

Health and Social Care Committee

Oral evidence: Social care: funding and workforce, HC 206

Tuesday 8 September 2020

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

Questions 150 - 232

Witnesses

I: James Bullion, President, Association of Directors of Adult Social Services; and Sarah Pickup, Deputy Chief Executive, Local Government Association.

II: Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care.

Written evidence from witnesses:



Examination of witnesses

Witnesses: James Bullion and Sarah Pickup.

Q150 **Chair:** Good morning and welcome to the House of Commons Health and Social Care Select Committee. We are focusing today on our inquiry into social care and issues around funding, the workforce and general issues. Shortly, we will hear from the Secretary of State for Health and Social Care, Matt Hancock.

First, I welcome two very regular witnesses to our Committee: James Bullion, the president of the Association of Directors of Adult Social Care; and Sarah Pickup, who is the deputy chief executive of the Local Government Association. Sarah and James, you are very welcome.

Our inquiry into social care focuses on two particular issues—workforce pressures and funding. We have a spending review scheduled for the autumn, so I want to start, if I may, by asking both of you what you are looking for from the Chancellor.

James Bullion: ADASS is very pleased to be providing evidence this morning. We are looking for two things from the Chancellor. First, we are looking for some acknowledgment of the immediate pressures in adult social care, both on local authorities' ability to spend and on the care sector itself and its ability to sustain. We are looking to the Chancellor to respond to those two needs immediately and then, as part of the reform package that the Government might bring forward, we are looking for the intention to invest in social care for the long term.

We are making a specific submission to the spending review to give the facts and figures that we believe are required for sustainability, because we have in the offing winter, Covid and provider sustainability problems. We have a great fear that the social care sector is on the brink of a collapse if we do not see an industry-level intervention. We see it as a great opportunity from the Chancellor for social care to be part of the economic recovery, because all it needs to do is grow.

Q151 **Chair:** Thank you. Sarah, what would you add to that?

Sarah Pickup: We would like the Chancellor to see social care in the context of wider council budgets; directing money to social care is really valuable, but if council budgets generally are under pressure, that has impacts on services.

Like James, we absolutely call for immediate funding to address immediate pressures. There were pressures as we went into this year even before the Covid crisis. The Covid crisis has exacerbated them, and of course the demography and inflation continue to rise, and the issues in the provider market are crucial.

Above all, we would not want the short-term solution to be a substitute for a serious announcement about getting on with reform, because reform is needed for longer-term sustainable funding, but it is not



funding for its own sake; it is funding so that people can live their lives in the way they want to live them. Councils are constrained in being able to co-produce services that people want and in working with providers in the way they want to. It does not mean that they do not do it at all—they do it well in many places—but there are huge constraints, and if we do not get finally properly on the road to reform, we will be in the same dilemma and worse going forward.

Q152 **Barbara Keeley:** You have talked about immediate pressures and having huge constraints, so can you describe to us briefly what has happened to social care funding, and the impact on people who use care and on the care provider market? I think that would be a useful place to start.

Sarah Pickup: Would you like me to start?

Chair: Please do.

Sarah Pickup: I will start with the overall funding position. If we look at the last 10 years, in the context of reductions in Government funding to councils overall of £15 billion, the position on adult social care is that over that 10-year period, budgets have risen by 16.5%, but most of it was in the latter three years, so there were pretty much flat cash settlements or flat budgets for about six years and then it started to rise. Over the same period, inflation and demographic pressures have risen by 28.3%, so there is an immediate gap of more than 10% between the budget rise at the end of that 10-year period and the pressures that have been experienced.

That is without taking into account that some of the increase in budget will have been to address new burdens and other responsibilities that have come along in the meantime. I do not think that the 28.3% is the sole sum of the problem. In the meantime, adult social care budgets have been protected by councils and they have risen from 31.7% of a total council budget on average to 36.1%. There is a gap, but some protection has been going on.

As to the impact of that on people who use services, clearly we have a situation where demand exceeds supply in terms of resources, so the only actions you can take are to prioritise and ration, and to achieve efficiencies and do things better and prevent need, and you have to contain costs. Significant efficiencies have been delivered. There has been an increase in services such as reablement that support people to need fewer services and be less dependent in the future, and there has been some investment in prevention where councils have been able to justify it and get a return sufficiently.

There is huge unmet need and there is also big undermet need. I know that some of the people who have spoken to you have their care needs met to a degree, but they would say it was insufficient to enable them to meet the aspirations they are entitled to under the Care Act. That



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includes support for carers and the Care Act aspirations around prevention.

The budget is under pressure. There is a financial thing, which is about rationing and prioritisation, but when budgets are under pressure it does not create the right conditions to engage with both individuals and providers because you are always worried that you are going to overspend your budgets. Councils are not allowed to overspend their budgets overall, so all managers are under pressure to keep within their allocations, which means that we have a fragile provider market and that we have not been able to work with people who use services in the way that we really want to, as the Care Act determined, to improve their wellbeing, not just to meet their immediate care needs.

James Bullion: To add to what Sarah was saying about the global numbers, what does that mean for the people we serve? We have seen a reduction of nearly 6% in the number of people who have been served by local authorities over the past five years. That is a reflection of two things: people fending for themselves, and the prioritisation decisions that councils have to take to meet their statutory obligations.

In the ADASS survey that we carry out every year, this year only 4% of directors, which is an astonishing number, feel confident that they can meet those statutory duties. Necessarily, directors have to prioritise—it is an invidious position to be in—between those who are in very high need, life and limb by and large, and people we might work with who have a preventive need. It has been estimated by Age UK and by the King's Fund that there are around 1.5 million to 2 million people who have unmet or undermet need whom we could be working with. One of the lessons of Covid-19 and our work with the NHS has been that, if we can identify those people, we can save ourselves demand in the future and NHS demand now and in the future. It is a frustrating position to be in at individual casework level.

As Sarah says, that situation creates discontent as councils increase their charges. Most councils have increased their charging for social care to the maximum and given fewer and fewer discretionary disregards for charges that are allowed under the Care Act. Of course, the Care Act itself is in need of reform. We never introduced the second part of it, which was the adjustments to the means test to bring in new people who could be helped and guided to make the best decisions for themselves.

