward an enabling power that will facilitate options in this space, but we need to wait for the work to be taken forward. We heard what Simon and Amanda said last week in this Committee as well.

Q157 **Dr Davies:** For clarity, Secretary of State, will you have the power to appoint or to block an individual joining a board?

Matt Hancock: Yes. It will be a power of veto where NHS England is responsible for the appointments, and a power of veto for chairs of the Secretary of State, essentially meaning that they will be joint appointments.

Q158 **Dr Davies:** On a completely different topic, if and when the legislation is

passed, what are your intentions with regard to rolling out fluoridation in water?

Matt Hancock: I will turn to Jason again to set out the details, but there are very clear public health advantages to the fluoridation of water. The power was devolved to local authorities as part of the 2012 reforms; however, because water courses do not respect local authority boundaries, and for all sorts of other reasons, very little progress was made. The vast majority of the public support fluoridation of water and it is very good for dental health. We should not be held back by the very small number of people who disagree, given that the clinical evidence is so strong. We are proposing to take responsibility back up to the national level where it more appropriately sits. Jason?

Jason Yiannikkou: I think you have covered it all pretty much, Secretary of State. I emphasise that it is an enabling power, so it gives flexibility, and there would be consultation and so on in the normal way

Q159 **Dr Davies:** Consultation, but the intention if possible is to roll it out nationwide.

Matt Hancock: Yes.

Q160 **Chair:** I would like to move on to some of the things that are not covered in the White Paper but have come up in our Committee's investigations. The first is around long-term workforce planning. The White Paper envisages the Secretary of State reporting to Parliament, once a Parliament, on workforce planning, but there is nothing about independent workforce projections. Given that it takes seven years to train a doctor and three years to train a nurse, and so on, how can we know if we are actually training enough doctors and nurses unless we have independent projections of what we are going to need in 10 years' time in the public domain?

Matt Hancock: That in itself is a judgment. The proposal in the Bill is to ensure that there is proper accountability for answering that question rather than a direct answer in the Bill on how to answer that question. The accountability will be made clear in the Bill. That is my proposal. I have been working with the RCN and others on this, and I think that having that accountability is important, and that makes it absolutely crystal clear that we need to do it. Ultimately, because these are judgments rather than objective facts, it is important that it comes down to assessing a huge range of factors and coming to an answer.

Q161 **Chair:** I think you understand this, but the problem for us is that there cannot be accountability on that issue, which we have so often got wrong over the years, unless we know, as Parliament and the public, what the long-term projections are. If they are not in the public domain, it is impossible to know that the number of nurses we are training, for example, is not the outcome of haggling in a spending review rather than something that the NHS actually needs.

Last week, we had Amanda Pritchard, the chief operating officer of NHS England, and before that Danny Mortimer of the NHS Confederation, and they both said that not training enough staff costs the NHS more, not less, because of the £6 billion a year we have to spend on locum and agency staff. Do you think they are right?

Matt Hancock: Yes, I agree with that argument. You will know that I am a massive champion of training more staff. We are on track to hit 50,000 more nurses over this Parliament. We have record numbers of doctors and doctors in training, in part thanks to your work. I absolutely agree that both a properly trained workforce and enough of a workforce to draw from make it easier to run the NHS and reduce things such as agency costs, which are thankfully coming down but are still too high.

I agree with the premise of the question and what Amanda said, but the question is how to deliver on that. You do not want false objectivity in this space. There is the idea that because a body is independent it can come up with the right answer in this space, but it is a judgment. How did we come to the judgment that we need 50,000 more nurses in the NHS? That was a judgment based on looking at the number of real-world vacancies. I do not mean the vacancy stats, which are not an accurate reflection of the real world because they do not take into account the number of bank staff, for instance, who are filling shifts. We looked at the pressures on NHS staff numbers, and at population projections, of course, and we came to the conclusion that 50,000 was about the right number.

Especially after this pandemic, everybody has learnt a bit more about how to deal with uncertainty in public debate. There is uncertainty over this question, and false objectivity undermines good policy making. Even if it may sound easy to say, "Let's have an independent target for this. Let's have some independent people set out the numbers on a spreadsheet," that does not make it any truer than the best judgment of a Minister.

