Health and Social Care Committee

Oral evidence: Coronavirus: recent developments, HC 1074

Tuesday 25 January 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Paul Bristow; Martyn Day; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 1 to 60

Witnesses

I: Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care; and Matthew Style, Director General for NHS Policy and Performance, Department of Health and Social Care.

Examination of witnesses

Witnesses: Sajid Javid MP and Matthew Style.

Q1 **Chair:** Welcome to the Health and Social Care Committee's session with the Secretary of State for Health and Social Care, Sajid Javid. You are very welcome. With you is Matthew Style, director general at the Department of Health and Social Care.

We are on quite a tight timescale because we have votes expected at 6 pm, so we will wrap up by then. If it is all right, we will crack straight on. I will give everyone a chance to ask questions, but I want to start with some questions on the elective recovery plan, which is rumoured to be due to be published this week. Around £10 billion a year for the NHS is going to come from the health and social care levy. Do you still support the health and social care levy?

Sajid Javid: Yes, I do. It is very important that we make sure we have the long-term funding in place for the NHS and for social care. Obviously, the levy is about that long-term funding, and that is why it was set out in the SR, especially the funding around the adult social care element.

It is also true that extra funding is needed to tackle the electives backlog—hopefully, it is a temporary increase in electives, and we will get through a lot of it over the next few years. The increased spending, because of the more generous means test in adult social care and the

new cap that will be introduced in adult social care, is a longer-term structural increase in spending, and there should be a proper way to pay for that.

Q2 **Chair:** With all the discussions in the press at the moment about delaying the introduction of the health and social care levy, no one in the NHS and care system need worry that the £12 billion a year that it is going to be raising from April is under threat.

Sajid Javid: The funding that has been announced for NHS and adult social care over the SR period is secure.

Q3 **Chair:** Thank you. When you publish it, will the elective recovery plan address how we are going to find the 4,000 additional doctors and nearly 19,000 additional nurses that the Health Foundation says are needed to do the backlog of operations?

Sajid Javid: I will say a word about the elective recovery plan. First, why do we need a plan? It is because of the impact of the pandemic, where we have seen, sadly, that waiting lists have risen. The elective waiting list is around 6 million and, as I have said before to your Committee and been very transparent about it, I expect the upward pressure to continue as more and more people who have stayed away from the NHS come back.

We estimate at least 7 million stayed away—because they were asked to, perhaps. There will be an impact, I am sure, because of the Omicron wave as well, but we want people to come forward. In doing so, we have to be prepared for a substantial increase in elective activity to get through as much as we can.

A number of things are going to be required. There are new ways of doing things, which we may get on to in a moment, but workforce is going to remain absolutely critical. Certainly, there has been extra spending allocated to the NHS over the SR period. It is £15 billion or thereabouts for the NHS over the three-year SR period from the levy, but in total, with the extra spending—not just the levy but in total—it is around £23 billion, and I would expect a substantial amount of it to go towards workforce.

Q4 **Chair:** My question is not about the funding, which we recognise is there; it is about whether the elective recovery plan, when it is published, will say how many extra doctors, nurses and other frontline workers you expect to be needed to cope with the backlog in operations. Are you going to detail those numbers, and are you going to say how we are going to get those extra numbers?

Sajid Javid: It will talk about the importance of the workforce and plans—

Q5 **Chair:** How we are going to get the extra doctors and nurses—the frontline workers.

Sajid Javid: Yes, but a number of initiatives are already in place to get more doctors and more nurses. In the last year, for example, we have been successful at getting some 4,800 more doctors and 10,900 more nurses. We need more, and we have been very clear about that. We will set out not just an elective recovery plan. Separately, we also have Health Education England working on a framework for the workforce, and through other ways we will set out the major workforce challenges, for both healthcare and the regulated adult social care sector, and how we intend to address that.

Q6 **Chair:** Will the elective recovery plan also address the pressures in the social care system? There are around the same number of beds inappropriately occupied in hospitals by patients who cannot get their social care package and cannot be discharged as there are Covid patients at the moment.

Sajid Javid: The plan will refer to the importance of integration between elective care in the NHS and social care. I think probably what is more important in addressing that is that we will also shortly publish an adult social care and NHS integration White Paper. I think that is going to be part of the important set of reforms we need to make to ensure that we are getting much more joined-up work and a much more improved system between the NHS and adult social care.

Q7 **Chair:** Finally on the short-term pressures, the money from the levy—the extra £10 billion going into the NHS—starts from April. There are lots of long-term pressures with workforce and the social care system, but from next April, when it comes to recruitment, some people say that we should continue the suspension of the 16-hour rule to make it easier for people who have just retired from the NHS to come back into the workforce. Some say we should cut the visa application fees for overseas doctors and nurses and extend the workforce retention and recruitment fund. There should be in place those kinds of short-term measures, alongside short-term measures to help people get home who are stuck in hospital and who need to get into the social care system, so that from next April we can really get cracking.

Sajid Javid: I think these kinds of measures are important. You mention the 16-hour work rule. There are rules around pensions, some visa changes and some more recent ones we have announced for the social care sector. For the NHS, there is also the emergency register; I think around 50,000 people have come forward and registered. All of this is important in our thinking to make sure that we have the workforce that we need for the challenges that lie ahead.

Q8 **Chair:** I want to move on to some slightly more strategic questions about workforce before moving on to my colleagues. On 8 June last year we published a report on workforce burnout in the NHS and social care systems. We quoted a figure from NHS Providers that 92% of trusts have concerns about staff wellbeing, stress and burnout—92%. Six months after that report we still have not had a Government response. Why is that?

Sajid Javid: First, can I say in terms of workforce—I have said it before but I cannot say it enough—how incredibly hard the NHS and social care workforce work in normal times, even before the pandemic, but during the pandemic they have really risen to the challenge and performed with distinction? All of us, whether it is the Department I represent or parliamentarians generally, have a duty to support them in every way we can.

We will respond to the work the Committee did—and thank you for that work. It does not mean there isn't work going on to support the workforce and its resilience. Plenty of work has happened, and it will continue, but there will be a more formal response to the report.

I can say a bit about the work that we will be doing. We have a people recovery task force—

Q9 **Chair:** We will get to that, but can you understand the scepticism people feel about the Government's real commitment to this issue if it takes six months to respond to a Select Committee report? We understand there is a pandemic and we have been flexible with the timings of responses, but workforce is the No. 1 issue across the whole of the NHS, and for us not to have had a response six months later is a big concern.

Sajid Javid: There should not be any scepticism because the evidence is in the work that we are already doing. For example, I was about to mention the people recovery taskforce that we have set up. Even before the pandemic, there were a lot of workforce pressures, which Committee members will recognise. It has got much more challenging, of course, because of the pandemic.