We would urge that there is a business case for investing in social care for councils and the wider budget that Sarah described, because we have pressures in children's services and other areas. There is also an NHS prevention equation. We look with envy at the NHS plan and the plans around the Ageing Well programmes, population health management or social prescribing, where the NHS is doing excellent prevention work. Councils are unable to do that because of the lack of resources that we



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have dealt with over time. We have reached the bottom of demand management.

Q153 Barbara Keeley: I have a second question on funding. There have been various short-term funding allocations that have been provided from Government. Can you say briefly whether you think they address those issues? During the Covid pandemic, providers have had to take on higher costs due to PPE and staff absences. In the current situation, before anything else changes, how concerned are you about whether we would see a wave of closures of care providers across the winter and what the capacity position is if that happened?

James Bullion: In our ADASS survey, we have seen in the last year some 5,000 people affected by hand-backs of contracts to local authorities as a result of providers ceasing to trade. We estimate that currently perhaps a third of all providers are making a loss, and that might rise. That is as a result of the increased costs of Covid, even with the intervention that authorities have made.

There was £3.2 billion given to local government directly. Councils have allocated the right proportion of that to adult social care, remembering that there are pressures across the council, and that has enabled councils to assist with PPE payments; it has enabled us to provide payments to care providers on book, as it were, to pay for what we would normally pay for, irrespective of whether it is delivered; and it has enabled us not to charge our service users irrespective of whether they have received care or not. Most councils are now reaching the end of the pot of that allocation directly in time for winter, so we have a great fear that providers will now face those additional costs over the winter period without local authority intervention.

The recent infection control grant has been very welcome, but it has been very narrow in its limitation, mainly focused on staff sick pay and staff movement and not on the broader business costs that providers have faced. There is a very dangerous scenario whereby most providers start to make a loss over the winter period, so I would urge—I have participated in this so I am cautious about my language—common sense to prevail as the outcome of the recent social care taskforce, and to extend in-year some of the payments that we have received so that we can cope with the winter period.

Sarah Pickup: As well as the Covid issues in relation to short-term funding—of course the funding has been welcome and I will not repeat what James said—there is a tendency each year to not quite get to the point of tackling the need for reform but to put in some more, very welcome, money. The last couple of Budgets have provided additional resources for social care but on a short-term basis, which means it is really difficult to reshape the market, and to plan forward with any degree of certainty.



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It applies in the context of wider council budgets as well, because, sitting within a council, when you do not know what is coming next March, it is very difficult to make radical plans. We know that most councils spend most of their planning time preparing for the next lot of savings they have to make, not necessarily for reshaping and investment in services. It is unfortunate, but that is how it has been for the last number of years.

Q154 Paul Bristow: I remind the Committee of my entry in the register of interests.

You have talked a lot about the pressures on local authority budgets. Are local authorities the right vehicles to commission social care?

Sarah Pickup: I would be the first to recognise that there is a mixed picture on commissioning in councils, but I would probably conclude by saying that I think they are the best place to deal with social care. The reason is that commissioning is not just contracting. A lot of what we hear about councils being not good at commissioning or in complaints from providers is based on the contractual arrangements that are in place and those sorts of services.

Commissioning is about assessing need and working out how to meet that need. It is not just about contracting for it. It is about enabling things to happen in your local area, building community capacity, working with the voluntary sector and enabling people to do things—for example, working with housing associations to enable the provision of extra-care housing. For me, that is all part of the commissioning picture, and formal contracts are in there too.

There are great examples. We have best practice examples published on our website, and in many other organisations' publications, of innovative services and partnerships with the voluntary sector and providers that show commissioning at its best. But the resource and capacity constraints that councils have faced are not always conducive to working in the way that commissioning ideally should work, because people are worried that if they talk to providers about what they aspire to, and to people about what they aspire to, what they will aspire to will be way more than the council can afford. There are, of course, cases where people have used challenge to work with people to deliver better solutions, and ideally that is where you get to, but the fear of not having enough to address presenting needs is quite evident in commissioning at the moment.

Local government at its best is really good at partnership working and creativity. Its commissioning role is way broader than the NHS. The NHS largely commissions NHS organisations to deliver a set of services and can work within a much wider budget. Councils' commissioning role goes into communities; it crosses into housing and into many different sorts of support from the voluntary sector. We absolutely recognise the need to build on good practice and to enhance co-production with individuals and constructive partnerships with providers as we go forward, and that local government is well placed to do that if it is resourced to do so.



James Bullion: In some ways, one of the trite answers is that in the last 10 years or so we have managed to save £7 billion or £8 billion, as part of the journey of putting the nation back in balance, albeit that that has been of necessity rather than being alongside a plan to invest in certain areas of social care. At one level, we are very efficient and we are now very good at demand management. Our colleagues in the NHS might have some lessons to learn in partnership with us about how to dampen down demand.

Secondly, recent experience has been discharge of people from hospitals with social care or councils in the lead of that commissioning, with pre-existing relationships with providers. That is why it works so well. The change in the dynamic, though, was having the resources with which to commission, and that is why it worked so well.

A third point I would add to Sarah's description is that people are the best determinants of what should be commissioned on their behalf. The Care Act promise of people writing support plans with professionals and then having a strong say in the commissioning of services is where we need to place further emphasis. If you are old enough, like me, to remember the days of supplementary benefit—before local authorities commissioned social care and it was in people's benefits—it was not a better system. It needed local authority intervention to have a market strategy, and a social care market that has changed markedly over the past 20 years now needs shaping. Providers need to be brought into that conversation, so that it is not local authorities doing unto; it is a partnership of providers, the NHS and service users.

Q155 **Paul Bristow:** You both talked about the complexity of commissioning social care within local government and you, James, talked about the benefits of care plans. In reality, especially in home care, what you are commissioning is activity. Do you not think it would be better to create a system where you are commissioning for a particular outcome rather than just activity?

James Bullion: Absolutely. I thoroughly agree. We are far too transactional and we do not have an outcomes-based approach to home care. We do when it comes to short-term care. For reablement, for example, we pay for an episode of care that has a goal in mind of achievement. In some areas of social care, if we think about adults with disabilities, where we are working with people over 20 or 30 years, we have an outcome in mind. Those people are much more involved in the way that services are shaped around them.

