HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Clearing the backlog caused by the pandemic, HC 599

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Dr Luke Evans; Barbara Keeley; Anum Qaisar-Javed; Dean Russell; Laura Trott.

Questions 198 - 276

Witness

I: Rt Hon. Sajid Javid MP, Secretary of State, Department of Health and Social Care.

Examination of witness

Witness: Rt Hon. Sajid Javid MP.

Q198 **Chair:** Good morning, and welcome to the Health and Social Care Committee's inquiry into clearing the backlog caused by the pandemic. This morning, we are pleased to welcome the relatively new Secretary of State for Health and Social Care. Thank you very much for being with us this morning. Welcome to the first of what we hope will be your many appearances before our Select Committee. We are genuinely pleased that you are joining us.

We would like to start, as we often have in the last couple of years, by thanking you and your team and asking you to thank everyone in the NHS and care system for the incredible work that they have been doing through the pandemic and, indeed, in dealing with the backlog.

May I start with some questions on the Budget and spending review settlement announced last week? We know that the health and care levy will generate around £10 billion a year for the NHS, which, according to the Red Book, is about a 3.8% real-terms increase per annum. Obviously, if we do not have additional doctors and nurses to do all the extra procedures that will need to be done, we will not get the improvements that everyone wants. We know that over the last year there have been 4,000 more doctors and 10,000 more nurses. On top of the extra doctors and nurses we already have, how many more do you think we will need to tackle the backlog?

Sajid Javid: Thanks for the welcome. Before I answer the question, I will take a minute, if I may, to say something up front. This is my first appearance before your Select Committee, but, like you, I look forward to many more. It is a pleasure to be in front of you all today.

When I reflect on the past 18 months or so for everyone in the country, but especially anyone who works in health and social care, it is hard to imagine a more challenging time. Clearly, it has been the most challenging in living memory. Those in health and social care have been on the frontline. One thing that was clear to me even before I took the job, but is even clearer now that I have done the job for a few months, is that many of the people who have served, and continue to serve, on the frontline of health and social care have shown extraordinary skill, dedication and compassion. What they have done has been absolutely essential to our recovery from this awful pandemic.

As you know, my job is to do the best I can both to support health and social care and, ultimately, to make sure that health and social care are there for everyone in our country. As I do that job, the work of this Select Committee will be really important to me and my team. The scrutiny that you provide, and will continue to provide, as Committee members—including today, of course—is an important part of our democracy and ultimately leads to better outcomes. I thank all of you, particularly you,

Mr Chairman, for the work that you are leading through this Committee. I look forward to working with you all to deliver on that.

Turning to the settlement and your question specifically around workforce, perhaps I can start with this. I was just getting acquainted with some of the more recent up-to-date numbers on workforce and where we are. As you know, the NHS is one of the largest employers in the world. The latest numbers I have show that, as of August 2021, we are at 1.2 million full-time equivalent people working in the NHS. The total headcount is 1.3 million. That already includes record numbers of doctors and nurses. Just in the last year, especially to try to help with the pandemic, we have seen an increase of over 20,000 qualified clinical staff, which includes some 5,500 doctors throughout the NHS and over 10,000 nurses.

As the Committee will be aware, the Government have a number of commitments on workforce and workforce planning. Some of them were there before the pandemic. There is the commitment to 50,000 more nurses by the end of the Parliament. So far, we are on track for that, with 10,000 more nurses. There is also a commitment for 50 million more primary care appointments, which will need more doctors and other primary care staff.

On the settlement itself, the Committee may already be aware of the headline numbers of the recent SR outcome, but I will just make sure. In terms of workforce, the major impact will come from the resource spending, called RDEL funding, that we will receive. For the NHS, that will be £15.7 billion. The 1.25% levy on national insurance over three years will raise £36 billion—£12 billion a year—over that three-year period. That is extra spending. It is an addition, on top of what was already planned for the NHS, through the long-term plan and in other ways. That funding is untouched, in terms of increases. This is on top of that.

The NHS will be working to break down the extra £15.7 billion of spending into what will be needed for workforce to deal with electives, primary care and the other levels of care that it plans. By the end of November, it will set out an elective recovery plan that will detail how it plans to meet its workforce requirements.

Q199 **Chair:** That is very helpful. The NHS says that in order to deal with the elective backlog it will need to increase its capacity to 30% above pre-pandemic levels. The Health Foundation said in evidence to the Committee that that will need 4,000 more doctors and 18,000 more nurses. In order to ask the Chancellor for those extra sums of money, you must have done calculations as to how many additional doctors and nurses you are going to need, because it is impossible to know the sums of money that you will need without knowing the extra capacity needed. What is your calculation as to the number of extra doctors and nurses that you believe the system will need in order to deal with the backlog?

Sajid Javid: I cannot give you an exact number for what we are going to need right now. As you know, the SR was only last week. In trying to reach an agreement internally in government on what the funding would be, of course, we had to make assumptions around workforce need, capital need and other needs. Once we got the final settlement, we wanted to make sure that we had looked at it again properly in detail and publish our plans. We will set out what those are in terms of actual numbers.

Q200 **Chair:** I just want to be clear. The concern that a lot of people have is that there is absolutely no detail about the number of extra doctors and nurses that you think will be necessary, but you have those assumptions, and before the end of November you will publish the number of extra doctors and nurses that you think will be necessary to tackle the backlog.

Sajid Javid: What I will say is this. We will be publishing an elective delivery plan around electives specifically. Of course, the work that the Department and the NHS do is broader than that, but specifically on the delivery plan we will go into some detail about the workforce requirements—

Q201 **Chair:** I am so sorry to interrupt. It is a very specific point. I understand that there is going to be a delivery plan and that you are going to be planning how many more operations will be done every year. I understand as well that you cannot tell us whether you are going to deal with the backlog, because we do not know by how much the waiting list is going to swell in the months ahead. We are looking at something much more specific, which is a workforce plan. How many more doctors and how many more nurses?

Let me give you some numbers. You will be very familiar with these numbers. The royal colleges say that we are going to need 500 more obstetricians, 1,400 more anaesthetists, 1,900 more radiologists, 2,000 more midwives, 2,000 to 2,500 more A&E consultants, 2,500 more GPs and 39,000 more nurses. In fact, there are 93,000 vacancies in total across the NHS. The royal colleges and the Health Foundation are talking about very specific numbers in each specialty. You must have those numbers. Do you have those numbers privately? We know that you have not published them yet, but do you have your own internal estimates of what we are short?

Sajid Javid: Of course. We have internal estimates. Now that we know for the Department and, therefore, for the NHS, what our final financial settlement is, we will be working on and fine-tuning that plan.

As you may be aware, it is not just about identifying immediate need. Colleagues will know that there was a shortage of clinicians in the NHS even before the pandemic began. You have just rightly referred to the approximately 93,000 vacancies at the moment. Those include, for example, almost 10,000 vacancies for doctors in the NHS. A lot of this challenge existed even before the pandemic. It has become more acute

because of the needs. I think we need better long-term planning of workforce needs and—

Q202 **Chair:** I am so sorry to interrupt. I will come on to the long term, but I want to deal with the short term first. There is an immediate short-term need, and there are immediate short-term things that you could do—for example, increasing retention, bringing back retired clinicians and changes to immigration procedures to make it smoother and easier for people coming from countries whose medical training we trust. By the end of November, we will have a workforce plan that says, "These are the gaps, specialty by specialty. These are the extra people we are seeking to recruit, specialty by speciality. These are the things that we are going to do in the short term." The money from the levy starts in April, so we have to get cracking pretty quickly to fill the workforce gaps. That workforce plan is what we are going to see by the end of November.

Sajid Javid: Let me be a bit clearer. What I referred to earlier for the end of November is a delivery plan specifically around electives. Of course, that has a workforce need that comes with it. When it comes to electives, in our delivery plan we will set out how we hope to meet both short-term and long-term workforce needs.

Of course, there is a broader workforce need, beyond electives—for example, in primary care, in community hospitals and elsewhere. There is also social care. We need to think about the long-term need there and the interaction between need in healthcare and social care in terms of workforce. Planning better for that is a separate piece of work that is already on the way.

Q203 **Chair:** When will that be complete?

Sajid Javid: It is work that has been commenced already by HEE. I asked HEE, in July I think, to start a piece of work on what we call a 15-year plan to set up a strategic framework for long-term workforce need. It is a big approach.

You ask me when it would be complete. Spring next year is roughly the timing that we have set for that. The reason is that HEE is consulting widely. You could call it a big-tent operation. They are speaking to academics, some of the organisations that you have already mentioned and think-tanks. They are looking at demographic changes, technology changes, the use of technology and how that impacts on workforce, the educational environment and economic changes, and even at what the behavioural changes towards work that we have seen because of the pandemic might mean. They are trying to take all of that into account and will come back to me, hopefully by spring next year, and set out a framework for long-term planning of workforce needs.

Q204 **Chair:** I want to talk about that, but I need to be clear. There is a workforce crisis now. You will be hearing this every day. There is a particular crisis at the moment in A&Es. The money from the levy starts

next April. In the short term, will you publish by the end of the year, not necessarily November, what you think the short-term gaps in the NHS workforce are, specialty by specialty, and what the short-term plans are to deal with those gaps? Will that be part of what we get?

Many people on the frontline of the NHS are absolutely desperate at the moment. They love the idea of a long-term plan, but they want to know that there are things that are going to happen right away. Are you happy to make the commitment that, at least by the end of the year, there will be a workforce plan that says what you are going to do for the next 12 to 18 months to deal with the short-term issues?

Sajid Javid: I am happy to say that by the end of the year we will set that out, not just through one document, but through a couple of different ones. For example, on winter planning, we are working on a strategic narrative between the NHS and social care, which will address some of the workforce concerns. That, too, will be published before the end of the year.