Q162 **Chair:** Sure, but the way to deal with false objectivity is not to ban independent organisations from publishing their forecasts. It must be to get people to get better at modelling. Anita Charlesworth from the Health Foundation said that a solution might be for Health Education England to have a legal obligation to publish independent workforce projections every year. Is that something you might be open to?

Matt Hancock: I think the way we have structured it in the Bill, where we set out that there is accountability for answering the question, is the best way to do it. Of course, endless bodies produce workforce forecasts. That is totally reasonable. What you need is transparency from Health Education England and a public debate around what the judgment should be.

I come back to the very first question you asked me about the CQC role. A combination of transparency around the figures that we are working

off, so that everybody is working off the same figures, then a public debate, and, ultimately, a judgment call, is the best way for us to make decisions on this as a body politic. Trying to say that one particular independent expert has sole veracity and truth is false.

Chair: Thank you.

Q163 **Sarah Owen:** Secretary of State, I want to push a little further on workforce and workforce planning, please. When it comes to accountability for Ministers in answering questions, we know that there are numerous levels of accountability for Ministers to answer questions that they actually fail already. Why do you think that you should be trusted on the issue of workforce planning and accountability when it comes to answering how many healthcare staff we actually need when so many questions that you are accountable for so far have been unanswered?

Matt Hancock: I think we are in an incredibly strong position on this. Obviously, I completely reject your assertion. The first point is that 18 months ago we committed to having 50,000 more nurses in the NHS over this Parliament, and we are already well on the way to doing that and on track. In addition, we have not just focused on the number of nurses—

Q164 **Sarah Owen:** Secretary of State, how many are planning on leaving?

Matt Hancock: You will have seen in the People survey, fewer than a year ago.

Q165 **Sarah Owen:** How many more do we need? The point that I think the Chair was trying to get to is that it is very difficult to say we are training enough nurses and doctors if the public are not being told exactly how many we need. Why wouldn't—

Matt Hancock: But—

Sarah Owen: Why wouldn't you just include it in the Bill and cut out the middle man?

Matt Hancock: It is quite hard to be accountable for answering questions when every time I try to answer one, you cut in. The point I was making is precisely that there is not a single true answer to this; there is uncertainty. In a way, the questions that you have asked demonstrate why the approach of trying to pretend that if you ask an independent expert you will get the correct answer is wrong. You have to take into account all considerations and make a judgment. The 50,000-nurse commitment is a really good example.

We could have asked an independent expert—we could have asked five, and they would have come out with five different answers. Ultimately, you have to make a judgment and deliver against it. We made a judgment and we are delivering against it. By the way, we are not just hiring nurses. We are hiring other healthcare professionals and, thanks to

the Chair's work, we also have record numbers of doctors in the NHS. That is what delivering on these commitments is all about.

If you look at the People survey from last week, the proportion of people who feel that there are not enough staff to do the work has fallen significantly, so I am really pleased with the outcomes in this space. I will bow to no one in my enthusiasm for having a properly staffed NHS. More than that, Sarah—

Q166 **Sarah Owen:** Thank you, Secretary of State. Before I move on to my next questions, I would like to say that I think the way you just spoke to me is beneath your office and beneath how we should be speaking to each other as MPs. I will move on to my next question.

The numbers in the workforce that we have are not just about training new people; they are also about retaining people. In terms of workforce planning, will pay and terms and conditions feature as part of future workforce planning?

Matt Hancock: The good news is that again the People survey showed that fewer people were thinking of leaving their posts in the NHS over the last year. I am really pleased about that. In a pandemic it could easily have gone the other way, but because of the sense of mission, I think, and because of the support that the whole nation has given NHS staff over the pandemic, that has improved. Thank you for allowing me to answer that question.

Q167 **Sarah Owen:** Another question is that we are around 100,000 full-time carers short, or that is what the experts say; you may differ. Will the workforce planning and supply document cover social care as well as the NHS?