But largely, for the sake of making savings over the past few years, we have, as it were, stacked them high and sold them cheap and tried to suppress prices. I would characterise the last 10 years as being the first five achieving savings by procurement, as it were—stack them high and sell them cheap—and the second five as having to recognise that that is the wrong answer. We need to focus on outcomes and on shaping the



markets ourselves, and sometimes being in the market ourselves as local authorities.

Q156 Sarah Owen: This question is to James and then I have another question for Sarah. A handful of care providers during the pandemic have paid their staff more than statutory sick pay. Frankly, £94.25 a week is not enough. We have heard that there are fears that this has forced care workers to go into work when they may actually be sick themselves. Does it concern you that not every care provider wants to, or can, offer the same to their workers, and do you think that offering just SSP to health workers puts them and the people they care for at risk?

James Bullion: I would put the answer to that in the broader need for a workforce strategy for adult social care, with fairer pay and, as part of the fairer pay, consideration of whether the overall terms and conditions of our care workforce should include more enhanced levels of sick pay.

It has come to our ears as well from the TUC, from individual employees themselves and from provider organisations, where we have had conversations, that there is the dilemma that some workers have faced—let's imagine that it is not Covid but another illness all together—on whether to go to work not feeling so well, because they do not have the right sick pay, or to stay at home. It is absolutely a dilemma. We recognise it. We think the answer is a broader approach. ADASS, as part of its nine statements, recently called for a national care wage of £10.90 an hour, linked to a band 3 NHS healthcare assistant, as a way of starting the journey of giving some platform to build out from a very low-wage economy. The median wage in 2019 was £8.10; it is only slightly above the living wage. It is clearly a problem that bedevils us in vacancy factors and turnover rates.

Q157 Sarah Owen: Thank you, James. Sarah, councils across the country have incurred greater costs during the pandemic with spending on PPE and greater need throughout the crisis in staffing costs. At the beginning of the pandemic, Robert Jenrick promised that no one would be out of pocket, but councils across the country, including Luton, are. Can you give us an idea of the scale of the gap in funding now?

Sarah Pickup: Overall, the MHCLG surveys, to which the LGA has access, suggest that the total losses and increased costs arising this year are about £11 billion. Part of that is tax losses and they do not materialise until next year, so I will address the rest first.

The IFS has recently done some work for us looking at the pressures that are faced compared with the funding that has been given. The pressures, excluding tax, are £7.2 billion this year, and there is a gap, after all the Government funding is taken into account, including the new income compensation scheme, of £2 billion this year so far. That is without taking into account what James was saying about councils starting to draw back on their social care additional payments because they are worried that



they do not have the resources to pay for them, so there may be further pressures.

On top of that, there is an estimated shortfall of £3.7 billion this year in council tax and business rates. As I said, that falls next year. We have had some work done by Local Government Futures, and they estimate that around £2 billion of that will be irrecoverable as well, and we do not yet know about the Government's co-payment. They have talked about sharing that pressure and said councils can spread it over three years, but it is nevertheless a pressure.

A council like Luton is going to have to think not just about how it bridges the gap this year—I know you have already had an emergency budget in your council—but also about next year and going forward. That is without taking into account the fact that things like some of the council tax support increased demand is unlikely to fade away, so it is not just this year's issue we are tackling. Until we taper back to more normal levels of income collection and council tax support, there will be further pressures on council budgets.

Q158 Sarah Owen: When you talk about the gap in funding, is it just being able to keep the existing levels of services afloat, or are you talking about even more bare-bone services?

Sarah Pickup: That is just the Covid gap and keeping where we are with the Covid gap. There is a funding gap going forward for council services generally. The IFS is doing some more work for us on that, which we will be putting into the spending review. Our previous estimates, pre-Covid and in the last spending round, were a funding gap of £6.4 billion¹ for social care alone by 2024-25. It is about £800 million or £900 million a year. That is without meeting any unmet need, without any investment in prevention and without paying the workforce more.

Q159 Sarah Owen: I know the answer to this, but I think it is really important for the rest of Committee to hear it. This year and in future years, do you think that local authorities can take another round of cuts to their budgets from central Government?

Sarah Pickup: There is a very short answer to that. No. If you think about councils now with their emergency budgets, planning into next year and looking at savings plans, where are they going to get them from? Any council that is looking for significant savings from adult social care, for example, which is big—as we heard, 37% of council spend is on adult social care—where are they going to get savings in adult social care? Already many councils have not been able to deliver this year's planned savings because of the crisis, so planning further savings when they are already behind in their savings plans going into next year is going to be extremely difficult.

¹ Note from witness: This figure should be £3.9 billion.



We have seen the funding that we talked about—the reduction of £15 billion of Government funding over the decade. It is hard to see where else we would go and still be able to deliver even our core responsibilities. I think James has said that for the directors as well.

Q160 **Chair:** I want to follow that up, if I might, with both Sarah and James. We heard on the Committee from the Health Foundation, looking at the adult social care budget, that demographic pressures and the planned increase in the national living wage—just those two factors alone—would mean that by 2024-25 the adult social care budget would need to go up by £3.9 billion. Then if we wanted to do, for example, the Dilnot reforms, there would be another £3 billion a year on top of that. That makes a £7 billion increase as a starting point if you are talking about any kind of serious reforms. Do you recognise those figures? Do you have different figures? Do those feel like the right ballpark?

Sarah Pickup: The figure I have on the piece of paper in front of me is £3.9 billion. It is our calculated figure for what is needed to meet inflation and demographic pressures alone to maintain current levels of service by 2024-25. The Dilnot reforms, are, I think, published figures, but we also need to remember that the Dilnot reforms did not deliver extra resources to meet unmet need or to deliver prevention. They tackled the issue of unfairness but not the issue of sufficiency of services.

Q161 **Chair:** They raise the thresholds, don't they, at which people are able to claim state support? There is some element of unmet need that is helped by the Dilnot reforms.

Sarah Pickup: There is, although a lot of unmet need is because of unmet need for care eligibility, not financial eligibility. That is the main reason, I think, for people not receiving services. They do not cross the "substantial and critical" threshold. Finance is a part of it.

To go back to the workforce question, James talked about NHS band 3. If you went to band 2 and you tried to go for parity of pay for the social care workforce and you took into account the need to retain differentials, it would cost, we estimate, about £830 million, just to make a step in the right direction. There is another billion for you, I am afraid.