Q205 **Chair:** That is great. Thank you. I now want to move on to the long-term things you were talking about, which are very important. As you know, it takes seven years to train a doctor. Thinking about the number of doctors that we will need in seven, eight or nine years, it is incredibly important to be training the right number now. The Health Foundation says that between now and the end of this decade we will need 488,000 more staff in the NHS and 627,000 more in the care system. HEE has not published what it thinks the long-term need for doctors and nurses in the NHS is since 2017. Will we get that number by the spring? I want to check that that is the piece of work that is going to be done.

Sajid Javid: Let me say a bit more about that piece of work. By the way, the reason I commissioned that work is that what you have just said, and what you and others have said in the past in Parliament, about the need for long-term workforce planning, both for the NHS and for the care system, is absolutely right. As you say, the last plan was done pre-pandemic. We could not have seen more change than we have seen since that date. We need a better approach to this.

I have asked HEE to do that piece of work independently; we refer to it internally as framework 15. It involves looking to a 15-year horizon—a very long-term horizon—taking changes into account. We can more or less predict some of those changes, such as the long-term trends in demographics. Some will be harder, around technology, the educational environment, the economic environment and behavioural changes to the approach to work in future. HEE will take all of that into account, consulting far and wide with organisations that you have just mentioned, such as the royal colleges, and other important players in the health space, academics and others. It will then produce for publication publicly—not just for me, although it will, of course, be of huge value to me—a framework to make those decisions.

You just asked me whether HEE will put a number on that and say, "You need X of this type of clinician and Y of this. This is the need for nurses or midwives." At this point, I cannot tell you whether that is exactly what they will come up with. I have given them a mandate to set out the framework, and I want them to go as far as they feel they need to go. I agree very much that the way this has been approached in the past has to change. We need a much longer-term approach. Think of it as a significant step in doing that.

The step that we have taken might not satisfy everyone. I am constantly reviewing to see what more we can do, in the context of the Bill that is in front of Parliament now, the Health and Care Bill. There has, perfectly rightly, been debate around this from many, including yourself and other members of the Committee. I am listening carefully to that and looking at whether there are more steps we can take to get progress.

Q206 **Chair:** I am really grateful for your engagement. I am sorry, but I need to move on. There are so many things to talk about.

Two weeks ago, Amanda Pritchard came before the Committee. She told us that any reduction—a real-terms reduction, a cash freeze or any kind of reduction—in the Health Education England budget would be a real concern in the spending review. We raced to the part of the Red Book that would tell us what was happening to the HEE budget, but there was absolutely zilch about what is going to happen. Can you tell the Committee today what is going to happen to the HEE budget in the spending review?

Sajid Javid: Not yet. Now that we know exactly what the settlement is, we are still making some final decisions, working with HEE and, of course, the NHS, and making the final allocations. We are still working through those. I cannot say what they are right now because the process is not complete.

Q207 **Chair:** I absolutely understand that these things take time. But can you understand the concern on the frontline when there is a workforce crisis and shortages in every specialty, but there is no workforce plan for the next year or 18 months, and the Budget does not even say what is happening to HEE's budget? There is so much uncertainty and it feels like there is a lack of direction and specificity in what is happening with workforce and what the Government are doing. Do you understand why that is a concern to many people on the frontline?

Sajid Javid: Given the demands on health, and social care for that matter, the focus on long-term workforce planning and, for example, training budgets is perfectly understandable. I think people will also understand that the SR settlement has just been made. It has been allocated for all Departments, and there will be some decisions that are made once the final allocation is known.

Perhaps I could also say this about long-term planning. People recognise that a huge amount of work and investment has gone into workforce to

try to meet the vacancy rate you talked about, which is roughly 7% of the workforce. When it comes to HEE and students, for example, we have a record number of people studying in our medical schools at the moment. In fact, I believe that this year the entrance for GP training was the biggest cohort ever. We have some 35,000 people training to be student doctors, some 4,000 training to be dentists and 60,000 junior doctors in postgraduate training. Many of those numbers are record highs. This year, I lifted the cap on medical school numbers again. A huge amount of investment is still going in.

That said, I very much agree with a point that you have made in the past and have made again today. As well as the short-term steps that we are taking now, we need better long-term planning. I think that is right. I hope that what HEE is working on—framework 15—will help to do that.

Q208 **Chair:** I have two final brief questions. Can you not see that there is a problem of accountability in the system at the moment? Because the Government will not publish the number of doctors that we think we will need in 10, 15 or 20 years' time, because they do not publish the Health Education England budget and because we do not know whether the number of doctors and nurses that we are going to train in the next few years will go up or not, we have absolutely no way of knowing whether or not we are training enough doctors and nurses for the future. That means that it is very difficult for us to hold you to account as to whether you are doing your duty in terms of what the long-term needs of the NHS are.

Sajid Javid: There has been an approach thus far, involving HEE, the NHS and others, through which the Government have set out their long-term plans for workforce. I would like to see a change in that approach. I am very comfortable with more accountability and more transparency. I have already set out some of it today. In the Bill that is in front of Parliament now, we have added a duty for me, as Secretary of State, to make a regular report on the workforce system, at least every five years. This is all new. It is all part of being more transparent and clearer about need.

I think that there is more to be done. We are certainly moving in that direction. I hope that what we will publish, especially by the end of this year and the report from HEE in the spring, will help to set out our plans more clearly.

Q209 **Chair:** I appreciate that there has been engagement from you in public and in private on these issues. However, you can see why, with so much concern about burnout, shortages and unsafe care, 50 health organisations, including all the royal colleges, all the health think-tanks, people like NHS Providers and the Select Committee have all come together to ask for an amendment to the Health and Care Bill that would give Health Education England a statutory duty to publish two-yearly independent estimates of the numbers of doctors and nurses that we are going to need over the next five, 10, 15 and 20 years, specialty by specialty. Can you see why people feel so strongly that we need that kind

of amendment? Are you willing to engage with the possibility of having it?

Sajid Javid: I am willing to engage. Like you and members of the Committee, I think that getting workforce right will be absolutely crucial. It makes absolute sense to listen to those who have looked into this in depth. Of course I am happy to engage. As I have not yet had full engagement and have not yet listened to voices on all sides of this debate, there is no final decision on what amendments the Government might or might not be willing to support, but of course I am happy to engage.

Chair: Thank you.

Q210 **Anum Qaisar-Javed:** Thank you so much for joining us today, Secretary of State. In May 2020, the Scottish Government released a Covid-19 framework for decision making called "Re-mobilise, Recover, Re-design." It suggested that there is a need for relaxed access to the international labour market. What role, if any, does overseas recruitment play in tackling the workforce issues that we have in the NHS?

Sajid Javid: Thank you. Overseas recruitment is an important part of it. To put that in context, when we look at our workforce need, there are two or three things that have to be taken into account. Obviously, there is domestic recruitment. I talked a bit about that a moment ago—for example, the record number of people in medical schools. There is overseas recruitment, which I will come back to. There is also the retirement rate; how many people might be leaving the system. Some have come back during the pandemic, but can we sustain that? That is an important part of it as well. Also, could we be using technology, for example? Can we find ways to have clinicians spend more time working on things such as elective procedures and less time on paperwork and bureaucracy? Can that help to free up more time?

Overseas recruitment is a very important part, at every level of need. A number of nurses come from abroad, as do doctors. For example, recently I made a visit to the GMC's assessment centre in Manchester for training potential new overseas recruits as GPs, once they have passed the GMC's assessment procedures. When we recruit, we have an ethical recruiting policy. We work carefully with the Governments of countries to see whether they would support our recruiting in those countries and whether we think that it is broadly an ethical approach. It is an important part of meeting our workforce needs overall.

Q211 **Anum Qaisar-Javed:** I am thinking about lower-paid jobs, specifically those in social care settings. It is widely recognised that the workforce in social care, specifically, may be impacted significantly by Brexit and tighter immigration controls. If we look at average pay for social care and the fact that many staff have come from EU nations, there is real concern that the proposed future immigration system will impact on the recruitment of care staff. That may mean that many social care and health jobs do not meet the requirements for the minimum skills or

salary threshold. Could it not be argued that this is not a priority for the Government?

Sajid Javid: No. First, there is a shortage in social care staff, both in residential care homes and in domiciliary care. Over the last couple of years, we have seen shortages in many parts of the labour market.

It is important that we continue investment in social care domestically. We should always try to look domestically first for our workforce needs. There have been funding announcements during the pandemic. An extra £34 billion went to health and social care this year. Much of that goes to support workforce. There is also longer-term planning. I referred earlier to the new health and social care levy. At least around £500 million of that is earmarked for workforce training. There is over £1 billion for local councils, to make what are called the fairer cost of care payments. That will all help with workforce and workforce retention.

When it comes to overseas recruitment, you will know that the rules around that are set by the Home Office, in the so-called points-based system. It is important that it meets our workforce needs. It is also important that it is reviewed regularly. I know that it is. Although this Department will not lead that review, to me it is reassuring that the Home Office does that regularly. If we need to make a change for health or social care, I am confident that that change can be made.

Q212 **Barbara Keeley:** Thank you for joining us, Secretary of State. I want to ask a couple of questions that follow on from what you have just said about the adequacy of social care funding, the impact that that may have on the NHS over the winter and some related areas, such as workforce, which you have just touched on.

I want to read back to you some quotes about the funding announced for social care in the Budget. The £4.8 billion announced for local government over the three years is not ring-fenced for social care. The response of the Association of Directors of Adult Social Services was, "It is deeply disappointing that the Chancellor failed to recognise the crisis in social care that is already upon us and will now only deepen this winter. We are facing a perfect storm, with care staff quitting, family carers reaching breaking point, care agencies going out of business, and people with support needs waiting longer and receiving less care and support."