There is the work we have done on both physical and mental health support; the work on retaining staff—creating the time and space for staff to make sure they have time to reflect and to take rest and respite; the wellbeing guardians we have introduced at board level; and the investment in wellbeing, including wellbeing conversations proactively asking people in the NHS in particular what further support will be provided.

I am in no way suggesting that this is enough—we need to absolutely keep working on it. The work you have done as a Committee is important, and we will respond.

Q10 **Chair:** Let me ask you another question. Training for NHS staff is funded by Health Education England. The last time you were with us you said you had only just got your settlement from the Treasury and you would set HEE's budget for the next year. Has that been done?

Sajid Javid: As far as I am aware, it is not finalised at this point. It is almost done, but it is not finalised at this point. Of course, it will be in advance of this financial year.

Q11 **Chair:** The workforce is the biggest concern facing the NHS. HEE is going to be merged into NHS England, but it is the body that funds the training

of new doctors and nurses. The numbers of new doctors and nurses to be trained are decided by HEE; the financial year starts in two and a half weeks, and we still do not know how much money it is going to get. You understand why people are sceptical about the nice words the Government say about workforce when something as central as that has still not been sorted out.

Sajid Javid: Of course it is hugely important that you set the budget in time. The budget will be set in time. A number of discussions have gone on with HEE and the NHS, especially in the light of the forthcoming merger. Once that is complete, we can set the budget. In the meantime, the work of HEE and NHS on workforce continues.

It might be helpful to point out that over the past year, if you look at what has changed in the workforce, there are 44,700 more people in the NHS; that is the increase in the workforce. There are around 127,000 doctors and around 310,000 nurses—the highest number for both doctors and nurses we have ever had. If I look at doctors at medical school, last year's entry at something like 4,000 was the highest number ever. We have a good pipeline of GPs and potentially other types of doctors going through medical school. I think dentists are at record numbers as well. So there has been a huge amount of investment in workforce.

Q12 **Chair:** Yesterday, Simon Stevens recognised in the House of Lords that there had been increases in the numbers of doctors and nurses during the pandemic. He said that was very welcome, but he used a very strong phrase to describe the Government's refusal to do long-term workforce planning. He said it was "wilful blindness". He said the Government had known these issues were happening for a long time—over several years—but at every stage had refused to support Health Education England to do that long-term planning and still now was not even setting Health Education England's budget. What would you say to that phrase—"wilful blindness"—used by Simon Stevens, the man who used to run the NHS?

Sajid Javid: Where I would agree with him, and I read his remarks after he made them, is on the importance he attaches to the workforce and the need for a long-term plan for it. I absolutely agree with him on that. If we talk specifically about the NHS—it applies very much to social care as well, but focusing on the NHS for a minute—when we try to look at the demographic changes in the country, the impact of the pandemic, the new medicines and treatments, and new ways of diagnosing people, obviously we want to make sure we have the workforce for that.

What have we done about it? The bit I would not agree with is the idea that the Government do not have a plan to deal with these workforce pressures. Back in July last year, I commissioned HEE to do what I called a workforce framework to look at the key drivers and trends in workforce; to look at the skills that are needed; the longer-term training; the values that we want to represent and see represented through our workforce; and what should be the shared assumptions throughout the system, not just HEE but the NHS and other parts of the wider health and social care system.

One thing I have also done very recently, and I am happy to tell the Committee about, is to commission the NHS to develop a long-term workforce strategy. That had not been done before because I wanted to kick off the work first with HEE. Hopefully, it will report in the next few months. It has done a lot of work on this, and I wanted that framework to feed into the NHS. The fact we are doing a merger now of HEE and NHS England will help a lot and make the whole thinking around workforce much more joined up. Having now commissioned the NHS to do this long-term workforce strategy, I hope Committee members, Lord Stevens and others will welcome it as the right way forward.

Q13 **Chair:** I have a final question on this. This Committee has suggested that the way through this is a very simple one, which is to ask a body—it could be Health Education England; it could be NHS England—to do independent forecasts of the numbers of doctors and nurses in every specialty it thinks we will need in 10, 15, 20 years' time. We proposed an amendment to the Health and Care Bill, which was voted down by the Government on 23 November, that would have done just that.

May I draw your attention to a letter that the then DHSC Minister, Nadine Dorries, sent to me on 22 April last year about midwife numbers, because it tells a slightly different story? She sent a very detailed and very good letter in which she said that there were 844 unfilled midwife posts. The Government had used an independent tool endorsed by the Royal College of Midwives, Birthrate Plus, and on the basis of that independent tool, on top of filling the 844 places, there needed to be another 1,088 midwives. She was then going to put £95 million into funding those additional 1,100 midwives.

A really scientific process was put in place to tell us exactly how many midwives we need to fill the gap. If that is good for midwives, why not for obstetricians, anaesthetists, doctors in every single specialty, and why not for nurses, across the system? That is all we are asking for. What is the problem with that?

Sajid Javid: In the example you just gave around midwives I very much agree with that kind of approach. How much we invest in the workforce—the numbers that we try to recruit in the short and longer term—must be based on a proper analysis based on the needs of our healthcare system. I very much agree with that. That was the reason for me to first commission HEE on the workforce framework it is doing, and the reason I have asked a body to do this.

You are right that it should be a body. I do not think it should be my Department directly. In this case, the body that I have asked to come up with a long-term workforce strategy is NHS England. I think that is the right body to do it, and, once HEE is merged into NHS England, it is right that the organisation that will hire and pay the workforce and ask them to do electives and other work is the same one that should be focused on their training, their hiring and all that. I had never quite understood why HEE was a completely separate body from NHSE, although obviously still part of the Government, and I think it is right it is merged. I think, along

with my ask of NHS England, that will lead to an outcome which is very much like the example that you gave.

Q14 **Sarah Owen:** I am going to move on to the social care workforce as workforce seems to be the word of the day. The unprecedented sick rate combined with a shortage of over 100,000 care workers is putting immense pressure on existing staff. Why is there no equivalent of the NHS People Plan for social care?

Sajid Javid: There is a lot of focus on the adult social care workforce with different names for different types of initiatives. One very recent example is the work that we set out through the White Paper. The White Paper on adult social care that was published very recently, "People at the Heart of Care", sets out how, for example, we are going to use about £500 million from the levy that was mentioned earlier to have better training for that workforce to make sure that it is given the support that it needs, it is sustainable and it is a more recognised workforce.

Q15 **Sarah Owen:** So you will have a people plan for social care.

Sajid Javid: You can have different names for it, but there is already a plan in place for the adult social care workforce. It is what we set out. The longer-term view is what I pointed to in the White Paper.