Q162 **Chair:** James, do you have any comments on those numbers? It is a pretty stark increase. You are talking about the adult social care budget going up from £18 billion to a minimum of £24 billion—£25 billion actually—and possibly even more on top. Do you recognise those numbers?

James Bullion: Yes, I certainly do. ADASS has similar numbers. You can add and subtract, so the band 3 costs per year would be about £2.2 billion eventually, in 2021-22. Depending on your aspiration, the costs you have described are the costs of standing still and sustaining the system. We feel in ADASS that actually that would not be enough in itself to stop the thing rolling backwards, because of the essential nature of the marketplace. It is no longer a place that is sustainable in its current form.



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Many people will now make different choices about residential care, so the 410,000 people in residential care across the country may not be the same figure going forward. That might fundamentally mean the market becomes unstable, creating more costs for the system to get to stability again.

The numbers seem eye-watering, but at the end of the day that is 1.6 million jobs. All we want is to keep that stable and to add jobs that are needed. The NHS and the country would see the payback of that money in economic growth and sustainability of communities. In a sense, where you draw the line around the service determines one figure. In the broader picture that local councils think about, in terms of communities, you see a different number.

Sarah Pickup: The need for the Dilnot reforms arises due to the lack of a system of funding that pools risk. In a sense, it is a slightly different requirement for funding from the requirement to fund services and pay the staff; it is because we have a system where individuals who need care have to pay for it if they have the means to do so, rather than a pooled risk like the NHS. I see funding the Dilnot reforms as slightly different from the need for increased resources to make sure that people can live the life they want to lead and that we deliver on the Care Act. I know it is all hard for the Government—don't get me wrong—but risk pooling is where we are missing something.

Chair: Thank you for showing such compassion to the Government, Sarah.

Q163 **Neale Hanvey:** Thank you, Sarah and James, for everything you have said so far. We have spoken a bit about the immediate pressures and the costs of that, and about the need for additional funding for a reform agenda. I would like to explore with you, if I may, the mechanism of funding and whether that is something that would enable the social care sector to reform in a more helpful way. At the moment, funding is on an annual basis through the local government settlement. What are your thoughts on that in terms of uncertainty and ability to plan, and would a longer-term settlement, akin to the five-year settlement that the NHS enjoys, allow more meaningful reform? If so, what would that look like?

Sarah Pickup: Local government has long asked for a multi-year settlement for its services overall, and social care is absolutely part of that. At the moment, it is extremely difficult for councils to plan, as I said at the beginning, and the same applies to social care. We think that we should be able to have a long-term plan for social care delivered locally but with some aspirations as set out in the Care Act. We need a multi-year settlement to be able to do that.

Because social care is not an island, it has to link to the NHS. That is why the parallel kind of long-term planning is needed to go along with the NHS. Equally, it does not live in isolation from housing services and leisure services, and public health services in particular. All those services



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are critical to how communities work and how people live their lives, so it is for all those services that we need the multi-year settlement. With a narrow social care hat on you might say, "Oh, yes, let's get this one sorted," but because social care itself is dependent on more than just the core services, it needs to be addressed by whole councils.

James Bullion: If you compare the NHS plan you are describing, that 10-year plan, five-year settlement, is £34 billion, I think, of increase for the NHS, which is more than the total spend on social care altogether. Additionally, £13 billion of debt is written off for that period.

Local government cannot plan with a kind of horizon change unless it has a multi-year settlement. It takes two or three years sometimes to move from a residential care model for disabled adults to a housing model for those same adults, to get them to a place where you do not have a form of restrictive and expensive care to a place where they take more choice and live in their own home.

In my own council in Norfolk, for example, we have a 10-year building programme for 3,000 homes, £39 million of capital expenditure, and we do that because every home of 60 flats that we open leads me to spend £200,000 less on my care purchasing budget. Councils are good at that horizon; they are really good at thinking 20, 30 and 50 years ahead. There will always be something, local government review permitting, that can take that broad approach. We are actually designed for long-term work.

Housing is crucial. Every care decision is a housing decision, and that horizon needs to be at least 10 years, so we must get to that position.

Chair: Thank you. To sum up, you are saying that you need a 10-year plan for the social care sector, and ideally it should be coterminous and completely integrated with the NHS 10-year plan. Indeed, as they had a five-year funding settlement, that is the kind of thing that you are looking for. Neale Hanvey has a quick follow-up question.

Q164 **Neale Hanvey:** It is about the implications. I think the point that Sarah made is whether there is a mechanism to tease out the social care element from the likes of housing and others to at least get some notional settlement. I would be interested in the implications of something like that for integrated commissioning services and commissioning more generally.

Sarah Pickup: What are the challenges? It is not a challenge; it is a challenge and an opportunity. Social care is funded largely from council tax and business rates, and councils decide how much of those taxes they devote to each service that they manage. That is local democracy in action, isn't it?

In each council they have a separate budget for adult social care. The Government could say how much they plan to contribute to adult social



care, but most of the funding does not come directly from Government; it comes from locally raised taxes, so you need to think about the model you would have if you wanted to extract adult social care from council budgets and say, "This is the long-term plan." The settlement normally makes assumptions about council tax and business rates for council budgets as a whole, so you can have a three-year or a five-year settlement for local government. You could say adult social care was part of that, but if you were on another committee, you might be talking about children's services, and should we separate those because they are really important? Local choices have to be made because priorities differ from place to place.

Q165 Chair: We have various reform options on the table. There is the national care service, there is free personal care and there are the Dilnot reforms. Do you have a favoured reform at the LGA or ADASS, and could you tell us so that we can spell it out for everyone? Indeed, the Health Secretary has just arrived to give his evidence. What do you think the minimum uplift in the adult social care budget has to be if you are to have any possibility of coping over the next five years?

James Bullion: The figure is the tricky one because there are so many baselines that you can take, but to state the obvious, for the next couple of years, while reform proposals are brought forward, agreed and then legislated for, if that is what is required, you at least have to plug the gap of sustaining the now, which is the £4 billion-odd. Then you have to work on a sensible expansion over the next two years that readies the system to do its job alongside the NHS and alongside housing colleagues. That is at least another £2 billion, so you are talking £6 billion to £8 billion to keep the thing stable and in a decent state while you plan for long-term reform.

Q166 Chair: Sarah?