The King's Fund said that the funding allocated "is not enough to keep pace with demand and meet current pressures, including being able to adequately reward the workforce". It described the sector as "at breaking point". The Health Foundation described adult social care as "one of the biggest losers" in the spending review. To tackle unmet need and to meet future demand, it is estimated that adult social care in England would require additional funding of £7.6 billion next year, rising to £9 billion the following year.

How do you think that the NHS can be expected to cope with the coming winter and tackle the backlog when social care is under such immense

pressure and there was very little in the Budget or the spending review to indicate that there is going to be any relief of that pressure?

Sajid Javid: Thank you. There is a short-term need and a long-term need; and in the short term, it is especially because of the impact of the pandemic. I know that I referred to this earlier, but I cannot say it enough. Everyone working in social care has done an incredible job. They always do, but especially over the last couple of years. You cannot imagine a more challenging environment for them. It is important that we continue to provide all the support that we do.

In the short term, I mentioned earlier to our colleague that in this financial year, before we even get to the spending review, there have been billions more put into health and social care. In social care in particular, on the issues you have asked about, in October I announced £162.5 million for a workforce recruitment and retention fund specifically for social care to boost staffing and support existing workers.

Q213 **Barbara Keeley:** I will come on to the workforce. I read to you, Secretary of State, the comments of the directors of adult social services; ADASS, their association, said that it was deeply disappointing and that there will not be sufficient funding to deal with that crisis.

Sajid Javid: Are you referring to the spending review?

Q214 **Barbara Keeley:** All the measures you have announced. Obviously, additional grant funding is going to councils, but that is not ring-fenced for social care. It has to be spread across a wide range of areas. Councils are cash-strapped to start with, so any additional funding that goes in, particularly if it is not focused on social care—

Sajid Javid: On the funding going in this year, there is a record amount of extra funding going to social care to deal with a lot of the challenges around the pandemic. It is support, of course, to bring about better social care. In the NHS settlement, I announced £5.4 billion extra for the NHS a couple of months ago for the second half of this financial year. That included some £500 million roughly for a social care discharge fund. You may be aware that there are some people in hospital who are ready to be clinically discharged, but they may need to go to a care home or may need domiciliary care at home. That is extra support for the sector.

On longer-term support, I think you mentioned a moment ago that the £5.4 billion was not ring-fenced. I think you were referring to the £5.4 billion that is in the social care levy—the £5.4 billion from the £36 billion.

Q215 **Barbara Keeley:** No, the grant to local government is not ring-fenced for social care.

Sajid Javid: Which grant are you referring to?

Q216 **Barbara Keeley:** The extra funding that is going to councils over the next three years is not ring-fenced for social care.

Sajid Javid: There are different sources of funding. As you know, although my Department has overall responsibility for overseeing the sector, the other Department is the Department for Levelling Up, which is very much involved with that and working with local councils. I think I am right in saying that, if you look at the settlement that was announced last week, there is around £1.6 billion extra a year via local councils into social care. That is specifically for social care.

Q217 **Barbara Keeley:** I see. You are talking about the funding they raise themselves, the funding they raise through—

Sajid Javid: No, the funding that goes to local authorities has two sources. One is central funding from central Government, and the other would be through the adult social care levy.

Barbara Keeley: The points I raised were to direct you to the reaction that there was to the Budget and the spending review, and to all the announcements, in effect. There was a sense that the social care sector was waiting for funding that would relieve the crisis. I read you those comments because the reaction was that the Chancellor had not listened and that there is not enough funding, and the crisis will not abate. Do you recognise that there is a crisis in social care, that the reaction was pretty damning and that the view is that there is not enough funding?

Sajid Javid: Of course, I recognise that it is an incredibly challenging time for social care. I think that was the case before the pandemic. There were huge pressures, and the pandemic has obviously made it even more challenging. Part of the Government's response has been unprecedented levels of spending and financial support for social care, whether that is directly to the sector, to the care homes; indirectly through the local authorities; or through the NHS, such as the discharge fund. We also provided, for example, some £388 million in the second half of this year for infection control measures that are needed in care homes.

There are different levels of support. You asked me if I recognise or hear the response of the sector. Of course I do. We talk to the sector at all times, and their representatives. I hear what they are saying—

Q218 **Barbara Keeley:** In that sense, do you think that you and the Chancellor have got it right? I can read you more quotes. Care England, which represents care providers, said: "There will be serious and far reaching consequences" from the lack of recognition of extra funding. The Care and Support Alliance, which is all the charities that support carers and the care sector, said: "If the Prime Minister's ambition to 'fix social care' is ever to be realised, Rishi Sunak has to play his part by providing enough funding. He hasn't done so, and therefore…the future of social care remains as uncertain as ever."

Sajid Javid: I don't recognise that. Of course, there are huge pressures. There will be stakeholders who feel that, in their opinion, those pressures have not been met. I think in all the time that—

Q219 **Barbara Keeley:** It is all of them, though, isn't it? It is all the stakeholders. It is not some stakeholders who think that it is in crisis: it is all of them.

Sajid Javid: I was just going to say that in all the time that I have had the privilege to work with the social care sector and providers, including in my time as Local Government Secretary and as Chancellor—all pre-pandemic—I do not think I have ever known a time when stakeholders in the social care sector have been 100% satisfied with the support that they are receiving. They are entitled to their views, but what I am most interested in are the facts on the ground, especially from organisations like CQC, for example, which you know will look at—

Q220 **Barbara Keeley:** Can we come on to the social care workforce, which my colleague raised with you and which you touched on briefly?

Recently, the Care Quality Commission published its "State of Care" report, and described the social care workforce as "exhausted, depleted and drained in terms of both resilience and capacity". That clearly has an impact on the quality of care they can deliver and the knock-on impact for the NHS that you mentioned of wanting to discharge patients from hospital.

When the care Minister was interviewed on this, her response was that the goal was to get millions more hours into the care system. Do you think it is possible for an exhausted and depleted workforce to suddenly produce millions of hours of extra care? That is what your care Minister put out there as the Department's goal. What you were going to do was to get millions more hours out of them, and there was a view that there was spare capacity in the social care workforce, which, I have to say, nobody outside here thinks is the case.

Sajid Javid: I think the sector is very stretched. There are significant shortages in the workforce, especially in domiciliary care when compared with residential homes. It is something that absolutely concerns me. It concerns the care Minister. As well as the short-term extra funding that we provided, as I was alluding to earlier when the Chair raised the long-term issues around workforce, it is as important that that includes the needs of the social care sector.

I referred earlier to the work that the HEE had begun that I have asked them to do, taking a big-tent approach and working with the care sector included. I want that to include the needs of the care sector both because there is an issue and a long-term challenge—I accept that; I have never shied away from it—and because I would like to see more work, even more than we see today, between the care sector and the healthcare sector. There are some natural linkages. Working together, they can produce better outcomes for people. As we look at long-term need for the workforce, I want the review to take account of that as well.

Q221 **Barbara Keeley:** I do not think anybody could see where the support is coming from and where the funding is coming from. You mentioned £500

million, which is meant to cover training and the fairer cost of care payments by councils. That is what you included. There is nothing there to increase the pay of care staff. There are 100,000 vacancies in the social care sector and a turnover rate of more than 30% a year. You can now earn more flipping burgers at a burger place than you can caring for somebody. That is a real damning indictment of our society, I think, that we do not value that job—

Sajid Javid: You will know that almost everyone who works in social care—the vast majority—are employed by the private sector, unlike for example when we were talking earlier about healthcare workers in the NHS.

Q222 **Barbara Keeley:** But the funding comes from your Department through local government.

Sajid Javid: A huge portion, the majority, of the funding comes from direct or indirect Government sources, but there is still a significant amount that comes directly through personal payments. The point I make there is that the Government do not set the salaries in the sector. The salaries are set by the private—

Q223 **Barbara Keeley:** You do indirectly because you provide the funding.

Sajid Javid: We do indirectly, and what we have done just last week is accept the recommendations of the Low Pay Commission on the national living wage, which will be an increase I think of 6.6%, starting in April next year. That will be of significant benefit, probably disproportionate benefit, to those working in the social care sector. That is one way that the income someone gets can be influenced. Of course, that will have to be met when the Government are setting the national living wage. Obviously, in this case I will rightly be accepting the recommendations of the LPC. The Treasury certainly would have taken into account the extra funding that might be required for the sector to meet that commitment.

Q224 **Barbara Keeley:** It is certainly of interest to the care sector because three quarters of care staff get only just the minimum wage, or less than the minimum wage. Very large numbers of them are on zero-hours contracts. Those are the conditions we are talking about. That is why turnover and vacancy rates are so high.

Let's leave that because there is another important aspect. I want to raise the impact on carers of discharging patients early from hospital under the new discharge to assess process. During the pandemic, 3 million more carers stepped up to care and the time people spent caring increased, but less money was actually spent on supporting them in 2020 than had been spent in 2019. They get very little respite and even less support.

The impact assessment for the new discharge to assess process, in the changes that are going through in the Bill at the moment, says: "There is an expectation that unpaid carers might need to allocate more time to care for patients who are discharged from hospital earlier. For some, this

could require a reduction in workhours and associated financial costs."

I can tell you, Secretary of State, that people who support unpaid carers were outraged by the assumption of the Government that they would just drop everything, including their paid work, and be able to take on a new caring burden. It has actually been a very damaging move by the Government to make that assumption and include it in a new process.

Sajid Javid: On discharging and trying to find better ways to do that, just to be specific, we are talking about people who are in hospital and no longer need to be there for clinical needs, but they need social care if they are discharged. It is about making sure that that care for them, wherever it comes from, is there and the Government provide whatever support we can, either directly or indirectly.