Matt Hancock: This is one of the points I was trying to make earlier. You have to be very careful with how these sorts of figures are published in case they are misinterpreted, whether wilfully or not. The vacancies statistic is not a good reflection of how many more people are needed in the NHS. Let me give you one example.

If I put more funding into the NHS and as a result NHS trusts want to hire, the first thing they do is publish vacancies, and that implies that the vacancy level, and therefore the level of staff shortages, has gone up, but actually they are resolving a problem of staff shortages. The 40,000 figure, and the 100,000 figure you have just quoted, are not accurate and, more so, they do not take into account people working bank. When you are working bank, that is effectively increasing the flexibility of the workforce locally. Both of these—

Q168 **Sarah Owen:** Sorry, Secretary of State, I have worked bank shifts as an HCA on wards. I have also been a care worker. When we saw the experts a week ago, we were asking how care workers and healthcare workers are plugging the existing gaps. Whether you think there are 100,000 or 10,000, the experts told us that in the workforce carers are cancelling

leave and they are doing extra hours. We are having an inquiry about workforce burn-out. How are you going to address that in future workforce planning?

Matt Hancock: Yes, obviously the pressures that some have been under have been absolutely intense. My disagreement with some of the ways that this is measured does not take away from my determination to fix the underlying problem. The two are separate. There is the fundamental problem of how to make sure we get enough staff in the NHS. The critical thing about that will be delivering on the commitments we have made, which we are on track to deliver on, including 50,000 more nurses, for instance.

On burn-out, it is absolutely vital that people get the R&R they need and that people get recovery time. What people in the NHS are asking me for when I go and do shifts and listen to people is to make sure that there is enough time to recover and to internalise some of the experiences they have been through, and I am absolutely determined that that is provided.

Q169 **Sarah Owen:** For those 50,000 nurses you say have been trained, how many does that leave us short, in your expert opinion?

Matt Hancock: We have not trained them all yet. Over the last year, there have been just over 10,000. In the last 18 months, it is more like over 15,000 more nurses in the NHS. That still means we have to deliver just over 30,000 more over this Parliament, but we are on track to do that.

Chair: Last question, please, Sarah.

Q170 **Sarah Owen:** Obviously, a large number of people will still be coming from overseas to work in our fantastic NHS. I know there has been a pause while the pandemic is on, but do you think that post pandemic NHS and care workers who come from overseas to care for our loved ones should continue to pay the immigration health surcharge?

Matt Hancock: In many cases, it is paid by the NHS trust. The good news is that international recruitment is incredibly strong at the moment. I am absolutely delighted about that. Again, we have more to do in that space, but international recruitment is going really well.

Chair: Thank you very much.

Q171 **Paul Bristow:** In your previous answers, Secretary of State, you talked about the danger of false objectivity and how much uncertainty there is in this field in terms of NHS staffing needs and the importance of ministerial judgment. In that regard, is the five-year reporting duty, or once a Parliament, enough?

Matt Hancock: It needs to be, essentially, permanent. The point about setting it out once a Parliament is to set out, once a Parliament, who is accountable and how that system works. The accountability for answering questions, like the exchanges that we have just had with your colleague,

is permanent. You have to constantly be looking out for the future workforce of the NHS—of course you do.

Q172 **Paul Bristow:** The White Paper sets out plans to abolish local education boards—the statutory bodies. How will that help overall workforce planning?

Matt Hancock: It is a matter of making sure the system is more aligned. Health Education England essentially leads on this area, and that is what really delivers in practice. Maybe Jason can set out more details.

Jason Yiannikkou: The function does not really change and the importance of the function does not go away. It has become recognised that, when the 2012 Act went through, we introduced a bit too much rigidity around how it was done through the LETBs. This will give systems more flexibility about how they do the work, but the work absolutely continues.

Q173 **Paul Bristow:** Isn't there a danger that those bodies can be replicated by other bodies? There will always be a need for a regional body to do that.

Jason Yiannikkou: Workforce planning needs to be done at all levels. The general thrust of the Bill is to introduce flexibilities. There will be rigour in the way that organisations are held to account about how well they deliver, including working with others at different levels.