Sarah Pickup: It would be difficult to dispute those figures, partly because we, the IFS and others are all still working on our figures, as we have not done that work for the CSR yet. Certainly, a minimum is needed of £1 billion each year, so one, two, three, four, and that is without funding the workforce changes.

In terms of—

Q167 Chair: You mean the national living wage; is that what you are talking about?

Sarah Pickup: No, not just the national living wage but funding parity with, say, for example, at the lowest point, NHS grade 2, so it would include funding the national living wage at that minimum level, but it would not cover anything new or different, prevention or unmet need and so on. I think there is something, even pre-reform, about tackling the workforce. If we were able to increase pay for the workforce, and it would have to be Government funded, we might reap some rewards by way of reduced costs of turnover, so maybe the net costs would not be as great



as the up-front costs of doing it, but obviously time would tell. Would you like me to talk a bit about the preferences around reform going forward?

Q168 **Chair:** I think we are running out of time. If you have a quick comment, Sarah, we can take it, but I think we will have to wrap it up if not.

Sarah Pickup: The LGA in its previous work, which the Committee will have seen, talked about the need to increase income tax or national insurance, or to put in place a social care insurance or premium, and that is on a cross-party basis.

The need for a cap or a higher threshold to protect assets is affected by the way in which the funding moves forward. If risk pooling works and it funds overall costs, you may not need the same sort of cap or taper. It depends on how you run the new funding system whether it is needed or not. I thought that was a relevant point. The LGA has recently published seven principles for reform, which are more about how we should do it rather than the financial side, signed up to by over 40 organisations.

Chair: Sarah Pickup from the LGA and James Bullion from ADASS—regular visitors to the Committee—thank you very much for joining us this morning and for your very helpful contributions to our forthcoming report.

Examination of witness

Witness: Rt Hon. Matt Hancock MP.

Q169 **Chair:** I am very pleased to introduce the Health Secretary, Matt Hancock, who joins us as our next witness. People often thank frontline NHS and care workers, but let me thank you, and particularly your team at DHSC, for the incredible efforts they have been making during the pandemic, which deserve recognition. If you could pass on our thanks to all your team back at the base, I know the Committee would appreciate it.

Matt Hancock: Thank you.

Q170 **Chair:** We are going to start the first half of our time with you this morning talking about the social care sector. We are shortly going to be doing a report into social care funding and the social care workforce.

I want to start, if I may, by playing you a couple of clips of evidence that the Committee received earlier in the year from people who have been using the social care system and experienced particular problems. The first clip is from a lady called Anna Severwright, who is a 34-year-old woman with a neurological condition, which means that she is totally dependent on the social care system.

A video was shown.

She obviously cannot do any of those activities without help, which is why she has to plan very carefully and make choices about the different



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activities.

The second clip is from a lady called Deborah Gray, whose husband, Atherton, has early onset Alzheimer's. She found herself facing huge unexpected care bills.

A video was shown.

As well as welcoming you, could I ask for your reaction to those two clips?

Matt Hancock: They are very powerful videos, aren't they? They in a way effectively capture the challenge that we face as a society with finding long-term reform for social care, because they capture two sides of the problem: one is the high bills and the high cost, and the other is the extra demands and needs that people have over and above that for which the state provides.

The current way that the social care system operates clearly has embedded in it a series of injustices that have grown up over time. One is the system of deciding which care is paid for in the social care system and which is paid for in the NHS, which, as you will know from your time in my job, is essentially decided over a number of court cases rather than anybody taking a policy decision.

The second is the fact that many people, including some very vulnerable people, need care, and that care needs to be paid for. As we heard in the first video, some people would like to have more care than can currently be paid for. That in a way highlights the size of the challenge.

Q171 **Chair:** Obviously, money is not the only solution to these issues, but it is part of the issue. I want to ask you about some of the figures that were given to the Committee. If you look at the next four years, until the end of the Parliament, and you look at the demographic pressures on the social care system—the ageing population—and the increases in the national living wage that the Government have committed to, the Health Foundation says that those alone, just additional pressures, no increase in the quality of care provided, would mean the annual budget would have to go up by £3.9 billion a year by 2024-25.

If we wanted to do something like the Dilnot reforms, Andrew Dilnot, who also gave evidence to the Committee, said that is an extra £3 billion on top. We ran those figures by James Bullion and Sarah Pickup just now, asking whether £6 billion to £8 billion is the minimum necessary if you are to sustain current pressures and start on the road of reform. I wondered whether you recognise those figures.

Matt Hancock: I recognise the pressures. The first, as you say, is the demographic pressure. The best estimate is that the number of people who will be needing care will rise from around 730,000 this year to around 820,000 by 2025, and then eventually to over 1 million. Of course there is a rising pressure through demographics because people are living longer, and that is a good thing—notwithstanding Covid and very much in



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the anticipation that within the next period we get that under control and we do not have another spike with the impact that it had earlier this year. Setting that to one side, looking through that at the long term, there is a demographic pressure.

There is then a question of the pressure on the delivery of the system at the moment, which has also been challenged because of Covid. We have put in short-term funding, but there is a challenge. Then there is the long-term funding reform question, which the videos you showed played into. I absolutely acknowledge the direction of the challenges, and we are currently in the depths of a spending review discussion about exactly the level at which those manifest.

Q172 **Chair:** The numbers I gave you are from external bodies. You will obviously have your own Department's calculations as to what the numbers are. Would you be willing to share those with the Committee in order for us to produce the best possible informed report, which we hope to bring out in the next month?

Matt Hancock: Of course, I am absolutely happy to share with the Committee the work that we have done so far, but we have not yet fully landed on a set of figures, because we are at that point in the spending review.

Q173 **Chair:** Okay. It would be helpful in the next couple of weeks if you could let us know where the Department thinks demographic pressures will take the cost base of the system. The Dilnot figures are, I think, in the public domain anyway.

Matt Hancock: Absolutely.

Chair: We would really appreciate that. Paul Bristow and Laura Trott have some questions on the social care workforce.

Q174 **Paul Bristow:** Secretary of State, I would like to ask you a couple of questions, if I may, about the new health and care visa. It says on the Government's website that the new health and care visa will make it cheaper, quicker and easier for healthcare professionals from around the world to come to the UK. Why are social care workers excluded?