Q225 **Barbara Keeley:** But you are not. The assessment now comes later. Up to now, that assessment has occurred before discharge. Discharge to assess means that the assessment comes later, which means that the day the person is discharged from hospital, earlier in cases than they would have been, somebody has to take responsibility for them. You cannot get a care package up in 24 hours.

The Government's assumption, from what I have just read to you, is that it is going to be a family carer and that it could require a reduction in their work hours and associated financial costs. You are expecting millions of unpaid carers to take the hit of earlier discharge from hospital. That is the impact.

Sajid Javid: Each situation is different. There may be some families that are able to care. Of course, there may be others that cannot provide that kind of support. If they—

Q226 **Barbara Keeley:** But the Government are making the assumption.

Sajid Javid: If they cannot, that support should be there. I mention here that I want to make sure that we look at this now with the impact of the pandemic as well, and we take a fresh look at the integration of health and social care. Discharge is really at the heart of that. How can we do it better collectively between the health and social care system? There are some good examples and better examples around the country of that.

Q227 **Barbara Keeley:** Could I stop you there? Really, there is a very strong thought that this should be looked at; that it was a mistake to put down the assumption that family carers will just be able to drop everything and drop their work, despite the financial implications of that, and take on a caring burden without any assessment or involvement, or asking them if they are able to do that. That is implicit in this procedure.

Sajid Javid: I want to make sure that we get it right. As I understand it—

Q228 **Barbara Keeley:** Will you review it?

Sajid Javid: Before I became the Secretary of State in this Department, I understand there were some changes out of necessity, because of the pandemic impact, that were made around discharge. I think that is understandable as the priority was to make sure that the health system was doing everything it could to take care of over 500,000 people who entered hospitals, sadly, with Covid-19. Some changes were made related to the pandemic. What you are pointing out is beyond that—

Q229 **Barbara Keeley:** It is the knock-on from that. This new process actually says that when patients are discharged earlier from hospital, and everybody understands, with the backlog, the need to try to clear hospital beds—

Chair: Barbara, I think we had better make this the last one.

Barbara Keeley: Yes. The expectation falls on to carers. The thing that is wrong in this is that carers have stepped up during the pandemic—

Chair: Secretary of State, could I suggest that you write to us, reflecting on Barbara Keeley's comments, with any thoughts?

Sajid Javid: I was just going to suggest that.

Chair: Thank you very much indeed.

Q230 **Barbara Keeley:** I have one final point. It is about dementia funding, which is important to organisations out there. Diagnosis rates for dementia have fallen, and new analysis estimates that around 30,000 people are now waiting for a dementia diagnosis. It will cost an estimated £292 million to provide people with a diagnosis and clear the backlog. That is far more than the investment that was announced by the Department earlier this year. Given the impact of the pandemic on people with dementia, what plans does the Department have to tackle the dementia diagnosis backlog and ensure that people receive the support they deserve?

Sajid Javid: During the pandemic, of course, there was a significant impact, whether on dementia or mental health more broadly. We have set out the mental health recovery plan, which is half a billion pounds of extra funding during the pandemic. We also have the support that is going to mental health and dementia support, even before the pandemic, and we remain committed to that. That is an extra £2.3 billion of spending in general by the end of this Parliament. We are speaking to many people who are close to the issue to learn what more we can do.

Chair: Thank you. Barbara, I am sorry but we are going to have to move on now.

Q231 **Dr Evans:** Minister, welcome. On primary care, can you say briefly from the outset what your perspective is on the landscape of GP services from the doctors' perspective and from the public's perspective?

Sajid Javid: Yes. First, Mr Evans, what I would say is that I am really proud of our GPs up and down the country. There was a lot of demand

pre-pandemic, but of course because of the pandemic whatever demand they had before multiplied considerably for all of them. What we have seen throughout the country, especially over the last 18 months, is GPs really stepping up and doing what was needed of them and answering the call from the British public.

As the Secretary of State for Health, I think I speak for all my Ministers and certainly all of those in the Department, when I say that as a nation we could not be more proud of our GPs and what they have done. If you think of the vaccination programme, for example, which they are doing now, right from the early days of the vaccination programme to the booster programme and how vital that is, it is GPs who are getting out there to some of the most vulnerable in care homes and to those who are housebound, making sure that they get their vaccinations, including of course the flu vaccine now as well. It is hugely important. I have nothing but praise for our fantastic GPs.

Looking ahead at the challenges, during the pandemic we saw people stay away from healthcare in the normal way, including primary care. We were told to stay at home, so of course people were not able to go to their GP physically, if that is how they normally had done it. There was a requirement that there would only be remote consultation because of the rules for the pandemic. People understood that, and again GPs rose to that challenge.

As we are now moving more to normal—we are not quite there, and the pandemic is still there of course; it is very important that we keep up our defences against it—more and more people are coming back to see their GP because perhaps they had held back before. That demand is increasing, and GPs are getting record numbers of appointments. It is important that those patients can be seen as quickly as possible. When those patients have a desire to be seen face to face, which has been an issue of debate recently, I think that choice should be respected as well.

Q232 **Dr Evans:** There is a rub, isn't there? What is the correct percentage, do you think, between face to face and remote contact?

Sajid Javid: I do not think there is a right or wrong percentage. In my mind, there is no target. If you want to put some historical numbers on it, pre-pandemic approximately 80% of appointments were face to face in primary care. Now it is around 60%. I think last month it was around 60%. That is where we are today versus pre-pandemic, but for me it has never been that it should be 80% or 70%. It is not about a number. It is about doing the right thing. Ultimately, it is about choice for the patient. When a patient wants to be seen face to face—perhaps the initial consultation might have been remote, but they feel that they should be face to face—I think it is really important to try to meet that.

Q233 **Dr Evans:** I asked the same question of the CEO of the NHS, and she answered in exactly the same way. I guess the counter-argument, and where the rub comes from where I sit, is, what is clinically appropriate

and allows the NHS to do more, versus patient choice? It might be completely clinically appropriate for the doctor to say, "Send in a photo, if you've got a digital camera, of your skin lesion for the doctor to make a decision and for the doctor to decide if they need to see you." The patient might say, "I want to be seen face to face for that to be assessed." That is the rub that is happening on the coalface. Where do you stand on that, and how do we resolve it?

Sajid Javid: Ultimately, we must recognise that there is huge demand on primary care services. Where we stand is on the side of the patient and the GPs in helping the GPs to do what they love doing, which is seeing their patients. That was the purpose of the recent winter access package, as I think we called it. It is working with GPs, listening to what they have to say and to come forward with funding or other interventions that will help them do more of what they love doing, which is seeing their patients. That was the purpose of the package.

Q234 **Dr Evans:** You have brought up the access package, and that leads me on to the next part, which is productivity and access. Much was made about league tables. Do you plan on going ahead with league tables for GPs?

Sajid Javid: We never planned having league tables. We never have. That has never come from the Department. It has never come from the NHS. I think what that might be a reference to by some is that the GPs' last contract, which I think was negotiated in 2019, included the need for more transparency, which GPs rightly accepted, and being able to publish data at practice level rather than at regional CCG level. That is something that we intend to go ahead with. It was agreed back in 2019. I think, understandably, a lot of that data collection was paused during the height of the pandemic, quite rightly so. I do not know where the idea of league tables comes from.

Q235 **Chair:** Will that data include the proportion of face-to-face appointments by practice?

Sajid Javid: I think it will, yes.

Q236 **Dr Evans:** Broadly speaking, on the figures, 9% of the NHS budget goes towards general practice, where they see about 90% of the population. Do you think that figure is right, given the pressure they are under?

Sajid Javid: I do not know at this point, to be honest. Certainly, what we need, especially now in light of the lessons we have learnt through this pandemic, is a transformative approach to how we deal with future health needs. There is demand on healthcare, the waiting list, the elective backlog, and mental health, which we just talked about. I think that means a fresh look at how primary care works with secondary care, with community hospitals and people in the community, and with midwives, and to take a fresh look at all that.

I have started that process. Part of the leadership review is to look throughout the NHS and the care system, but especially focusing on the NHS. It is not just hospital leadership but primary care leadership and community hospital leadership, and it looks at where, in some parts of the country, there are different models for the relationship between primary and secondary care. Parts of Wolverhampton, for example, have a specific model where some GPs work directly for the NHS.

I think it is important to take a proper fresh look at this in light of the level of demand and the changes in demand. At the heart of it, in primary care, will be our GPs. They deserve a huge amount of support because they are facing unprecedented challenges. It is my job to make sure that we are listening, and working together.

Q237 **Dr Evans:** I am really pleased you picked up on that. I am not going to go through the long-term plan as my colleagues have been through it, but in the short term one of the things we saw in the pandemic was a revolution in thinking. We could suddenly get rid of the red tape, for whatever reason, and clinicians seemed to have thinking space. We have heard that from other witnesses in the last couple of sessions.

Is there a way you can foresee protecting thinking space for clinicians? There could be paid incentives through QOF, for example, where you could protect time for them to concentrate on the models of their local care. These revolutionary ways of enhancing improvement in the NHS at the coalface seem very sensible ways, in the light of what you have put in the winter access plan, for moving red tape, who is doing sick notes and things like that. Is there an emphasis in the plan on putting that kind of practice in place? It will make a huge difference in the immediate effect. How can the Department capitalise on that?

Sajid Javid: We have made the winter access announcement and we are putting all of that into place, although some will move more quickly than others. There is £250 million in the winter access fund. There is more use of the community pharmacy consultation service. Some GPs came to us and said, "With our telephone systems, in terms of cloud computing, we can change the patient experience when they call the practice", and we are investing in that. There is the access improvement programme as well. We have done all that, listening to GPs. If there is more we can do, I am ready to try to do it. It is a really important partnership, and we will continue to work with them.