Q174 **Paul Bristow:** Secretary of State, you mentioned in your introduction at the start of the session that one of the goals of the Bill is to build on best practice, when systems work together. I understand how integration in an ICS can do that, but is there a role within the legislation to set forth how we spread best practice from a particular ICS to other parts of the country at pace and scale?

Matt Hancock: Yes. That is a really important question. Somebody asked me when we were doing the work—it might have been Jason—of where the improvement organisation would be. Where will the transformation organisation be—doing the role of spotting an ICS that is working really well and ensuring that what they do in that secret sauce is spread across the country? The answer to that must be NHS England, accountable to the Department.

The role of the centre is absolutely to spot and spread good practice: first, to support local areas, so that they have the support needed in order to deliver; and, of course, to hold them to account, but also to be the transformation agency. One of the problems of the framing of the current legislation is that, formally, after all, NHS England is the NHS commissioning board. Its actual legislative role is to commission services, not to lead the NHS. Under Sir Simon Stevens, it has morphed that role from the original legislative intent to, essentially, NHS HQ. In my view, that is fine. The merger of NHS Improvement and NHS England has been a good thing. What this does is that it entrenches—entrenches is the

wrong word. It reforms the role of NHS England to be a supportive transformation agency rather than a quasi-regulator. That is a very important cultural change in NHS England that I know Sir Simon is excited about.

Paul Bristow: Thank you very much.

Q175 **Barbara Keeley:** I will take you back very quickly, Secretary of State, to a question about workforce shortages. A very specific workforce shortage is that of learning disability nurses. There has been a 40% drop in the number of posts since 2010. There is not actually a problem with training, because we already have many thousands more trained learning disabilities nurses than paid posts. What will this Bill do in cases like that, to ensure that we have enough staff employed by the NHS in roles like the vital, much-needed learning disability nurse role?

Matt Hancock: I know that you have done a huge amount of work on this, and it is an area I care deeply about. It will be a responsibility of the ICS to look after the health and care needs of the whole population. Exactly how we frame that to solve real-world problems and make sure that there is constant improvement on the ground is important. The enhanced accountability will be important. If you think about the debates you and I have had in Parliament, and the discussions we have had, about how to make improvements in this space, lack of accountability has been at the heart of some of the problems. In fact, to refer back, Rosie Cooper and I had a robust exchange about accountability, but ultimately with emphatic agreement that accountability is vital to getting to the bottom of failing areas of healthcare.

Q176 **Barbara Keeley:** The problem is that there is a big gap, the 40% gap I have talked about. We have 17,000 trained learning disability nurses in this country and only 3,000 in post. How does that happen? Why are we training those people, who are needed, and then there are not enough posts for them? Trusts are not appointing them.

Matt Hancock: There is a multitude of reasons for that. I hope that the new governance will give us a better opportunity than now to fix it, because there is more direct accountability. If you pushed me on this as Secretary of State and I agreed with you, which I do, I would have more powers to be able to go and fix it.

Q177 **Barbara Keeley:** Let's move on to social care because that is an important area where there are some issues. Clearly, we are waiting for and hoping that we see the proposals that are coming forward this year. Will that be in the form of a 10-year plan for social care to complement the NHS 10-year plan?

Matt Hancock: The goal of course is to deliver on our manifesto commitment to ensure that there is reform of social care to remove the injustices in that system, and the Prime Minister is committed to publishing that plan this year. Last year, we of course intended to publish, and the pandemic got in the way of the work, as I am sure you

can imagine, as everybody was focused on dealing with the pandemic both in social care and in terms of policy making.

Q178 **Barbara Keeley:** There is an issue though that people can quite clearly see what happens to integrated care if the social care financial settlement is not—*[Inaudible.]* Social care is seriously underfunded by billions of pounds. Without adequate funding, will it just pull money in the integrated care system across? It is not a situation that people think will work.

Matt Hancock: There are two ways to answer the question. The first is that the reforms we are discussing today are one of four sets of reforms across the health and care piece. Social care is clearly one of those, but we have not yet published a White Paper on it. That is one way of answering the question and explaining where we are up to without putting any meat on the bones.