Matt Hancock: It is not true that all social care workers are excluded. The health and care visa extends to those who have a registered qualification—for instance, in nursing or as a doctor—including if you go to work in social care. However, we also have a challenge to ensure that we recruit people into social care who are already in the UK. In fact, we have a significant recruitment campaign under way now, which you might have seen. Actually, that is starting to work. The number of vacancies, the proportion of vacancies, has fallen. Two years ago it was 8%; last year it was 7.8%, and now it is 6.6%. The vacancy rate is coming down, but the point about the health and care visa is that it is aimed at those with a qualification that is registered.



Q175 **Paul Bristow:** As you have quite rightly said, parity of esteem between NHS and social care staff should be a lasting legacy of this pandemic. Don't we undermine that by having two different immigration systems?

Matt Hancock: No, I don't think so, because parity of esteem, which is a goal that we should seek, is about employment in the sector. It is about what it is like to be employed in social care, and increasing professionalisation, as in the recognition of the skills and the capabilities that are needed to work in social care, and making sure that it is a rewarding career in the same way as we try to do in the NHS.

The challenge in the immigration system is to ensure that you have a robust immigration system, yet can deal with the challenges where we have shortages. Basing the visa on registered qualifications is a reasonable way to ensure that we retain the robustness that, understandably, our immigration procedures require.

Q176 **Paul Bristow:** Countries like Denmark seem to have made it easier for professionals to switch between health and social care, as we heard through this inquiry. Is there a case for a more integrated approach to training, in your view?

Matt Hancock: Yes.

Q177 **Paul Bristow:** How do we reach a sustainable supply of new social care workers?

Matt Hancock: Yes, I definitely think there is a case for a more integrated approach to both training and employment across health and social care, and indeed support. In the crisis, in the peak of the coronavirus, one of the things we did was ensure that there was a named clinical lead for each care home, for instance, bringing the NHS closer to and tying it in with the provision of care in a way that had not been done before. That is just one example off the top of my head of ways that we can try to make the system of employment more integrated.

Q178 **Laura Trott:** Secretary of State, to follow on from Paul's question about integrated training, I agree that it completely makes sense to have greater integration in working, but in career progression and development, and developing it for social care workers in the same way as you would for a nurse, for example, is that something that is under consideration?

Matt Hancock: Yes, but let me try to pick up on the point you make about a nurse. I would love to see it become easier for a nurse to move between working in the NHS and working in social care—a particular profession that has a recognised qualification, which makes it easier to design a system around it because there is a formal system of recognition: you are either a registered nurse or you are not, and that is all governed by the RCN. That is why it is easier to make policy, for instance, around immigration based on registered qualifications.



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There is a broader point, which is trying to ensure that people working in social care who do highly important jobs that require crucial skills get more recognition than at the moment. I think that is another direction I would like to go in because it then makes those sorts of transfers easier. Essentially, when a skilled profession, like working in social care, has the recognition of formal qualification around it, for instance, or of professional recognition—there are a number of different ways you can do it—it makes it easier for that sort of transition.

Q179 Laura Trott: When are you thinking about bringing forward proposals along those lines?

Matt Hancock: We are working on it as part of the social care reform, where we had got to quite an advanced stage of work ahead of the pandemic. In the debate around social care reform, it is entirely natural—I understand why it is this way—that the first thing people think about is the funding reform. Of course that is critical, but there are so many other parts to social care reform than funding reform. There is support for the workforce, including these sorts of flexibilities and integration. It is a common part of employment practice that those with recognition of capabilities and qualifications find it easier to have flexibility and to transfer between different parts of a profession. For instance, in the use of technology and around the use of intergenerational care, there is a whole series of areas where we can improve the way that social care is delivered, over and above funding reform.

Chair: Thank you. We are going to come back to you later, Laura.

Q180 Barbara Keeley: The last 10 years were littered with promises on social care with plans for White and Green papers, an actual commission, and legislation brought in and then postponed. In terms of the answers you have just given, Secretary of State, when can we expect a long-term funding settlement for social care to be announced, together with the Government's plans for reform? It would be easy to get lost in the complications that you have just outlined. Local authorities and care providers need to know when there are going to be plans announced and when we are going to see the plans for reform.

Matt Hancock: It is even worse than that Barbara, isn't it? It is over the last 20 to 25 years that people have come forward with proposals and commissions and then not implemented them. In fact, the legislation that you mention—

Q181 Barbara Keeley: Your Government are responsible for the last 10, if I could just point that out. You are responsible for the last 10, so let's look at that: why haven't we had the promises realised from the last 10 years?

Matt Hancock: Yes, I think it is actually better for the nation to try to depoliticise rather than politicise this, and that was the point I was making: this is a long-term challenge that the country has faced. The answer is that we have made clear manifesto commitments, and we were



doing a huge amount of work on this immediately after the election. Obviously, the coronavirus crisis has delayed that work. I think people can understand that. It is not that we have not been working on social care; we have put a huge amount of money in. Actually, we can come on, potentially, to some of the reforms that we undertook in the heat of crisis that have made some positive differences. But that is another challenge. The internal discussions on these reforms have since then picked up again.

Q182 Barbara Keeley: So no answer on when. One of the most negative aspects of the underfunding of social care is the way it leads to autistic people and people with learning disabilities being left or transferred to secure hospital wards, very often when local authorities cannot afford to pay for the care that those people need to live independently. You know well, Secretary of State, the case of Bethany and that it took 14 months to get her moved out of an ATU into community care, where she is now happy, I understand.

This is a key issue. It is a win-win situation because good community care can be cheaper than the millions spent by the NHS in inappropriate institutions, and we have 2,000 people stuck in them; but local authorities have to be able to fund it. I know that you have announced £20 million a year for this, but that level of funding is nowhere near what is needed. My party announced £355 million a year for that policy. What are your plans to ensure that the more than 2,000 people like Bethany can get the support they need to live independently in the community?

Matt Hancock: I am very glad that we managed to make significant progress in the individual case that you raised, but it should not have to take my personal intervention to solve that sort of problem. I am very glad to say that the number of people in secure in-patient units has fallen further since then. I was looking at it—I do not have the exact figures in front of me—and it has fallen further.