Q238 **Dr Evans:** My final question is about wellness and the wellbeing of GPs and the workforce in primary care. A lot of them are facing abuse. A lot of them are also facing burnout. Is there a programme that the Government could consider about how to look into simple measures that would support the welfare of the frontline services in primary care, be it time to think, places to speak to or the ability to use some of the funding for team-building? All of those kinds of things could make a huge difference to the quality of their working life, which may encourage more members of staff to stay on and continue to contribute to the NHS.

Sajid Javid: The short answer is yes. I think there is more we can probably do to help with that. It is important that we look at that.

Can I say something about that, as you rightly mention it? Sadly, we have seen abuse of GPs and other healthcare workers, nurses for example. Sticking to GPs for a second, there will never, ever be an excuse for any kind of abusive behaviour. We have seen horrific abuse of GPs. I will not mention the practice, but we saw real serious injuries and someone could have lost their life in the attacks that we have seen.

This Government will never tolerate any kind of abuse to any kind of healthcare worker ever: zero tolerance. In the package I referred to earlier, one of the things I insisted on putting in, to make sure we were showing that we wanted to help in every way we can, was £5 million of funding for any kind of security need for any practice—be it CCTV, panic buttons or anything—if a practice thought that they needed it. If that money was not enough, we would certainly look to add to it and support our fantastic GPs in every way we can. We want them to feel absolutely confident in the incredible work that they do. We will always support them.

You have just mentioned some ideas. I know you speak with experience, and with family experience as well. You mentioned thinking space and team-working. I think those kinds of things are the way to go. There is probably more we can add to that, but it is really important that the welfare needs of our GPs and all the primary care staff working with them are met and prioritised.

Q239 **Chair:** Thank you. I want to follow up with some questions about GP numbers. In 2019, the Government announced a target to get 6,000 more GPs by 2024, so about 1,200 more a year.

There is a bit of debate as to what has happened in the last year. NHS Digital says that it is up about 300, excluding locums and trainees. Other numbers say that full-time equivalents are down 400 over the last year. Whether it is up 300 or down 400, we are a long way off the additional 1,200 a year that we were hoping for when your predecessor announced that new 6,000 target. What are you doing to get that target back on track?

Sajid Javid: First of all, the latest numbers I have, if that is helpful, are to June 2021. In terms of the 6,000 number, there are just over 1,200 more doctors in general practice.

Q240 **Chair:** Full-time equivalents? Obviously, if you include people who are working part time that does not give you the whole picture, does it?

Sajid Javid: I want to say full-time equivalent, but I am going to be careful. My notes here say 1,200 extra doctors in general practice to June 2021, so towards that 6,000 number.

Q241 **Chair:** Perhaps I could guide you because I have looked at the numbers.

I think, when it is full-time equivalents, there is actually a decrease. The general point is that the numbers have not been going up—I am sure you would accept that—as fast as we would like them to be going up.

Sajid Javid: By the way, we also have a target of 26,000 other clinicians in primary care—

Chair: Equally important.

Sajid Javid: The latest number I have to share with the Committee is 8,880 to June 2021.

Q242 **Chair:** Is it your view that we are on track to meet the 6,000 additional full-time equivalent GPs by 2024?

Sajid Javid: No, I do not think we are on track. What are we doing about it? Earlier, I referred to the record number of students in medical schools. We lifted the caps last year and this year. That is part of it. Colleagues on the Committee referred earlier to the importance of international recruitment. That will be part of it as well. We are not on track. I certainly am looking at what more we could do. I definitely want to see that increase, but I am not going to pretend that we are on track when clearly we are not.

Q243 **Chair:** The reason I ask the question is that the 6,000 target came after a target that I actually introduced in 2015 to have 5,000 more GPs by 2020, which we did not succeed in delivering. In that period, we had a big increase in new graduates from medical school going into general practice. The reason we did not hit that target was that, at the same time, there was a big increase in the number of GPs going part time or retiring early.

The BMA says that from its recent survey a quarter of GPs are planning to go part time in the next 12 months. How do we stop history repeating itself?

Sajid Javid: Obviously anyone, whether a GP or not, has the right to move to part time or, in some cases, they might retire earlier than otherwise. Part of the answer comes back to the point made by Mr Evans earlier—sorry, Dr Evans. We have to make sure that we are listening to what can help GPs with their general work environment.

As I said, and I absolutely recognise, the pressures have been immense. They are unimaginable. Pre-pandemic, we would not have thought about this kind of pressure on our primary care clinicians, including GPs. We have to look at what other ways we can support them. It has to be about investment in recruitment as well. For those who want to work extra hours, if that is a question of some extra funding or some other changes, it is important that we provide that as well. The £250 million access fund that I announced earlier, just for the next five months to the end of this financial year, was partly put together because a number of GPs and their representatives came to us and said that there will be some GPs who can work extra hours but you have to be able to fund it properly, whether

they are locums or it is other types of support. It is not all about funding, by any means; it is about looking at the whole spectrum of things that we can do to help.

Q244 **Chair:** One of the consequences of the crisis in workforce for general practice is that some new GPs are qualifying and, rather than joining a surgery or a practice, they are going straight into locum work because it can be better paid and more flexible. What do you think the impact is on patients when, rather than seeing their own GP, they see a locum who they may never have seen before and may never see again?

Sajid Javid: There may be some people who are quite happy not to see the same GP, but as a general rule, even if someone thinks it is okay to have a different GP every time, I think it is always better, where you can, to have someone who knows you and knows your medical history. If it is not necessarily the same GP in the practice, the practice knows your history. I think that is important.

What we are also seeing, related to that, is that newer GPs graduating have less interest in becoming a partner in a GP practice. A GP can obviously join the practice as a salaried employee of the practice rather than a locum, but there seems to be less interest in becoming a partner now. I do not remember the latest numbers. I was looking just the other day. There seems to be a significant fall in that interest.

Going back to Dr Evans's point about the way people access GPs and demand, there has been such a huge change over the years that I think we are getting to the point where we need to take a fresh look at that as well. If there are things that are getting in the way of perhaps becoming a partner or a salaried GP belonging to a particular practice, we need to work out what those are, listen to the GPs and make sure that we are reacting.

Chair: Thank you.

Q245 **Laura Trott:** Thank you, Secretary of State. The Royal College of Emergency Medicine set out its view that virtual GP appointments had led to increased demand on emergency departments. It is fair to say that when we had the head of the Royal College of GPs here, he refuted that. Where do you stand on it?

Sajid Javid: Can I ask you to explain a bit more? Are you talking about virtual access to GPs in general?

Laura Trott: Yes.

Sajid Javid: During the pandemic it was understandable why virtual access—most of it through phones rather than video, but either way—became a necessity. For many people, sadly, there was no alternative because of all the necessary rules. Where we are with that now is that, as we move back to normal, the rules that kept people away are no longer there, plus there will be people who stayed away from their GPs

understandably, when they were broadly asked to protect the NHS. People are now rightly coming forward, and in fact I want them to come forward. I want people to know that the NHS, whether GPs or otherwise, is open for them. As they come forward it is important—the point I discussed a moment ago with Dr Evans—that ultimately there is a choice in how they are seen.

Q246 **Laura Trott:** Do you think that, as we see rising face-to-face appointments, that will help reduce the excess demand we are seeing in our emergency departments at the moment?

Sajid Javid: As we get more and more access to primary care, it will certainly help with demand in accident and emergency, and more generally emergency care.

I want to share with you a statistic that I am trying to recall. I will refrain from sharing the statistic, but I can tell you that a significant portion of people are turning up for emergency care when they could have actually gone to their GP. That is not the fault of those people at all. They stayed away from the NHS when they were asked to, and they now want to be seen, and that is right. As I said, I cannot emphasise enough that I want people to come forward for the care they need.

Part of the reason that I think people are turning up at A&E, perhaps when they do not need it, is that they are not able to get through to their primary care services in the usual way. The 111 service has a big role to play. The people operating that do a fantastic job in trying to direct people to the right type of care for them. I mentioned earlier that we will be setting out more around our winter planning for the pressures that we will see. Part of that is also increasing the capacity of the 111 service.

Q247 **Laura Trott:** The point that the Royal College of Emergency Medicine was making was exactly that: lack of availability of GP appointments has led to increased pressure on emergency departments.

Sajid Javid: That general point is correct.

Q248 **Laura Trott:** In terms of the pressure on emergency departments more broadly, you mentioned that you are going to be looking at 111 as part of helping to relieve that pressure. What are your other plans for helping to reduce wait times in emergency departments?

Sajid Javid: We, or more correctly the NHS, very recently set out a 10-point recovery action plan for urgent and emergency care. That has been published. The kinds of measures that have already been set out in that are for work with ambulance trusts; there has been extra funding that has gone in for this winter of, I think, £55 million on recruitment numbers. There is help to recruit more 999 call handlers and clinicians to work in the control rooms. There is more capacity for frontline staff.

That is on top of some of the investment that had taken place both pre and during the pandemic. I believe some £450 million of investment went

into A&E facilities, to upgrade them, and funding went to 120 separate trusts that needed that kind of support. There is the 111 First initiative, to try to get more people to see the 111 service as a kind of front door to emergency care, and if it is possible, to call that service first. Of course, if it is an emergency, they can perhaps even direct you to the emergency department you might get seen in more quickly, or tell you if it is something that can be dealt with by the non-emergency part of the NHS.

Q249 **Laura Trott:** What effect do you think that package of measures will have on wait times? Do you have any view on the number of people you expect to be waiting beyond the four hours, as we go into winter? It is obviously very high at the moment. What effect do you expect that package of measures to have on people's experience of A&E?