The other way I think of it is this. In the much-needed reform of social care, there are many parts. There are parts that are non-legislative. There are parts that require better integration with the health service, which this White Paper and Bill will deliver. Then there are broader questions around the long-term funding—who pays for it—within social care. That is for a separate set of reforms, and a separate White Paper, and will be legislated for separately. All of those are important.

Q179 **Barbara Keeley:** There is a lot of attention being drawn to what is not in the White Paper. The White Paper has some things to say about the way the NHS works with formal social care services, but it does not make a single mention of unpaid carers. They are partners in care. There are 13.6 million unpaid carers, including 4.5 million who started caring during the pandemic. They feel that during the crisis they have been forgotten, partly because in many cases the NHS failed to involve them around important issues like discharge from hospital. What steps will you be taking in the legislation to strengthen the rights of carers and ensure that they start to be included in health and care planning?

Matt Hancock: That is a really important point. In a way, it underlines the importance of Select Committee scrutiny of Government White Papers before the publication of a Bill because of the point you have made, which I take on board. Unless Jason has a better answer, all I can say is that it is something we should work on together.

There is one point that I would pick up on. Unpaid carers have been put front and centre in the vaccination effort. The fact that unpaid carers are in category 6 is a reflection of the importance that we put on making sure that all unpaid carers get the opportunity to be vaccinated ahead of their position in terms of age.

Barbara Keeley: Could I come in on that?

Chair: We have to move on, Barbara. We will do it by correspondence, because that is a very helpful suggestion from the Secretary of State.

Q180 **Neale Hanvey:** Good morning, Secretary of State. I want to start by asking you about timing. Why now for the White Paper, and particularly why in this sequence? We have known for some time, certainly from when I arrived in Parliament, that there is a desperate need to reform social care and a desperate need to secure significant investment for social care; and we understand in very clear terms following the pandemic how interdependent both social care and the health service are. It seems peculiar to me that, following the questions we asked the Care Minister when she arrived at the Committee, she could not give us a date for social care reform.

Given that the ICSs' success or failure will be dependent on robust services all round, and—I am sorry to load you like this—in the context that the Budget did not deliver additional funding for the NHS, and there are many esteemed voices who have spoken out, from NHS Providers to the charity sector, raising concerns about this work being conducted now without funding, I cannot understand why you would expect people who have been working their socks off to deal with a pandemic to deal with major reform, without funding and solving some of the vital issues, particularly in social care, that we know exist.

Why put the cart before the horse? The cynic in me, the person who has worked in the NHS and heard many Secretaries of State, including the Chair, make announcements, and greet them with a wry smile, particularly the warm words, would be very interested to understand why it is happening. It feels a bit like a squirrel for a dog: let's make you focus on something else, rather than deal with the real fundamental issues that we need to tackle.

Matt Hancock: Why now? I will tell you. The reason is that these reforms will help the NHS. They will help the NHS to deliver the services that it needs to. They will help to improve the health of the population. They will help to ensure that we can recover the backlog in the elective waiting list. They will help to make sure that we have proper and full accountability.

These reforms largely, the vast majority, come from the NHS, as Sir Simon set out last week. They are of the NHS, building in the needs of local authorities. Why now is because I want to get on with supporting the NHS to do the incredibly important work that it is doing.

Q181 **Neale Hanvey:** But forgive me, Secretary of State—

Matt Hancock: I am terribly sorry, Mr Hanvey. I am going to finish my answer. I know I was interrupted earlier.

Q182 **Neale Hanvey:** But it is not an answer. That is the problem. It is not an answer; it is a political speech.

Matt Hancock: I will carry on with the answer.

Q183 **Neale Hanvey:** It is not an answer, Mr Hancock.

Matt Hancock: Chair, it is very difficult. I am terribly sorry.

Chair: Let's ask the Secretary of State to finish his answer and then, Neale, we will come back to you.