Separate to that, there has been a lot during the pandemic, including more recently in the last few months, with the extra funding that was given to the adult social care sector—the £162.5 million retention fund for that workforce, plus, I believe, an additional £300 million that was given at the start of the Omicron crisis.

Q16 **Sarah Owen:** I have a couple more questions, so could we keep the questions and answers short?

Your Department's adult social care workforce survey showed that over a quarter of care workers were leaving because of pay and over 13% because of working conditions. Terms and conditions and pay are big concerns of care staff, especially for overseas healthcare workers. How many care workers have been refunded the immigration health surcharge since the Prime Minister made that promise? Will that refund continue for all healthcare staff in the future, or is it just for the duration of the pandemic?

Sajid Javid: I could not tell you how many have been refunded; I do not have that number with me. I am happy to write to you and share it with the Committee. You are right of course to point to the importance of pay across health and social care, but I think some of the recent changes—for example, the announcement of the 6.6% increase in the national living wage—will help.

Q17 **Sarah Owen:** The national living wage is still in poverty pay. It is not actually a living wage that you can live off, and a number of care workers are still not being paid for in-between travel times. Will you look at that?

Sajid Javid: I think the increase in the national living wage will help anyone on that wage, and I am sure they certainly would welcome it. You will know that the workforce in adult social care, as opposed to the workforce in the NHS and health more generally, is not directly employed by Government, or even indirectly. There are independent employers in the private sector, although, obviously, the Government have a say through the national living wage, and in other ways.

What was the second part of your question?

Q18 **Sarah Owen:** Will the immigration health surcharge refund scheme continue into the future, or is it just for the duration of the pandemic?

Sajid Javid: It was a decision made during the pandemic and we keep it under review. I could not commit to you now whether we were going to keep it or not.

Q19 **Sarah Owen:** You will understand that hundreds of pounds for healthcare staff who are on the minimum wage is a huge amount of money.

Sajid Javid: Of course. I understand that.

Q20 **Sarah Owen:** And it would be really good if they understood whether it was going to continue into the future.

I am going to move on now and ask a specific question about the pandemic. What practical changes have been made to ensure that, if there was another pandemic, infectious patients would not be released back into care homes, as we saw during the Covid pandemic?

Sajid Javid: I think it is fair to say that during the pandemic we have learnt a lot in the Department, the NHS and social care. What I would point you to—you ask about the practical changes—is how the Government responded to the Omicron wave. As you know, it is very recent and because of what we had learnt—the infection prevention and control guidelines that were in place and the contingencies we had in place—we were able to act very quickly with care homes in enhancing the PPE requirements and changing the visiting arrangements.

One of the big differences today compared with the start, notwithstanding the vaccines and making sure that everyone in care homes—all the residents and staff—is vaccinated, is the testing regime that we have, which, as you know, did not exist. There was no such thing as a lateral flow test for Covid, for example, at that time. Now, with the use of those tests and PCR tests for residents on a regular weekly basis, a set of protections exists. I think we have seen the positive impact of those in the last few weeks with the Omicron wave.

Q21 **Sarah Owen:** I have a short, quick question related to that point. You would have had a chance to see the recommendations from the Covid inquiry of the Joint Select Committee. How many of those recommendations have been put in place?

Sajid Javid: I couldn't tell you specifically. We saw the recommendations. Some of them may have already been in train and some of them would have been put in place, but I couldn't tell you exactly how many of the specific recommendations.

Q22 **Sarah Owen:** My last question—I am pretty sure it is in everybody's inbox—is on access to GPs. The 111 service across the country is increasingly being used if you want to speak to a GP or to see a GP. This is not exactly what 111 was originally designed for. Is this a permanent change in the use of the 111 service, or is it until we see an ease in pressures on health services generally? Is there an ongoing review of it?

Sajid Javid: It is not a permanent change. What you are referring to—the increase in the use of 111—is really a reflection on the pandemic. In the early days of the pandemic, when we had all the social distancing rules in place, people couldn't see their GPs in the normal way and they could not go to hospital in the normal way. For example, people were reluctant in some cases to go to A&E, and I think they were more likely to use the 111 service.

Very recently, as in the last few months because of Omicron, because we rightly asked GPs to focus on the booster drive—the need to get so many more people boosted, especially in the month of December—GPs were asked to focus only on urgent care other than the work on vaccinations, and I think that has been reflected in 111 as well.

To help with that, we have provided extra funding to 111 services—in the winter, I believe, it was around £75 million. Don't hold me to that, but there was a significant investment made in 111 services and in GP services with the £250 million winter access fund.

Q23 **Sarah Owen:** If that is the case, why are our inboxes so full of people saying they cannot see their GP?

Sajid Javid: I would say, if it is in the last couple of months especially, it is because GPs have, rightly, been focused on the vaccination drive. There is only so much GPs can do. GPs have been working with distinction throughout the pandemic and whenever they have been called upon—look at the recent booster drive when they were asked to visit care homes and home-bound people to vaccinate them. They responded incredibly well, and that has made a huge difference, but because they have been focused on that it has been harder to access GPs in the normal way. I think people understand it and understand that it is right to focus on the vaccination drive. That said, and if, hopefully, Omicron case numbers continue to fall—hospitalisations are falling—GPs will have more time to behave in the usual way, especially with the support of the winter access fund.

Chair: At which point we will go to our very own resident GP, Dr Luke Evans.

Q24 **Dr Evans:** On Covid, Secretary of State, what is the probability of there being another variant that we may well need to take measures for?

Sajid Javid: There will be more variants. Let me answer it this way. Will there be more variants? Yes, absolutely. There have been loads of variants of Covid and, thankfully, we have not had to worry about most of them. We probably have the best surveillance system in the world, in the work that the UKHSA does, and we saw that with Omicron.

On your question about a variant that we have to worry about, I think there likely will be a variant that will be trouble in the future. By the way, there is already some lineage, let's call it, of Omicron, BA.2. We are not particularly worried about it, but, Dr Evans, just to mention how we have to stay on top of this all the time, if you look at the case rates of BA.2 in Denmark at the moment, it is spreading very rapidly. There is absolutely nothing to suggest that the vaccines are not effective against it and it seems it is just as contagious as the original Omicron BA.1, but it is a reminder of the importance of staying vigilant and to stay vaccinated.

Q25 **Dr Evans:** That is really helpful. We have heard time and again about moving to live with the virus. What plan do the Government have to avoid going into further lockdowns and to have a broad consensus on how we put measures in place for the future, should we need them?

Sajid Javid: As I have said and the Prime Minister has said, we have to learn to live with Covid. I think we are learning more all the time and we have put a lot of that into practice over this recent Omicron wave. First, we will be setting out, hopefully in the next few weeks, by the spring, a plan on how we think in government we can learn to live with Covid as a country.