Sajid Javid: They are all measures to help—the extra funding, the extra support, and the extra people like the call handlers. You are asking me about the effect of the measures. They will clearly be helpful, in that they will get numbers moving the right way.

If you are asking me what it means in the number of people seen or what might happen to the wait, it is incredibly hard to say. I could not put a number on it. All I know is that these are the right type of measures. We constantly keep them under review. Obviously, every single day the NHS has a whole team that looks at this. I, personally, have a meeting twice a week at least on winter plans.

We are constantly looking at what else needs to be done, based on what we are seeing. What we are seeing at this point, to put it into perspective, is that first of all winter is tough anyway. In normal years, winter is tough. This year, it is going to be extra tough because we still have a pandemic. I cannot emphasise enough how important it is for people to take their vaccinations if they are eligible, especially the booster vaccinations, but there are still some 5 million people who have not yet taken their first jab in England. The vaccination programme remains hugely important.

The flu vaccination programme is the biggest that this country has ever had. That is going to be even more important this year than before because there was virtually no flu last year. It is going to be around this year, and we need to be prepared for that.

Then, of course, there is all the suppressed demand—the missing referrals. The NHS estimates that there are possibly 7 million to 8 million people who would have come forward to the NHS normally but did not because of the pandemic. If you take all of that together, the pressures, including those on A&E, are immense. It is a very unusual time and we want to make sure that we are doing everything we can to help the NHS cope with those pressures.

Q250 **Laura Trott:** This is my final question. You have helpfully set out that there is to be a plan for how we address the elective waiting times.

Sajid Javid: Yes.

Q251 **Laura Trott:** That will correlate the 30% increase that has been promised to the plan to achieve that. Is the 30% increase a permanent increase, as you see it, in the capacity of the NHS, or is it something that you expect to be ramped down? If so, will the ramp-down plan be included in the plan that you are going to set out at the end of November?

Sajid Javid: I am not sure that it is going to have, as you describe it, a ramp-down plan. To your main point about whether it is a permanent increase, we are still finalising these plans, but I would like to think that there is a permanence about them. A lot of the investment that we are making to get there will be things that will make the number of electives the NHS can get through much more efficient.

Perhaps I could give an example. We have announced a huge amount of investment—about £2.3 billion or £2.4 billion—in community diagnostic centres. We have already announced 44. There will be at least 100 with the extra funding that was allocated in the settlement last week. They will be in communities, focusing on diagnostics such as MRIs and CT scans. There will be other diagnostics, tests and scans. They can help massively in dealing with the wait lists.

If you take the official waiting list—the 5.7 million number—the majority of people on that list are waiting for diagnostics. We will have separate hubs that can do that. We plan to have the first 44 that we announced up and running within 12 months. They can make a huge difference. Once you get to the end of the SR period, the diagnostic centres will remain, and the major investment will have been made. Of course, there will be a continuous workforce requirement, but that will be covered in the long-term plans.

Chair: Thank you.

Q252 **Dean Russell:** Thank you, Secretary of State, for your time this morning. I have a set of questions on mental health and then on technology. Before that, I want to ask you a very specific question relating to a visit I had to my local GP surgery on the subject of inefficiencies.

One of the things that was really noticeable to me was that they could not do PCR tests. I sat in on a surgery where there was a young child. The GP needed to get them tested, but they had to then send them away to get the PCR test. I just wondered if there was a reason why GPs, as I understand it, cannot do PCR tests on site.

Sajid Javid: Do you mean just to take the swab?

Q253 **Dean Russell:** Yes, take the swab and send it off. That was my understanding, unless I misunderstood on the visit. It was a cause of concern.

Sajid Javid: In the NHS system, NHS trusts can do PCR tests. You specifically asked me about a GP practice. I am not aware if a GP has a special allocation of tests. Certainly, GP surgeries will be able to access the test, but if I understand your question correctly it is, would they have a ready supply?

Q254 **Dean Russell:** Or could they do the test? If they have a patient they are seeing, and they think perhaps they should be tested, could GPs be enabled to do the test?

Sajid Javid: But if they took the swab, they would still need to send it to a lab for assessment.

Q255 **Dean Russell:** Yes, absolutely. I do not think they can take the swab itself, as I understood it. Perhaps I could follow up with you separately.

Sajid Javid: Yes, I will find out. I can certainly write to you about that and get you a full answer.

Q256 **Dean Russell:** Thank you. My first set of questions is about mental health. I am conscious that one of the big issues that has come out of the pandemic is increased awareness of mental wellbeing and mental health, which is a good thing in reducing stigma, but there is also an increased rise in people with concerns around their own and family members' mental health.

Specifically around children, and the use of CAMHS, when do you think that the funding and the initiatives that are happening at the moment, which you mentioned earlier, towards reducing the backlog on mental health will start to be seen? I am very specifically conscious of parents who are concerned about their kids, and who are having to wait weeks or sometimes months to be able to see someone on that front.

Sajid Javid: First, I recognise that mental health challenges have risen significantly because of the pandemic. While I think everyone understands why we were all asked to stay away, stay at home and distance, not being able to see our friends and family, it had an unintended consequence, through isolation and in other ways, of increasing mental health problems, especially among young people, as you point out. It is important that everyone recognises that and understands why it is a priority that we deal with it.

In the most immediate term, that was the reason why we put together the mental health recovery plan. It was because of the immediate impact of the pandemic. That was an additional half a billion pounds, just in this financial year. As you would expect, it has been targeted to the people affected the most because of the pandemic. At the top of the list have been young people—children or younger adults—as well as frontline staff, whether in the NHS or the care system, who have been affected.

That plan includes £111 million of support for extra workforce. Trying to meet that need is an important part of it. Longer term, beyond this

financial year, we will have to see how we can deal better with the challenges. We had already committed, pre-pandemic, an extra £2.3 billion a year by 2024-25. That has not changed, but in the financial settlement that we just received as a Department last week, we are looking at what more can be done to support mental health.

Q257 **Dean Russell:** Very briefly on that, I have to praise the work that has gone into mental health over this past year, especially the support for the workforce in the NHS. It was incredibly welcome.

Going back to timing, obviously April is a key date, but do you think that over the course of next year we will start to see the backlog for CAMHS mental health for children shortened and start to reduce? I want to get a sense of the timing of success on this.

Sajid Javid: Unfortunately, I would say that the backlog—we are talking about mental health, but also more broadly—will increase before the overall number goes down. Why? As I mentioned a moment ago, there were some 7 million to 8 million people who stayed away—the missing referrals. Of course, they are starting to come back. I do not know how many will come back, whether it is 50% or 60%, but whatever the number is, it is a huge number. As I said, I cannot emphasise enough that I want people to come. If they have any kind of health need, whether a mental health need or any other need, I want them to come to the NHS and know that it is there for them.

There is the normal demand you would have in any case, on top of the returning demand. If you take all that together, it means that waiting lists in general will rise before they get better. Within that, obviously more people than ever before will be seen. We have said that the elective recovery funding that we have already allocated, both from the SR and what we allocated this year, means that there will be something like 9 million more scans, procedures and tests and things. A lot more people will be seen because of that, but I think we have to be realistic: there is an unprecedented level of demand. We have never seen anything like it. This is true throughout the world in any developed country that has a universal healthcare system. It is true through every part of the UK; what I am saying is true in Scotland, Wales and Northern Ireland. There will be certain priorities within that.

If it is helpful, Mr Russell, because mental health has remained a priority in the NHS, I can share with you some of the latest numbers that I have. It might give you some confidence that it remains a priority. The figures on the waiting time standard for psychological therapies for common mental health care conditions for the year to July 2021 show that 98.8% of people completing treatment waited less than 18 weeks for their treatment, against a target of 95%: 98.8% versus a 95% target. Also, 92.3% of people completing treatment waited less than six weeks, against a target of 75%. I hope that reassures you that it is an absolute priority.

Q258 **Dean Russell:** Finally on the mental health topic, do you think that under your leadership as Secretary of State we will finally get parity between mental and physical health in the NHS and social care?

Sajid Javid: I absolutely believe in that. I am glad that that is the clear policy of the Government. I will do everything in my power to make sure that happens.

Q259 **Dean Russell:** Thank you. I now want to ask a few questions on technology. I chair the all-party parliamentary group on digital health, and we have been looking at lots of different areas, such as data and so on. I have a few questions about where the priorities are for technology and, probably more fairly, digital in the NHS and social care.

Obviously, a lot of money is coming into the system with the levy, the spending review and the announcements recently. Is technology being seen on the same level as capital investment in bricks and mortar, given the fact that things like virtual wards have proven to be very successful? Virtual appointments, when they are done well, can be very powerful. I want to get a sense of your priority for technology in the review for the next 10 or 20 years.

Sajid Javid: It is an absolutely huge priority. From the settlement last week, if we look at the increase in capital, which had already been increased significantly in the previous SR, there was an increase in this SR of £4.2 billion in cash terms. That is on top of the £32.2 billion we had already planned. Taking the whole allocation of capital, I see that technology will be the absolute priority. It has to be. There is no way that the NHS can meet the demands on it without embracing the very latest technology.

I have seen it at work. There are NHS trusts that have really gone out and properly embraced technology. I recall a visit to Milton Keynes hospital. I was told it was the first hospital in Europe to use robots for general surgery. Not only can they see more patients more quickly, but there is a better outcome for the patient because they can be incredibly accurate in a way that the human hand cannot. What should drive this is the outcomes for patients.

With digital patient records—cloud-based technology—there is the use of AI for looking at images and assessing the health challenges from those images. We are investing hundreds of millions in AI. Not only is it going to be an important part; it will be absolutely essential. Without embracing the very latest technology, the NHS will just not be able to keep up with the very best treatments for patients.