Matt Hancock: Thank you very much. The other way to explain why now is that I am proposing a White Paper that will lead to legislation. That legislation takes time to pass through Parliament. Do we want to wait, or do we want to have this in place by April 2022 when parts of the NHS are crying out for these reforms? People have been looking for the integration of the NHS and social care for years. Here we have an opportunity to deliver it, and I am absolutely going to seize it.

Q184 **Neale Hanvey:** As someone who has been through the whole process from shadow integration to the reality in Scotland, which we did a number of years ago, I can tell you that, without proper support and funding, this will not make a jot of difference, because the frontline staff will still be under the extreme pressure that they are now. That is being pointed out to you by the experts. The political lines on this are great ambitions. They are absolutely fantastic. I fully support integration.

Matt Hancock: Great, then let's get on with it.

Q185 **Neale Hanvey:** What I am saying is that I want to understand how. You have given a list of things that it is going to do. How will it do that without reform of social care? How will it do that without reinvesting the money that was taken out through the austerity years? How will you do that without significant investment? The most recent Budget failed to make any contribution to social care.

Matt Hancock: You will be a greater expert in the Scottish system than me. If your analysis is that the Scottish integration has, in your words, failed—

Q186 **Neale Hanvey:** That is not what I said. I said proper support and funding. It had proper support and funding in Scotland. You are not providing any support or funding.

Matt Hancock: I am sorry. I thought you said it did not work in Scotland, and I was surprised to hear that.

Q187 **Neale Hanvey:** No, I said it needs proper funding to work.

Matt Hancock: Others can make that judgment. The fundamental point is that we have put in a long-term settlement for NHS funding. It is a £33.9 billion increase in funding. On top of that—

Neale Hanvey: The funding went down this year.

Matt Hancock: Please. This is supposed to be a discourse about how to improve the laws of the nation. This political posturing and interruption—

Q188 **Chair:** Secretary of State, let me move on because I want to ask a

question following up on that, which is about the costs of the reforms. How much will they cost? Will the extra costs incurred by the reforms be picked up by the NHS or by the Government centrally?

Matt Hancock: The reforms will save money by reducing bureaucracy with the integration, where often the best outcome for a patient also is cheaper for the taxpayer. The savings are already baked into the long-term plan settlement and will be reinvested into the ICSs, into the frontline for the delivery of services.

Neale Hanvey: Chair, may I make one point?

Chair: I am so sorry, Neale, but we—

Neale Hanvey: The purpose of the Secretary of State to come to this Committee is to be scrutinised and held to account. If that means that we ask him difficult questions, he must answer the question, not give a political speech. I am sorry; I fully agree with my colleague Sarah Owen.

Chair: I understand that. Everyone has to make their judgment as to whether their questions are answered, and that is why you have time to ask more than one question if you do not get the answer you need. I am so sorry, Neale, but I need to bring in a couple of people who have not come in yet.

Q189 **Dr Evans:** Thank you, Chair, and thank you, Secretary of State. I am particularly interested in the removing bureaucracy and red tape aspect. When Simon Stevens came, he welcomed the changes that you are putting forward. He split them into the administrative side and the frontline side. On the administrative side, you have got rid of competitive tendering, which the NHS is very pleased about. You have talked about how much that will save. Are you able to give us a figure of how much we are likely to save with those changes?

Matt Hancock: I do not have an exact cash figure for those savings. It will depend on how effectively people are able to improve their procurement because of the reduction in bureaucracy around it, as well as the direct costs of the bureaucracy that is being removed.

Q190 **Dr Evans:** Would you be able to write to us with those figures even if they are an estimate? It would be really useful to see how much of a difference it would make.

Matt Hancock: I would be very happy to.

Q191 **Dr Evans:** On the second side, the frontline side, do you have a feeling of what these changes will make as a difference to red tape and bureaucracy for those in the wards or in GP practices?

Matt Hancock: Yes, because we have already seen some of that during the pandemic. For instance, the radical simplification in the data protection guidance that we put out in April last year has been warmly welcomed across the system. Previously, it was incredibly convoluted,

and we simply said, "Protect patients' data but use modern techniques if you want to. Of course, you can use WhatsApp so long as you use WhatsApp appropriately." What matters is the protection of the data. That is just one example that we were able to do on a secondary legislation basis. There is a whole load more on that.