You point out exactly why it is a good thing: often the patient outcomes are better and it is cheaper for the system as a whole. The money we have put in has been very effective. To be clear about what the money is for, there is an overall saving to the system of people being in the right care, especially if that right care is community care rather than a secure in-patient setting. The challenge was that there is a double running cost in the transition: as you support somebody to come out of an in-patient setting, often because of the sensitive nature of the vulnerable individual concerned, you need to have the community team ready and already employed and set up at the same time as keeping them supported in their in-patient setting. The money has unlocked the ability to get the community team there earlier to support a successful transition into the community for some very vulnerable people with very high needs.

I am really pleased at the progress that we have been able to make on that, and I pay tribute to those who campaigned on that front because I totally agree with the importance of the direction of travel.



Q183 **Barbara Keeley:** But there are 2,000 people. We need to be looking at that as a more urgent issue.

Matt Hancock: As I say, that number has come down significantly. There are some where, for judicial reasons, there are challenges, so it is important to go into each case. We have gone through to review the most serious cases to assess in each case whether there is the ability to move them to a community setting. As I say, we have managed to bring the numbers right down.

Q184 **Chair:** Thank you, Barbara. It is time to move on to more general topics. I want to ask one brief question about this morning's news on the pandemic and the recent rise in infection rates, which is obviously very concerning. Indeed, we are now, I think, higher than the levels above which we would ordinarily have decided to quarantine people coming from countries that have the levels that we now have of new infections.

I want to ask your judgment. Assuming we are following a similar trajectory to countries like France, Germany and Switzerland, do you see us going into a spike or could this be a need to hunker down for a proper second wave?

Matt Hancock: The number of cases has risen in the past few days and it has happened right across the UK. I am obviously concerned about that. There is no inevitability of a second peak. It depends on the actions that all of us take. Of course, in Government we are concerned about this and we keep all options open, but everybody has a part to play. The strategy that we have discussed many times and that we have outlined is clear, which is that the first line of defence is social distancing. The "hands, face, space" communications campaign—wash your hands, cover your face and keep that distance—is very important.

The next line of defence is testing and tracing, and that is radically stronger than it was in March, when we faced the first wave. We now, per head of population, have one of the biggest testing systems in the world and our contact tracing is very sophisticated.

The third line of defence is local action. You have seen that I have taken quite robust local action in areas where there are particular spikes. I do not like doing that, but I do not resile from doing it because it is necessary, and if you look at Luton or Leicester, you can see that it is effective. But it is so important, as Professor Jonathan Van-Tam said yesterday, that people take their responsibility seriously and do not become relaxed about this virus.

Q185 **Dr Evans:** Thank you, Secretary of State. I would like to talk about patient recovery from Covid. One of the great news stories that was hidden over August was that, if you are admitted to ITU now, you are 50% more likely to survive than where we were before because of the advances of dexamethasone. That creates a little bit of a challenge, though, because more people who go to ITU will come out of ITU and need rehab. What strategy does the NHS have in place to help rehab



patients who are coming out of ITU suffering from Covid?

Matt Hancock: The first thing to say is that people coming out of ITU alive who would otherwise have died is the sort of problem we like to have in the NHS; this is a good problem. There is also absolutely no doubt of the severity of the consequences of long Covid.

I want to reframe slightly the way you describe it, because the long-term impacts of Covid are not very strongly correlated to the severity of the initial illness. While we have a very significant amount of work going into supporting those who come out of hospital, having been hospitalised with Covid—in July we put £8.4 million into a research effort and the NHS has set up a long Covid service—it is not just about people who are hospitalised. That is really relevant for now, because the latest rise in the last few days has been largely among younger people. It does not matter how serious your infection was initially; the impact of long Covid can be really debilitating for a long period of time, no matter if your initial illness was not all that severe.

Q186 **Dr Evans:** I am glad you picked up on that and it is good news to hear, because the Royal College of GPs has said that we should have post-Covid clinics across the UK. Can you update us on the progress of when that is going to get sorted? I think you are exactly right: patients have differing streams of how they present and what they are left with. That is one of the big concerns that they have, so could you expand on what you have just said?

Matt Hancock: Yes. The NHS set up long Covid clinics and announced them in July. I am concerned by reports this morning from the Royal College of GPs that not all GPs know how to ensure that people can get into those services. That is something I will take up with the NHS and that I am sure we will be able to resolve.

Q187 **Dr Evans:** Research is still coming out, and you mentioned research going on, but what about education for professionals and for the public of what to look out for and what it looks like? People may not even be aware that they have had Covid and then have symptoms that leave them feeling tired, with loss of sense of smell and muscular weakness. Is there an education campaign that you could carry out to professionals and the public to make them aware of that?

Matt Hancock: We have been circulating the evidence to GPs, in the way that the NHS does, and with a new disease like this that is particularly important as new evidence comes through. That is partly what the research effort is all about, but we also need to highlight to the general public that there is support available in the NHS Covid service.

One of the challenges is that there are not easy and clinically validated treatments for long Covid. The treatments that our research programme has discovered, like dexamethasone—the primary one around the world, which was discovered in the UK—are for hospitalised patients, so there is



a challenge, which is supporting people when there isn't a readily available treatment.

Q188 **Dr Evans:** There is concern that you can get reinfected with Covid. Do you have any update for the public on whether that is still applicable and whether or not there is immunity out there?

Matt Hancock: It is clear that there is some immunity from having had Covid for most people because we can see the rise in antibodies that follows an infection, but we have also just started to see the first credible cases of reinfection. Through genomic analysis, you can see that it is a different disease from the one that the person got the first time round. But in all the cases that I have seen it has been an asymptomatic second infection that was picked up through asymptomatic testing.

Because one of the most difficult parts of dealing with this virus is asymptomatic transmission, the hard question and what we do not yet know is the transmissibility of the disease even from an asymptomatic person who might have had the disease before, but we have a huge amount of work going on into answering that question. The answer to that question obviously ties into the effectiveness of the vaccine. We have a much higher degree of confidence that the vaccine gives immunity, and that is one of the things we are testing as part of the vaccine trials, and, as you know better than anybody, you can never have confidence in them coming to a successful conclusion until they do. But they are making good progress.

Q189 **Chair:** I sent you a couple of weeks ago a letter from a lady called Robin Gorna, who speaks for an association, a group of people who have long Covid, as she does. Would it be possible to have a reply to that letter fairly soon, because they make some very sensible suggestions?