Q26 **Dr Evans:** So you are going to come forward with a variant plan which would have at what level we put in masks, at what level we put in social distancing, at what level we need to close schools—all this. Can you talk us through it?

Sajid Javid: I would not quite describe it as a variant plan, or even necessarily containing the kinds of measures that you suggest, but I think it will set out, taking into account everything we have learnt over the last couple of years, what we know is most effective. It will also have an understanding of the early days of the pandemic when we had the lockdowns and things, and what the knock-on, non-Covid impacts of that are on things like education, children's schooling, college and university education, people's life chances, not going to work in the usual way, and all of that—and the non-Covid health impacts as well, the mental health impacts, for example.

I think we will focus on the pharmaceutical defences. Vaccines are with us to stay indefinitely. I could not tell you today how often we would recommend a Covid vaccine or to exactly what cohorts it would be given, but I do not think they are going away.

There are antivirals and other treatments, which again we have today for Covid and which did not exist when we first learned about Covid. Testing will also continue to form a big part of our response.

I would put those three things at the top of the list: vaccines, treatments such as antivirals and testing.

Q27 **Dr Evans:** Let me pull that together and say those are the pillars that you have. It sounds to me that, for the first time, we are going to be pulling together, effectively, the economic impacts, the non-Covid as well as the Covid side. How will that be drawn together? You are the Health Secretary, but how does that involve the Treasury, BEIS, all the other representatives—education and these areas—fully to formulate a plan that can deal with this and be sustainable for the future, hopefully to protect against the foreseen problems that we might have?

Sajid Javid: My Department will lead on this and I will lead on this as the lead Minister, but, of course, it will draw in from across Government. It will be a Government response to how we learn to live with Covid. I said in the House in my Covid statement last week that we have to find a way to live with it, in the same way as we live with flu. I am not for a second suggesting it is like flu. Look, sadly, at all the deaths we have had from Covid—over 150,000 from the start. It is about understanding that we now have defences which we did not have before and, just as flu does not stop society and stop life, we must not let Covid do that any more.

Q28 **Dr Evans:** My final question is: how do we ensure the NHS has the time to relax and deal with the backlog but be able to scale back up like it did over the Christmas period for Omicron? That is a tough ask for the staff and the NHS itself. What approach will you use to deal with that?

Sajid Javid: It is a huge ask and, first, we must recognise that. The NHS has all its pre-Covid work to be getting on with. That has also increased—for example, with the waiting lists for electives—and there is the increase we have seen, sadly, in mental health challenges, and of course the NHS has to deal with that as well.

At the same time, it has to be preparing for living with Covid. How do I see that? That will be set out in this plan, but to give you a sense of it, part of it is the pharmaceutical defences—vaccinations. What we cannot do every time we are trying to encourage people to take a Covid vaccine—and I refer to the previous question from Ms Owen—is ask GPs to stop doing their regular work. That is an emergency response now, but in the future we have to have a national vaccination service that is able to deal with Covid vaccines as well as other vaccines without drawing in workforce from the rest of the NHS. That is one thing. The same applies, by the way, to making use of antivirals and testing and having a separate process to deal with that.

The other thing we need to think carefully about is what I would call surge capacity. Again, we have learnt this over the last couple of years. You will know about the Nightingales at the start of the pandemic; this time, we did it a bit differently with the on-site Nightingales, but we have to have some system of surge capacity that is pre-planned, pre-thought through so it can be in abeyance most of the time but if there is a new wave and there is a concern around capacity we can quickly switch it on.

Chair: From our resident GP to our resident pharmacist: Taiwo.

Q29 **Taiwo Owatemi:** Secretary of State, as a west midlands MP I am sure that you are aware some hospitals in the west midlands have the worst waiting times in the whole of the country. Data from University Hospital Birmingham shows that it has the longest waiting times of any trust in England. What steps are you taking to level up what seems to be a postcode lottery when it comes to waiting times?

Sajid Javid: When we look at the size and direction of elective waiting lists, which I referred to earlier with the Chair, it is right that we—and this is what we will do in the elective plan when we set it out—break it up in a few important ways. One is by region. I do not have exact numbers but, for example, the elective waiting list, weighted by population, is lower in the London area and the south-east than it is in the midlands and the north-east, for example. It is right that we direct resources, that we take into account the regional differences and ensure—in this case, for the west midlands—that the correct amount of resources are there to reflect the need of that area.

The other way we will break it down—there will be a regional differentiation in this as well—is by the length of time people have been waiting on the list. Obviously, the longer someone has been waiting, particularly for certain types of procedures, that has to be a priority as well.

Q30 **Taiwo Owatemi:** I want to move quickly on to workforce planning. You have spoken a lot about nurses and GPs, but I am sure that you are aware of the work that physician associates do in alleviating pressure from doctors. What is the Government doing to ensure that we have sufficient numbers of physician associates in the country?

Sajid Javid: We are talking to the royal colleges about physician associates and seeing what more we can do. There were some changes around the work that physician associates could do during the pandemic. We are looking at whether some of those changes should be made permanent.

When it comes to recruitment, physician associates are as important as other areas in the workforce that we are hiring. We talked earlier about GPs and nurses and certain consultants and specialists, and that is a focus as well.

Taiwo Owatemi: I want to move on to recruitment. You spoke about how we have 4,000 new medical places that have come into place this year.

Sajid Javid: Yes.

Q31 **Taiwo Owatemi:** What are you doing to address the fact that in many training places there is not enough capacity post-graduation? For example, in Coventry and Warwickshire we have capacity to take on more training places, but we do not have the necessary number of

places. What is being done to address that?

Sajid Javid: The first thing I would say is I am pleased that for the last two years we have been able to remove the cap on places and have more and more students entering medical schools, whether doctors or dentists. At the same time, we are looking at what should be the long-term investment in the training estate and training places. That is part of the work that the HEE is doing—what I referred to earlier when I talked about the 15-year workforce framework. I have asked them to look at precisely this: are we putting enough investment in the right places to create those training spots and places that we need for the long term?

Taiwo Owatemi: Post-graduation.

Sajid Javid: Yes.

Q32 **Taiwo Owatemi:** Lastly, I want to talk about two medical schools within the region. Yesterday, I spoke to the vice-chancellor of Warwick Medical School and he said how as a medical school it is willing to expand to help with the workforce demands. What discussions are you having with the Treasury with regard to the expansion of medical schools?

Sajid Javid: First, I could not tell you anything specific about Warwick Medical School. You probably would not be surprised to hear there are quite a few medical schools that could expand if they had the resource and they felt they had the demand. Again, I would point to the work I have asked HEE to do because I think, rather than Ministers or even officials in the Department deciding what the need is and where we should invest in training places, that is the point of having the HEE independently to assess this. In the spring, when that work is complete, we will publish that and it will help to set out our longer-term plans.