Q260 **Dean Russell:** That is very optimistic. It is an area I am very passionate about. At my own local hospital, Watford General, they have done fantastic work around virtual wards. Is there a plan to make sure that learning from where there are successes on the digital front is shared across the NHS?

Sajid Javid: Yes. The NHS is already running what it calls the accelerator programme for digital; pop-up clinics, virtual wards, 3D eye scanners, home antibiotic kits, AI in GP surgeries and lots of things all to do with innovation and technology taken together. The whole purpose of the accelerator programme, as it sounds, is to take the very best practice and make sure that all trusts are looking at it.

I want to link this back to something else that I have initiated, which is a leadership review. The reason I asked Sir Gordon Messenger to do that review is that I have already seen, in the few months I have been in the Department, some fantastic examples of NHS leadership, whether on the technology front, staff welfare or, most importantly, patient outcomes. I have also seen that there are trusts that could do a lot better. No one can claim that leadership is the only answer, but it is an important ingredient. Without good leadership, you will never get the best standards. In the NHS, we have some of the best leaders that our country has. They are really outstanding people. How can we replicate that throughout the NHS so that it can be in every part of the country? Ultimately, it is going to lead to better outcomes.

Q261 **Dean Russell:** Absolutely. I have a couple more questions. With regard to data, there was a lot of fearmongering a few months ago about NHS data and GPs accessing patient data. I have two comments on that.

Do you see a time, with regard to the use of data, when people will be able to access their summary care record throughout their lifetime? Could a child born today have almost a data wallet that they could carry with them throughout their lifetime, and which connects GP data to surgeries, the NHS and social care? Effectively, you would have a single patient view that carries through and helps them with health outcomes. Do you think we are heading towards data associated directly with the patient that can be accessed anywhere within the system to improve their outcome?

Sajid Javid: I hope so, but it is not round the corner. It will take time to do that. There are NHS trusts still using fax machines. Most NHS trusts, when they are scheduling someone for an elective surgical procedure, are using Excel spreadsheets and WhatsApp groups as well as traditional email. That is seen as great technology by some.

There is a project going on right now, to give you an example, with Chelsea and Westminster Hospital trust, led by NHS Digital. It is a pilot project. They have only been doing it for a few months. All they have really done is say to consultants: "Instead of using WhatsApp groups and Excel spreadsheets to try to schedule your elective procedures, why don't we just use something called a real-time database?" These databases have existed for 20 years. Just by making that change, the impact has already been transformational in that pilot project, in just a few months.

Some of the consultants themselves cannot quite believe how it has made their life easier and given them more time to do what they want to

do, which is their elective procedures. The patients have much more knowledge and confidence in their appointments. Sometimes they cannot make an appointment and need to change it, and they are doing it electronically. In this case, a patient will get a text message that tells them their appointment. They can then respond yes or no. They can change their appointment. It is all done electronically. That is something that is just happening now.

The good news is that something like that, once it is a proven concept, can be rolled out very easily. When it comes to costs, it actually saves money. It more than pays for itself. That depends a lot on better data. It is always important to reassure people that, whenever their data is used in the NHS, privacy will always be paramount, and there will also be appropriate access to that data. Most people accept that the more digital the NHS can become in terms of access to data in the appropriate way, the better the outcomes can be for patients.

Dean Russell: You have answered my second question already, so thank you very much.

Q262 **Paul Bristow:** Secretary of State, I really enjoyed your answer to that last question about the spreading of innovation across the system. I have been involved in health policy for perhaps 20 years. I have seen numerous plans to try to spread innovation and new pathways across the system, but they have only ever partially worked. You even talked about surgical robots. I remember the da Vinci robots. They have been used for kidney cancer, prostate cancer and bladder cancer for a long time, but the fusion of innovation and new ways of doing things has only ever partially worked.

You say that you want to tackle the backlog, quite rightly, by doing just that—spreading innovation across the system—but if it has only ever worked partially in the past, what is different now?

Sajid Javid: I would say a couple of things, if I may, Mr Bristow. The first thing, as you said, is that it is essential. I think we have got to a point, especially with the impact of the pandemic and the huge demand we are seeing in the NHS to get through the elective backlog, where we have to do things differently. When you look at that transformation, digital technology innovation is a necessity. Maybe in the past it was not seen as absolutely essential. Maybe you could use Excel and WhatsApp groups and get away with it. It is inefficient. It is not how you would organise things, but maybe you could get away with it. We cannot do that any more. It is absolutely essential that we have this transformation.

I mentioned earlier the community diagnostic hubs with the very latest technology. We want to be using, as soon as it is ready, AI technology in the diagnostics in those hubs and elsewhere. I have talked publicly about the surgical hubs and having a part of the hospital that can focus on a particular type of surgery—cataracts, for example. I went to Moorfields hospital where they are using the latest technology to see patients in half

the normal time. They see more patients more quickly, with much better outcomes for patients by focusing on and making the very best use of technology, including the technology used for patient interaction. It is an absolute necessity.

There are two or three other things that would help make it happen. I touched on one earlier with Mr Russell, and that is leadership. It is not just about knowing what the technology is and its availability; it is having the leadership that is willing to deploy it. I think leaders today who do not embrace digital transformation will not survive.

I am not talking just about the NHS. I am talking more generally. You can apply it to a company or any organisation. Technology is so vital that, if you cannot embrace it, you should make way for someone who understands the importance of technology. That is one of the reasons to have the leadership review. I want to make sure that every leader in the NHS understands that it is their job to promote technology and to embrace it. It is not your chief technology officer's job only or your chief information officer's job. It is your job, and if you do not understand that, you really should not be working in the NHS.

There is also funding. That is different as well. I have talked about some of the numbers, and I will not repeat them now. We are getting record amounts of funding for technology.

Lastly, there is the support—the ecosystem. We were talking about the accelerator programme, for example, and the work that happens in NHSX and NHSD to try to give general support. There is no need to ask every trust to duplicate effort. If, at the centre, they can give good direction for standards of data, so that different systems can talk to each other and it can be transferable, we can learn from the experiences of others. If the centre can co-ordinate that, it will make a big difference.

Q263 **Paul Bristow:** Thank you. I completely agree with you about leadership and some of the other points you make. Do you envisage any specific mechanisms or levers within the system that will encourage adoption of new technologies and new pathways to counter what I think has been a cultural aversion to innovation? It is the "not invented here" syndrome. Are you thinking about any sort of tariff mechanisms, best practice tariffs or levers in the system that are going to encourage or create the incentives for trusts to do just as you say?

Sajid Javid: Yes, but I could not exactly tell you what those are now. You will have to invite me back. Perhaps the Committee could really help with this and consider a real review of technology and innovation in health and social care. It is not for me to say what the Committee should or should not do, but I just throw that out there to see how it lands with the members of the Committee.

You may know this, Mr Bristow, but it is an important part. There was a very important independent review, commissioned by my predecessor, by

Laura Wade-Gery. I talked to her recently. She was asked to do a very wide-ranging review of technology in the NHS, the structures that can incentivise it and the support that exists. That review is almost complete. You have discussed the general direction of that. I think it will be a very important part of helping to set the right direction.

Q264 **Paul Bristow:** I would encourage you, if I may be so bold, to listen to my Westminster Hall debate this afternoon on NHS efficiency. I may be giving my own views on what those levers might be. It is for others to determine whether they are wise.

Sajid Javid: I may not be able to attend, but I will certainly read what you have to say.

Q265 **Paul Bristow:** Thank you. It is for others to determine whether they are wise or not, but they are certainly my views.

I want to move on to the independent sector. We have talked a lot about capacity and individuals, staffing and all that sort of thing. It is also about the capacity of cath labs and theatres to do the things we need to do. Could more be done to maximise the contribution of the independent sector to tackle the backlog and, if so, what do you think that is?

Sajid Javid: Yes, more can be done. We will set out what that is in the delivery plan referred to earlier.

Q266 **Paul Bristow:** Do you envisage the risk of an ideological or a cultural reluctance to use the independent sector that is being commissioned or gathered by this new money?

Sajid Javid: Not really. It is not something that bothers me. The important thing, especially given the huge demand that we are seeing and the backlog we have seen for reasons that people understand, is that we deploy everything that can help more people to be seen more quickly. Certainly, from what I have seen, if someone can get their knee operation done and paid for by the NHS, completely free to them at the point of use, as it should be and as it always will be through the NHS, but they can get that done in the independent sector, that is exactly what should happen.

Q267 **Paul Bristow:** Good. I hope that is absolutely right. I have a couple more questions. On capacity, in terms of staffing, I think one of the things we should be looking at is wider use of physician associates, surgical associates and anaesthesia associates. A lot of these professions are not yet regulated. What can we do to speed up that process and get them regulated? We want clinicians to operate at the top of their practice and not be doing things that other colleagues could be doing. I think that physician associates and others are a route to doing that. What can we do to get them regulated more quickly?

Sajid Javid: During the pandemic it is fair to say that in the approach to what certain clinicians could or could not do, there were some flexibilities that were given, and rightly so. That was because of the pressure of the

pandemic. It does not mean now, as we are in a better place—I cannot stress enough that there is still a pandemic: get your vaccines, everyone—and as we learn the lessons from the pandemic, that there might not be some things in terms of flexibilities for clinicians that we want to continue. If we do that, it has to be done on the very best clinical advice, working, for example, with the royal colleges and others. It should only ever be done for clinical reasons. Everyone should feel comfortable with any change. I think there are flexibilities like those you suggested that could be done.

I mentioned earlier, right at the start of this session, that the HEE is doing framework 15 and looking at the long-term needs in workforce. It is something that I hope they will be taking into account as well.