Q192 **Dr Evans:** I am really keen you picked up on that one. You mentioned at the start that this gives accountability. I am keen to see accountability at the frontline. Often, lots of doctors, nurses and receptionists have great ideas but have no power to change things. I wonder if there is a way to legislate to put them in a position of power. We have a named advocate for GDPR reasons. We have a named advocate for whistleblowing. Is there a case to have a named person for change, where they are brought forward and protected in law to allow them to suggest ideas that would have to be mandatorily picked up and considered by those above them? That drives change from the front that can, hopefully, unleash some of the potential that we have seen in the pandemic.

Matt Hancock: That is another excellent idea. How we operationalise it will be complicated, but I am very happy to work with the Committee on it.

Q193 **Dr Evans:** One of the biggest things I saw practising as a GP is the integration, or lack thereof, between primary care IT and secondary care IT. You talk about bureaucracy and data in the White Paper. Is there an IT road map that you will be producing to allow that integration to happen? Fundamentally, that is one of the biggest problems we have. We now do not have fax machines, but we pay someone to scan letters that are sent. That seems bizarre in the 21st century.

Matt Hancock: Yes. In fact, I was due to be giving a speech on that right now before the Select Committee request came in, but I am giving it on Thursday instead. We are coming forward with more details in this area. There will be clauses in the Bill to help improve the interoperability of data, which is incredibly important, not just between primary or secondary care, although that is critical, but across the board. There is a lot of work to do in this space.

The NHS has made big strides. NHS Digital has done a great job. The leadership of NHSX in setting it out strategically has been important. Again, we are learning from the vaccines roll-out, where the data architecture got sorted at the start, thank goodness. We went into it actively writing a clean data architecture. We know who has been vaccinated. We can get that back to their GP record. We can call people for their second dose at the right time as well. That is absolutely critical, and we should learn from the vaccine roll-out.

Chair: Last but not least, Dean Russell.

Q194 **Dean Russell:** Thank you, Chair, and thank you, Secretary of State, for everything you have been doing today, and to your team and to everyone

else as well through the pandemic.

My question is building on the digital and IT side of things. From virtual wards through to the use of Apple watches and Fitbits and so on, we see data and digital being at the heart of healthcare, especially personal healthcare. Can you build a little bit more on what you were just saying about the digital road map? How can we start to connect the data so that we have more of a single-patient view, not just for health but across social care as well?

Matt Hancock: I refer to my previous answer, as they say. What I said then absolutely applies across social care as well. It is more complicated in social care because the social care system is formally accountable to local authorities, but we have to make sure that we can also have a high-quality data platform in social care. There has been an incredible improvement in this throughout the pandemic. At the start of the pandemic, we had very little data centrally on the social care system. Now, we have coverage in data returns from almost the entire adult social care system. That is a critical part of this.

Q195 **Dean Russell:** Do you see as part of that road map a position at any point in the future where GPs may start to be able to access data from things like Fitbits and so on, to be able to help track and monitor patients, and vice versa where GPs might prescribe apps, for example, to help in clinical review and in terms of predicting potential health outcomes?

Matt Hancock: Yes, on all fronts.

Dean Russell: Fantastic. Thank you, Secretary of State.

Chair: Secretary of State, you have been very generous with your time this morning. We have covered a lot of ground and we have covered the things that people are concerned are not included in the Bill as much as the ones that are.

On the point about the costs of the reforms, could you write to me separately to confirm? There is a question about that. Most reforms are thought to be cost saving in the long run, but it is the up-front costs of change and of people being appointed to new jobs and so on. It would be helpful to clarify what you think those costs are and who will be bearing them before the savings come through. Subject to that, we can let you go. Thank you very much for your time this morning. Jason Yiannikkou, thank you for your time as well.

We will try to produce our report on the White Paper promptly, so that it comes ahead of any Second Reading debate, should the Government decide to bring forward legislation. Thank you very much indeed.