Taiwo Owatemi: Chester Medical School is waiting to hear back from the Government.

Sajid Javid: Which medical school?

Q33 **Taiwo Owatemi:** Chester Medical School is waiting to hear back from the Government with regard to the policy direction needed for it to start providing the doctors who are needed within the NHS. When are the Government going to get back to it, because it has been waiting for a while?

Sajid Javid: I do not know about that particular medical school and exactly what has been communicated to it in the past but, if you will allow me, I am happy to take that back to my Department and get back to it.

Chair: You will be delighted to know that we are doing an inquiry into workforce matters. so you will have plenty of opportunities to answer these questions again.

Sajid Javid: I am thrilled.

Q34 **Dean Russell:** Thank you, Secretary of State. May I through you congratulate everyone on the booster programme, which was phenomenal over Christmas—the NHS and volunteers and the whole team?

I want to touch on mandatory vaccination of NHS staff. I am conscious that the NHS is supportive of this. I have chatted to NHS workers who are very supportive. However, many staff are not getting the vaccine. I have spoken to constituents who are concerned that they are being put in a difficult position, because they feel they have the antibodies and are not getting the vaccination. Could you help my constituents, who would like to ask why they can't just be tested for antibodies to test their resilience to Covid rather than getting the vaccine? How do I respond to them, please?

Sajid Javid: First, thank you for mentioning the importance of the booster programme. We are the most boosted large country in Europe, and I think that has probably been the single most important intervention in dealing with Omicron.

When you look at the direction of travel of Omicron at the moment in terms of case numbers, hospitalisations and infection rates, they are all in a downward direction. There have been lots of important interventions, but the single most important thing is the boosters. Every single person who has stepped up to take their booster shot—and some 37 million booster shots have been delivered and over 90% of over-50s are boosted, for example, in our country, more than any other country in Europe—has played a part in our recovery.

When we turn to the NHS workforce and you asked me about vaccinations, I would say it is important for everyone to get vaccinated. I think we all know why. It is especially important if you are in a profession like the NHS and social care where you are caring for vulnerable people.

Your question specifically was around people who have asked you, "What if I have prior infection? Do I still need to get a vaccination?" The answer is that all the evidence is that, even if you had a prior infection, if you get a vaccination on top of that you are even more protected. You are more protected for yourself, but because you are less likely to get infected than otherwise it means you are less likely therefore to infect others, and that means you are less likely to infect your patients, who are already more vulnerable simply because they are in hospital.

Q35 **Dean Russell:** The date is looming for when workers need to get their vaccination as part of this programme. What is the plan for filling that gap if the number of people who say they are not going to take the vaccination, or currently have not, leave the NHS over the next few months?

Sajid Javid: I would start by saying, regardless of the mandate for NHS workers, it is the professional duty of every NHS worker to get vaccinated. It is a professional duty. Even before the mandate, since we announced the consultation in September, we had around 100,000 in the

NHS who were unvaccinated but have come forward, so there has been a very good response. Almost 95% of NHS workers have had at least one jab.

The latest numbers I have is that around 77,000 have not. That is improving every day. Not all 77,000 are in scope because to be in scope is if it is a patient-facing role, but the majority of those people would be in scope.

It is also reasonable to assume that not everyone ultimately is going to come forward. The NHS, rightly, has contacted and is in constant touch with every single trust asking them for their plans, and it has asked every trust to set out those people who they estimate will ultimately just not come forward, and to break down what kinds of roles they are and see how they would manage that.

To give you a sense—I will not name the trust as it was a conversation in confidence—recently I spoke to a chief executive of a relatively smaller trust of around 5,000 NHS workers. He told me its vaccination rate was 97% or 98%—so, very high—and a lot of that was an improvement in the last two months when, rightly, there has been a lot of positive work and persuasion of people about the importance for themselves and their patients. He estimated he had around 200 who had not got vaccinated. He had just completed a piece of work where he asked every worker if they are what is called a firm refusal, and he estimated he is going to have about 25 out of about 5,000.

That is just one trust. I do not want to pretend that it is the same sort of proportions in every trust. In some areas there might be higher proportions that ultimately do not. But what we are seeing is that through persuasion and making a positive decision more and more people are coming forward.

Q36 **Dean Russell:** That is good to hear. I want to touch on the different topic of mental health. You mentioned the work to support NHS staff, which is very good news. One of the areas that I hear a lot about is support for children and, in particular, for teenagers who have gone through the challenges of Covid and lockdown—in the early stages, not seeing their friends in school and so on, and the potential ramifications of that for the future. Could you elaborate on what support is going to be in place now, and in the long term, to improve mental health access support for teenagers, especially as they start to go to university and perhaps are away from family as well?

Sajid Javid: You will have heard me refer earlier to some of the non-Covid health challenges of the pandemic and, sadly, mental health is one of them, especially among young people, and teenagers in particular. That is why we are working on a refreshed mental health plan. We already had a good long-term plan for the NHS pre-Covid and we are working with the NHS on a complete reset of that plan.

The funding commitment that we made through the long-term plan is still there to keep increasing NHS spending year by year. There was the extra funding and support we got over the pandemic as well. When we set out our re-set of the long-term plan early this year, it will include a focus on mental health, and in particular for younger people.

Dean Russell: That is good to hear. Thank you.

Chair: I would like to welcome a new member of our Committee, Martyn Day, for the next set of questions.

Q37 **Martyn Day:** Much of what I would have liked to ask has already been covered.

Sajid Javid: That is all right.

Q38 **Martyn Day:** But one issue that I was very pleased with was when the Government announced the money for motor neurone disease research back in November. Can you give us an update on what progress has been made in allocating that?

Sajid Javid: Thank you, and welcome to the Committee. That was a really important commitment—making sure that we set out at least £50 million of spending over a five-year period dedicated to motor neurone disease. In terms of progress, what we have announced has all been put in place. We will be asking for people to come forward—researchers, academics and others—with the kinds of research they want to do, and the money will be allocated over time.

There is also the partnership we announced. It is quite early days, in that we promised we would work with all the stakeholders to make sure that they have an input in how we set up the partnership and how the research is prioritised. That is the consultation phase that is going on at this point. Once we have got through that, we will set out and publish in more detail how we will take it forward.

I was very proud of that commitment because I think for a long time, for a variety of reasons, we were not focused enough on this terrible disease, and, through research, there are breakthroughs that can be made. By the way, we also collaborate with other countries. It is not just the funding we are putting in, but if other countries we partner with come forward and make commitments, too, we will collaborate on research.

Q39 **Martyn Day:** What is the timescale for this consultation phase coming to an end?