Q268 **Paul Bristow:** Finally, Secretary of State, you talked a little bit about transparency when it comes to GPs and shining a light on some of the measures. What can we do to do the same across our whole NHS, especially on commissioning decisions? A lot of the problems I talked about—making sure that everyone is doing what GIRFT or NICE say they should be doing—would be improved if that light was shone on commissioning decisions. Are there other ways we can make the NHS more transparent?

Sajid Javid: We should always be looking at how we can improve transparency in the NHS. As we all know, it is an absolutely huge organisation. Understandably, there is a huge degree of complexity. We should be trying to find useful ways of producing all that information.

I would point to some of the work, for example, in the Bill before Parliament now. As we put the ICSs on a statutory footing, there are more transparency requirements than there were before. It is absolutely right that they become, or will eventually become, subject to the will of Parliament, statutory bodies. I think we should be looking to see, within the ICSs and the structures that are below them, what more transparency could be offered.

Earlier, we talked with Dr Evans about primary care. We should be looking at the different examples around the country of how primary care is done, how important transparency is and how we can use that. If I might point to the Office for Health Improvement and Disparities—OHID—in the Department, which I have created, that is, as it sounds, all about recognising that we have disparities in health outcomes across the country. If we are truly to tackle those, we need information. We need to understand where the challenges and problems are. It is not just primary care, but at every level. The more information we have and the more transparent we are about it, the better evidence we will have for targeting resources, especially when it comes to prevention.

Q269 **Chair:** To confirm, on transparency, is it your intention to publish the proportion of face-to-face appointments for each of the 8,000 surgeries in general practice in England?

Sajid Javid: It is my understanding that at practice level it will include that. I did not negotiate the 2019 contract, so I do not know the exact details. If you will allow me to write to you, I can confirm that and double-check it.

Q270 **Dean Russell:** I have a brief question. Last year, I did a lot of volunteering with my local hospital. I really saw the power of volunteers, in particular young people. I have raised in Prime Minister's questions before the idea of an NHS cadet workforce, as it were. Workforce is probably the wrong word, but there could be an opportunity to get young people engaged with the NHS and social care through a volunteering pathway.

I just wondered whether that has been delved into further. I have chatted to some of your other colleagues, including No. 10, about this further. It would be great to hear if there is anything happening.

Sajid Javid: First of all, I agree with you on the importance of that, for exactly the reasons that you have said. We have NHS cadets. I do not have the exact numbers with me, but it is in the thousands. It has been a very successful programme. I will be looking to work with our colleagues in the NHS to see how we can build on it.

Dean Russell: Fantastic. I would love to share some thoughts on that.

Sajid Javid: I would love to hear about it.

Q271 **Chair:** Thank you. You have been very generous with your time. I have three brief last questions, and then I am going to give the very last question to Dr Luke Evans. It is not just because you called him Mr Evans.

Let me ask my final ones. Two of them are about patient safety which, as you know, is something very close to my heart. The last time the NHS had absolutely huge waiting lists was back in the 2000s, when the then Labour Government set about tackling them. They tackled them pretty successfully, but one of the unintended consequences was a targets culture that led to some terrible tragedies in places like Mid Staffs. How do we make sure that this time we do not end up with those unintended consequences when it comes to the safety and quality of care?

Sajid Javid: Thank you for asking that. It is one of the most important things that there can ever be for a health system; ultimately, we are there to help people, and that means that patient safety must always be paramount. You are right, Chair, to point out that as we try to get through more and more procedures, and to get through the backlog with all the extra funding and new ways to do things, that we do not, unintentionally, set up some risk for a patient that did not exist otherwise.

How will we deal with that? First of all, with everything that we do, especially the new procedures, for the very reason that they are new and have not been tried or tested, we should put patient safety at the heart of

it. That is to reassure me and other Ministers that, whether it is officials or the NHS, they have thought about it very carefully and told us exactly what the risks might or might not be, and how they are going to mitigate any potential risks and manage them, with patient safety a key part of their coming up with new procedures.

The second thing is that independent scrutiny is really important. It is important to me, but also for reassuring all patients. The work of the CQC, for example, and what it does in terms of patient safety in hospitals and health settings, and care homes for that matter, is going to be an important part of it. As we set out more plans—our winter plans and the delivery plan for the electives—we want to be clear that patient safety will drive everything we do.

Q272 **Chair:** Thank you. One of the things that obviously will make a big difference is the way the new ICSs are assessed. We strongly welcome the fact that the CQC will be assessing the new ICSs. You said that will be part of the new Health Bill.

We have not yet heard that safety and quality will be one of the domains that they look at, although that was a commitment made by your predecessor. We have not yet had it confirmed that they will be Ofsted rated, in the way that hospitals, care homes and GP surgeries are. Could you confirm that that is your intention, even if it is not on the face of the Bill?

Sajid Javid: Safety and quality will be an important part of their rating in the work the CQC will do. An Ofsted-style rating is something that we are considering. I am just trying to recall exactly the style of ratings that may or may not be used. On the ratings issue, I would rather write to you and make sure I get it right because it has been under review for the last couple of weeks, and we have yet to come to a final decision on it across Government.

Q273 **Chair:** I think our concern is that if you have hospitals, GP surgeries and care homes being assessed in one way, and ICSs being assessed in a different way, it would not be fair across the system. The big benefit of the Ofsted system is clarity for the public, so that they know whether the ICS in their area is outstanding, good, requires improvement or is inadequate. You call a spade a spade, and if quality and safety are part of that assessment, that is also looked at. From our Select Committee's recommendations, we are strong supporters of that transparency.

Sajid Javid: I understand, and I will write to you on that.

Q274 **Chair:** My final question is completely different, but you have touched on it. I wondered what your sense was as to the future progress of the pandemic. You said that we may be coming towards the end. We know that there is still a high level of daily infections. There is a lot of pressure on the frontline. Are you cautiously optimistic that the days of exponential growth in daily infections, when there was a doubling rate of the disease of four days, seven days or 14 days, are now behind us?

Sajid Javid: First of all, to be clear, I do not think that anyone is talking about an end to the pandemic at this stage. There is still a pandemic. We are in a lot better place today, as are many countries, than we were just a few months ago. Think about what it was like at the start of this year. There is good reason to believe that the progress that we have made collectively can be maintained. The heart of that progress has been the vaccine programme, which has been one of the most successful in the world.

We should also recognise that we now know—we did not know before but we are learning all the time—that the immunity that one gets from a vaccine wanes. That waning is more important, generally, the older you are. That is why we have our booster programme. It is really important, and I cannot it stress enough, that to consolidate and maintain at least the progress that we have made it is vital that anyone eligible for a booster vaccine comes forward. I think we have now had almost 7 million in England, and there are more every day. We are opening up more channels to get that, but it is vital that people come forward for their booster vaccine to maintain the progress. On top of that, we have the testing regime and the surveillance. There are new treatments that are available that we have purchased and will use, subject to MHRA approval. That is all part of our defences.

It is also fair to say that it is in the nature of this virus, as we have seen, that there can be no guarantees on progress. We all know what we have to do. If we do our bit, that is what makes the difference. There will be new variants. There is a variant of Delta at the moment—AY.4.2. There is no evidence to suggest that it evades vaccines, which is obviously great news, but it could well be more transmissible than the original Delta variant. That is something that we, with our international partners, are doing more work on. It is just a reminder that there will be more variants, so we all need to keep up our guard, do our bit and get vaccinated. If we all do that, there is reason for us all to be cautiously optimistic.

Chair: Thank you. Last, but not least, Dr Luke Evans.

Q275 **Dr Evans:** I would like to take a step back and ask you a slightly personal question, if that is all right, Secretary of State. You have a new CEO of the NHS. You have been in post for a few months. We have the biggest crisis ever facing the NHS. What keeps you up at night, and what do you hope to achieve by the time you finish as Secretary of State?

Sajid Javid: Thank you. You save the best till last at this Committee. You ask, "What keeps you up at night?" I like to put my worries to the side and try my best to get a good night's sleep. I try not to worry about too much.

Giving you a proper answer, I would say that it is what we just talked about on the pandemic. For the reasons I gave, we are in a much better place, but I worry that if people generally let down their guard and think

that it is almost all over or, in some cases, that it is all over, it is not. To maintain this progress, we all have to keep working at it. The vaccines are the most important part, but not the only thing.

Related to that are the new variants. There will be new variants. We do not know what is going to come around the corner. If, one day, there was a vaccine-escape variant, it would be of significant concern. Of course, we think about that. Our international partners think about that. We work with our partners on that. We have a lot more defences today, even if there was a vaccine-escape variant. I think I ought to keep that at the top of my mind as well, and make sure that we are as best prepared as we can be for what the pandemic has in store for us. Of course, there are knock-on impacts of that, but if I had to focus on one thing it would be making sure that we continue to make progress against the pandemic.

What was the second part of your question?

Q276 **Dr Evans:** What do you hope to achieve as Secretary of State?

Sajid Javid: I have three major priorities, and I hope to deliver on all of them. No. 1 is the pandemic: Covid. I want to keep the virus at bay. No. 2 is recovery. We have talked a bit about that today, about the elective backlog and the recovery from that. No. 3 is reform, as we talked about today, whether it is digital, leadership or otherwise. To maintain the progress of the NHS and our social care system, we need some significant reforms. I have already set some of those in motion.

I do not have all the answers for that, but there are some amazing people out there. We need independent analysis as well, to help the Government come up with those reforms. If I can make progress on all three, Covid, recovery and reform, in the time I have in this job—I do not know how long I am going to have in this job; the Chair is a recordholder for that—it will be something I would appreciate.

Chair: Secretary of State, you have been very generous with your time. Thank you very much indeed.