Sajid Javid: It is an informal consultation, so in our mind we thought it should take three or four months to work with the relevant stakeholders and to put together a more detailed plan.

Q40 **Barbara Keeley:** I want to raise as a first question the detention of autistic people and people with learning disabilities in inappropriate in-patient units. There are 2,085 people in that situation, despite the Conservative Government pledging 10 years ago to close all those units.

I do not know whether you have seen this case, but recently we heard a lot of publicity about patient A, a 24-year-old autistic man held for four years in a box-like apartment in Cheadle Royal Hospital and given his medication and food through a hatch. This placement comes at a cost to the NHS of £20,000 a week.

My question is: Secretary of State, why don't you act on this Committee's report on this scandalous treatment and find suitable accommodation and support for all those autistic people and people with learning disabilities?

Sajid Javid: Again, this is another very important issue. I think I am right in saying my predecessor had, rightly, asked for a review of what more can be done here, with the principle being that in all these cases someone should be cared for in the community as close as possible to their own family, perhaps within their own family setting, and not in these types of settings.

You mention the patient A case. I know which case you are referring to because when I heard about it, through the media, I immediately asked my office for an update on that particular case and on the issue more generally, because it concerned me considerably, as I am sure it concerned you. I was provided with that information, but I should not talk about the detail of a particular case as I do not think it would be appropriate.

All I will say is that when you get the detail of that case, and perhaps of other cases, it is not as straightforward as it might seem, especially if you take into account where people are not in the community but in a setting where they are detained. There is usually a clear clinical reason for that, and that starts for their own protection, or possibly the protection of others. In many cases, it can be people who may well be autistic or have another type of mental health challenge who have been directed by the courts to be detained, and the courts are involved in how long they have to be detained.

A broader answer to your question is that this is an issue that concerns me a lot. I have asked for advice on the current policies that we have in place and the outcome of the review that was kicked off by my predecessor to see what more we may need to do.

Q41 **Barbara Keeley:** I can say to you I have done a lot of work on this, particularly with your predecessor. Four years ago, a young woman, Bethany, got a lot of attention in the media, and I raised her plight quite a lot here. Bethany just had her 21st birthday, living in an apartment in the community happily with care and support, yet Bethany was in a situation where she was held in a cell and fed through a hatch, so there are successful cases.

This really needs a complete change of pace, if you like, because it is more than 10 years since Winterbourne View. This Committee has written an excellent report on this. A response to it was due from you in September. We have not heard anything from you, and nothing is moving. I understand that, newly in your role, you asked for a review of

this, but there have been reviews, and reviews on top of reviews. People out there who care about this are sick to death of reviews, and parents like the parent of patient A, who go to the media to try to get something done about it, are worn down by our talking about it and talking about it.

It actually needs to change and, more than anything else you could do as Secretary of State, most of the alternatives for accommodation in the community are cheaper. We should not be spending £20,000 a week to keep an autistic young man being fed through a hatch in a hospital because that is £1 million a year, and that is ridiculous. I am hopeful that we will start to see a response from you. This absolutely has to change and it needs some determination from the person in your role to do that.

Sajid Javid: I am pleased you raised this. This is a very, very important issue, and whether it is the young man, patient A, or the young woman, Bethany, you referred to, of course there is always a financial cost to this but it is much more than the financial cost: it is about doing what is in the best interests of these individuals.

Q42 **Barbara Keeley:** There is no financial reason not to do it. That is the point.

Sajid Javid: There may well be a financial reason as well, but it is about starting with what is in their best interest. I can assure you it is a hugely important issue for me, and I have asked for that review. I am afraid I could not deal with the detail of everything that has happened before me on this, but because of some of the recent news around this I asked for this review and, now that you have raised it, it has made it even more important for me, and I will also make sure that we respond to your report.

Q43 **Barbara Keeley:** I want to talk to you about carers working in the NHS, not social care staff but people who are themselves in their own time carers. According to the NHS workforce survey of 2021, one in three NHS staff are juggling work and care whereby they work in the NHS and care for a family member. A very high proportion of your NHS staff are carers, but the current lack of social care is putting pressure on all staff who juggle work and care. Pressure is increasing due to underfunding and the shortage you know about, and have talked about with my colleague, Sarah Owen, of paid care staff. Carers UK reports that one in five staff risk having to give up work to care if they cannot get accessible and affordable care.

What I want to say to you is that a lack of care is putting pressure on NHS staff and it could cause large numbers of them to give up work to care, increasing those NHS workforce issues you talked about earlier, and recruitment and retention costs. What can you do to ease that pressure on those NHS staff who are also unpaid carers for a family member?

Sajid Javid: I think it is an important issue and it is important, obviously, for the group of people you talk about—NHS workers who also have caring duties outside their NHS work—and I am sure there are other professions where people are doing important work and have similar

responsibilities, so I recognise it is wider than just NHS workers with caring responsibilities.

Q44 **Barbara Keeley:** You have the NHS workforce to worry about.

Sajid Javid: We do, but as a Government we should be concerned about workforce more broadly because of the caring pressures on people.

What are we doing about it? I would point to the work on improving the adult social care system and the workforce. Earlier, I referred to the adult social care White Paper we published, which is about long-term investment in the workforce, the extra £500 million referred to there.

Q45 **Barbara Keeley:** That did not touch on pay though, did it?

Sajid Javid: No, that did not touch on pay.

Barbara Keeley: Because that is a big issue and it is worth saying that.

Sajid Javid: But to touch on pay, I also mentioned earlier that, in the more immediate term, whenever the national living wage has improved—the 6.6% increase—it is helpful to anyone in the care system, and it certainly helps with recruitment.

There is also the extra funding we have put into recruitment this year on top of the regular funding in adult social care. There is the £162.5 million retention fund that was for this winter, the extra £300 million of funding on top of that because of the Omicron wave, and the support we are providing to the NHS indirectly through the discharge fund. Almost £500 million extra was given to the NHS this year so that it can support them with top-up payments from local authorities and others to care homes or to domiciliary care workers to help with their own delayed discharge problem. There is short-term funding going in and a long-term plan, which is in the adult social care reform White Paper.

Chair: We are making excellent progress, but we are hearing the vote might come before 6 pm, and we still have three colleagues, so a very brief final one, Barbara.

Q46 **Barbara Keeley:** I just wanted to add to what my colleague Martyn Day has already said to you about the £50 million for the motor neurone disease research institute. Clearly, that is much needed, but you will appreciate that time is of the essence for people with MND and half of them will die within two years of developing symptoms. There is so much energy to give that a boost, but I am afraid what you said sounded a little slow. I want to add my voice to saying that if you could speed up on that it would actually be helpful.

Sajid Javid: We are doing everything we can to speed that up. The fact we were able to make that commitment for the first time—the biggest commitment we have ever made to MND, I think—is obviously a big step forward, but you are absolutely right to talk about now putting it into action as quickly as possible.

Q47 **Lucy Allan:** Secretary of State, last week you set out a much-needed new vision for cancer and improving outcomes. Can you say a bit more about that plan and when you will publish it?

Sajid Javid: Thank you very much for asking about cancer. In general, in cancer there is a lot we can be proud of as a country but, if we are honest, when we compare cancer outcomes in the UK versus other advanced economies, we are not doing well enough, particularly on early detection.

We are working on a new plan. I want there to be a long-term plan on cancer. I want there to be what I call a war on cancer. I mean it. I want to look at all different levels: early detection, of course, but new treatments as well for those for whom, sadly, the cancer progresses, and more focus on diagnosis.

I could not tell you right now what exactly is in that plan. I have started work with colleagues in the NHS and the Department and other stakeholders—academics and others—to learn more about what we could do in that plan.

You will be aware that in the NHS's long-term plan there is already a plan the Government set out to 2026, and I want to set out a longer-term plan going much further than that and start the investment for it.

I can tell you the kinds of things it will include because that will clearly be of interest. There is a much bigger focus on early diagnosis. For example, I was really pleased to learn recently about all the positive work that we have been doing through early detection of lung cancer with lung cancer mobile vans—targeted mobile diagnostic units. We sent them into areas where there was a high incidence of cancer, typically where smoking rates are very high. The detection rate soared from about 30% to 80%, and that is a fantastic result. We can really make a difference with things like that.

Q48 **Lucy Allan:** The community diagnostic hubs are really welcome. I have one in my constituency. Are there plans to increase the diagnostic capacity to improve cancer outcomes, and will those plans be within your overall plans?

Sajid Javid: Yes. I mentioned the lung cancer mobile units as one example. We have already opened 69 community diagnostic hubs and we want to get that to 100 this year, maybe more. That helps a lot because you can be referred directly to one of these centres without necessarily having to go through your local NHS. That is already in operation.

We are also doing trials of new technology, new ways of looking at things. The GRAIL test is a trial looking at taking blood samples and trying to detect from them the risk of cancer to certain people who would for certain reasons be deemed to be high risk. That is the first in the world and we are world leading in that.

I am also trying to see what else we can be doing with breakthrough technology to really help with early detection.

Q49 **Lucy Allan:** I want to push back on your answer to my colleague Dean Russell about mandatory vaccinations. You have said you are committed to mandatory vaccinations for NHS staff. If staff do not come forward for vaccinations in the way you have described, what is going to be the impact on patients? Are you comfortable with dismissing staff who have served the NHS so fantastically during the pandemic?

Sajid Javid: I will just take a minute on this as it is a really important question. The whole principle is about patient safety. That is what motivates me and that is what motivates the Government in this decision. It is about patient safety, and that principle is unchanged: patient safety must come first. What you have highlighted there, Ms Allan, is that when it comes to patient safety you have to think about the benefit of vaccination, and we have talked about that, and the cost element, if I can call it that, of some people who may, ultimately, whatever information you provide them with, for whatever reason, not get vaccinated. There will be a cost and no one wants anyone, not one person, to leave the NHS because of this reason.

When we made this decision, that was the principle and we weighed it up. The dominant variant at the time was Delta. The dominant variant now—in fact, it is almost all cases—is Omicron. I have had representations made to me, not surprisingly, where people have said, "Omicron is Covid but it is very different in some key ways to Delta." Of course, that is factually correct. We know now that Omicron is more transmissible, which again emphasises the importance of vaccination, but it is intrinsically less severe. For some people, it is severe and it certainly is for the 15,000 people in hospital with Omicron, but it is less severe than Delta.

The principle has not changed, but the representations I get are some people saying that we should add boosters to our mandation. "If you are going to do it, add boosters because the Government and others have already set out the evidence of why two vaccines are not quite good enough; you need three." Others say, "Why don't you drop mandation altogether?"

I think it is right in the light of Omicron that we reflect on all this and keep all Covid policies properly under review. Omicron is different from Delta. Equally, we do not know what the next variant is going to be, and we talked a bit about that earlier, but we are reflecting on this.

Q50 **Paul Bristow:** Secretary of State, forgive me if you talked about the elective recovery plan before I arrived. I want to ask you a question on that. There has been a report that NHS leaders are resisting what they call "ambitious" targets contained within any plan. Do you agree that ambitious targets should be included in the elective recovery plan to focus minds? What would happen if an NHS trust failed to meet these targets?

Sajid Javid: I absolutely agree it should be ambitious. There are lots of reasons, not least I want to get through as many electives as I can. There is a lot of money being put into electives, and we have a duty to make sure all of that is being well spent and the taxpayer is getting the most out of that.

I have not seen reports about resistance. Obviously, NHS England has all the various trusts underneath it and it is not as though I would speak to every individual trust independently, but I have not seen evidence of that. In fact, I would say the opposite at this point. In working on the elective recovery plan, which we will publish, we have seen very good co-operation and partnership work with the NHS.

Q51 **Paul Bristow:** The second part of my question was: if these targets were in place, what sanction or encouragement is there for trusts that fail to meet those ambitious targets?

Sajid Javid: I would say a couple of things. First, in terms of incentives, we are making it as easy as possible to reach those targets with some of the things I have mentioned already. There are new ways of doing things. We have already started some of those: the community diagnostic centres, the 44 surgical hubs that we have already opened during the pandemic, and the greater focus on digitisation. This is all an important part of it.

You talk about sanctions, but the way I would look at it is we have to do everything we can to make sure the leadership of every trust is as good as the best. There is a big variation in leadership. Already in the job I have seen trusts which I think are remarkably well run. You can really see the results, even before the pandemic but especially as they have been tested a lot during the pandemic and they have come out of it with great leadership.

I have seen other trusts that are consistently failing. They are failing local people. They are failing whether it is delivering on electives or other types of care, and that is a problem. There is an independent leadership review because I want to see how we can replicate the best and spread it throughout the NHS.

A final thing I would say on that is that we must be radical in the changes that we make. That elective waiting list is huge. No one wanted to see a waiting list at this level. We all understand why we have this Covid backlog, but if we are going to get through it far quicker than in the past when we had such waiting lists we have to be radical in the changes that we make and how we make them. For example, we are not making the most of digital technology. During the pandemic, we had over 25 million people download and use the NHS app. That is just one example. Just think of what we can achieve with the patient/NHS relationship in terms of the information to them, the transparency, seeing them more quickly. That is just one example of how we can improve patient choice.

Q52 **Paul Bristow:** There is a thought that targets lead to perverse outcomes

and incentives. I am a huge fan of targets because I am a huge fan of transparency and accountability. Will NHS England regularly report on achievements against any targets that are contained within the elective recovery plan?

Sajid Javid: Yes, it will. On the value of targets, of course targets work if they are the right targets. In the NHS, I have already noticed there are targets that are the wrong targets, and we have to change them. The four-hour A&E target is the wrong target. It does not work. It leads to really perverse outcomes. If you look at some of the NHS trusts, all of a sudden, when the individual in A&E has got to three hours and 59 minutes, guess what—they are just admitted? That is a poor outcome. There may have been a good reason to have that target in the past, but you have to keep those targets constantly under review, and I am doing that.

Chair: Last but not least, we had some questions from members of the public who asked us to put them to you. I am going to hand over to Laura Trott for the final set of questions.

Q53 **Laura Trott:** I am going to read the five questions from the public and, given that the Minister is on his feet, I would appreciate some fairly brief answers if you can.

The first one is from Marina. With restrictions being lifted, when are births being reviewed? It seems nothing has changed since 2020. To sit alone for hours waiting to go to theatre is not right. Both of us will have had PCR tests. Why is my partner having to wait outside the hospital?

Sajid Javid: That issue is being constantly reviewed and there have been significant improvements as we have learnt more during the pandemic with the protections that we have—with the testing, for example, and PPE. With the Omicron wave, I know the NHS has looked at seeing how it can make even further improvements.

Q54 **Laura Trott:** More broadly on visitors, when are you planning to review restrictions? Obviously, families and friends are advocates for patients and there is a real and significant deficit in care because they are not able to come in with them. When are you going to be able to remove those restrictions within the NHS more broadly?

Sajid Javid: When we set out the living with Covid plan we will have a lot more to say on that. We are not just going to wait for that. If there are any improvements we can make in the meantime, we will.

The tricky bit is always trying to get that right balance between protecting patients and making sure that their loved ones can see them. The benefits are not just for the patient, but for the whole family. The infection prevention and control rules are set by the UKHSA, and they are constantly under review. When Omicron began, we brought them in to try to control the rate of infection, particularly in hospitals and care homes, and now we have gradually started to move back from some of the rules.

Q55 **Laura Trott:** Can you guarantee they will not be there in the long run?

Sajid Javid: As we learn to live with Covid, there are some obvious things we should do differently in infection prevention and control. We should keep some things, if they make sense, in place.

It is not just Covid infection. If you are in hospital, for example, there may be things that we have learnt from Covid where we think, "You know what, maybe we weren't doing protection from infection as well as we could have in hospitals." So there may be some simple things that we can continue. As a general rule, I think we should try to remove as many of the Covid rules and regulations as we possibly can, as long as it is safe to do so.

Q56 **Laura Trott:** Moving on to the second question from Jerusha, which you have touched on slightly already: when will the elective recovery plan be published? Will you commit to a ring-fenced cancer nurse fund to double the number of cancer nurses by 2030?

Sajid Javid: I was planning to publish the elective recovery plan in December and then Omicron came along. I hope to get it out as soon as I possibly can in the next few weeks. I just cannot commit to a date today. It is a priority and you should not have to wait too long.

On ring-fencing spending for a particular part of the workforce, albeit a very important part of the workforce, as a general rule I think ring-fencing is not the right way to go. It might sound good, but I think it is important to let the NHS, when it is looking at all its needs, decide how best to allocate the funding it has for workforce.

Q57 **Laura Trott:** The third question is from Paul. How much of the £36 billion extra funding for the NHS is going to dentistry?

Sajid Javid: I could not tell you how much of the £36 billion. I do not think much of it will go to dentistry because it is very focused on electives—£8 billion of it, £5.4 billion on adult social care, just under £10 billion on vaccines, therapeutics and PPE, and then there is a big chunk, £4 billion or £5 billion, that goes under the Barnett formula. Dentistry is hugely important. It is a priority and that is why just today I announced an extra £50 million, paying for 350,000, I was going to say procedures, but fillings and things.

Q58 **Laura Trott:** The fourth question is from Stephen, who asks: what steps are the Government taking to reduce the racial disparities in the use of the Mental Health Act?

Sajid Javid: In our current long-term plan in the NHS that is a recognised issue because there are some serious disparities, but I think that the bigger change will come through our plans for reforming the Mental Health Act, because I think the way that Act is structured has led inadvertently to some of these challenges.

I know there is racial disparity in mental health, and that is really important, but there are also concerning racial disparities in healthcare that I have noticed more broadly. Recently, I set out some of the concerns I had over the pulse oximeters that were used during Covid and

how if you had darker skin they weren't necessarily giving the right reading. I think it might have been a reason why we saw a disproportionate number of black and minority ethnic people in hospitals, certainly in ICUs, and clearly that is not acceptable. I have said already I want to review this properly and independently around medical devices and racial disparities.

Q59 **Laura Trott:** A final question from Nigel was covered slightly in the questions with Sarah earlier: what is the workforce plan for social care? How will it address pay, reward and recognition?

Sajid Javid: There are two elements of the social care plan, the short term and long term. In the short term, this is extra support because of the pandemic, essentially. We have a shortage of social care workers and a lot of that short-term support is the funding I referred to earlier, but the long-term plan is the extra £500 million being allocated through the levy that will go on many aspects, including workforce training.

Q60 **Chair:** I have a final question before we wrap up. I noticed you said you wanted to have a war on cancer. Almost exactly 50 years ago, they launched a war on cancer in the United States. I am tempted to ask whether you have drawn any other inspiration from President Nixon, but that is not my question.

My question goes back to GPs, which we touched on a bit earlier. We are doing an inquiry into general practice. It has not opened yet. You talked about long-term reforms that you want to look at for the NHS. Last year, an enormous study appeared in the *British Journal of General Practice*, conducted in Norway, which said that if you have the same GP over many years you are 30% less likely to go to hospital and 25% less likely to die. Today, there was another survey, also in the *British Journal of General Practice*, of 9,000 dementia patients. It said if they have the same doctor over a long period of time they have a 35% lower chance of getting delirium.

When you look at potential reforms for the NHS going forward, will you consider whether, as we increase GP numbers, we could go back to GPs having their own lists of patients, as they used to, so that everyone has their own doctor?

Sajid Javid: Yes. I read a report of what you have referred to; I think it was a report of the report, and to me, instinctively, it sounds like a common-sense approach. It has to be the case that, if you are able to see the same GP regularly, as he or she learns more about you they can treat you better and look after you. I could not make a guarantee that we could do that. I think in primary care there are a number of issues we need to look at to make improvements for patients, but that should certainly be one of them. *[Interruption.]*

Chair: The Division bell has rung—perfect timing. Secretary of State, thank you very much indeed. I declare the session over.