Matt Hancock: Yes. I saw the letter last night and we will get a reply very quickly. This is an incredibly important area to me.

Chair: Thank you.

Matt Hancock: The other thing I would say on it is this. People of all ages are affected by long Covid. People who are younger, who might think that they are unlikely to get severe symptoms or die of Covid, can still have a terrible illness that completely changes their lives for months and months. We saw this morning the evidence from King's College that shows that they have found around 60,000 people who have conditions of Covid that last over three months. That is a really serious consequence of the disease.

Q190 **Neale Hanvey:** Any member of a clinical team would say that trust and confidence in the team is one of the most important aspects of the care that you provide to a patient. Public trust and confidence on Covid is absolutely essential. We have been reassured on multiple occasions that the decisions are led by the science. I want to explore that a little bit with you.



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Turning the clock back to June, Professor Sir John Edmunds said, and I will quote him verbatim: "I wish we had gone into lockdown earlier...I think that has cost a lot of lives unfortunately." On the same weekend, you said that you felt that the Government had taken the right decision. I would be interested to know if you can detail what scientific evidence you referred to when you said that you were guided by the balance of opinion. What were the convincing premises that were presented to you, and what enabled you to feel robust enough in your position to challenge the esteemed professor?

Matt Hancock: The advice on which, as Ministers, we base decisions, guided by the science, is obviously gathered broadly—there is a role for a number of committees and a breadth of scientists—and then is presented to Ministers by the chief scientific adviser and the chief medical officer, and the chief medical officer, obviously, in each nation of the UK. The decisions that we took in March were guided by the science in the same way that the devolved Governments in Edinburgh, Cardiff and Belfast took decisions at the same time. That was guided by the science in the same way.

Q191 **Neale Hanvey:** It is quite an extraordinary decision, and not something that Cabinet Secretaries or politicians take often, to lock down the country. I am curious as to whether you can remember what was convincing about the decision: what were the elements of scientific evidence that were presented to you that made you believe that that was the right time to make the decision? Can you recall what was the clincher?

Matt Hancock: The clincher was that the number of cases was going up and it was clear that we needed to take significant and urgent action, which we did.

Q192 **Neale Hanvey:** With regards to the comments that were made by Professor Sir John Edmunds later in the year, that there was a discussion about locking down earlier and that he regretted that that decision was not taken a week earlier and he projected, as an epidemiologist would do, what the consequences of that delay would be, what was your recollection that gave you the confidence to say that the Government took the right decision at the right time?

Matt Hancock: There is plenty of scientific debate around that question.

Q193 **Neale Hanvey:** What convinced you?

Matt Hancock: To take the action necessary, it was absolutely clear that the number of cases was rising and we had seen the rise in the number of cases happening elsewhere and it was clear that this was a very significant disease, so that—

Q194 **Neale Hanvey:** I am sorry, Secretary of State. I appreciate that in the heat of moment you felt that was right, but I am talking about your reflections on 7 June when you said that you discounted the opinion of



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Professor Sir John Edmunds, and you felt that the Government had taken the right decisions at the right time. What gave you the confidence to make that comment some months later?

Matt Hancock: The thing is that you take decisions based on the information that you have at the time, and all four of the UK Governments took those decisions at the same time.

Neale Hanvey: Sure.

Matt Hancock: I remember being in the meetings when they were decided on.

Q195 **Neale Hanvey:** I have a final point, if I may. I understand that in the heat of the moment you make decisions, but, although Sir John was able to reflect that perhaps we should have gone earlier, you did not feel that that was the case.

Matt Hancock: Well, as I say, there is a historical debate about that point, and, understandably, I am focused on ensuring that we stop the sharp rise that we are seeing right now. Different scientists will make their points. The good thing about science is that you have a debate and you listen to all of it, and then, formally, I am advised by the CSA and the CMA.

Q196 **Chair:** I would like to ask you, Secretary of State, about a report that we are shortly going to publish about the impact of the pandemic on core NHS services—the stuff we do in peacetime, as it were. I want to start, if I may, by playing you a clip from a lady who gave evidence to the Committee. She is called Daloni Carlisle. She is 55 and she has an incurable but treatable cancer. This is what she told our inquiry during the summer.

A video was shown.

What is your reaction to that?

Matt Hancock: My reaction is to try to solve the problem in that case, and I very much hope that, since then, communication from the trust has happened. My heart goes out to Daloni. Clearly, we need to make sure that people get the cancer treatment they need. There were, of course, important clinical reasons why sometimes treatments had to be paused, but it had to be done on an individual clinical judgment and with communication with each individual patient. I very much hope that that problem has been fixed already and, if it has not, I would be very happy to intervene to ensure that it is.

Q197 **Chair:** Thank you. I think in that case it has actually been fixed, but it was probably illustrative of some general issues. On 17 March, just before the big lockdown started, Sir Simon Stevens sent out an instruction to the NHS that cancer treatment and other clinically urgent care should continue unaffected. In your view, has the NHS delivered on that promise?



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Matt Hancock: There are some cancer treatments that, according to clinical advice, were not appropriate to do when there was a pandemic. I defer absolutely to the clinicians who should make those decisions, but where it was possible to continue cancer treatment, of course, it should have continued. In some cases it was not clinically appropriate—for instance, when a treatment was going to reduce the immunity of a patient and might leave them more at risk, because there was a pandemic about and people might have caught coronavirus. I appreciate that some treatments had to be delayed for clinical reasons, but that had to be done on the basis of an individual clinical decision about each individual patient.

Q198 **Chair:** You are confident that, where there was a clinical reason that it would be unsafe for someone to continue their cancer care, it might have been interrupted, but otherwise it should have continued.

Matt Hancock: I am confident that was the policy, but the policy was also that you should communicate with each individual patient, and that clearly did not happen in each case.

Q199 **Chair:** People like Professor Karol Sikora say that delays in cancer care could potentially have caused, or will cause, the death of 30,000 cancer patients. The IPPR said recently that five-year survival rates will now fall for lung, breast and colorectal cancer. Do you have an estimate of the number of excess cancer deaths that may end up being caused by the pandemic?

Matt Hancock: We do not yet because it depends on the speed at which we can get through the backlog. The backlog measured by the number of 62-plus days' wait has now more or less halved, and I am pleased we have been able to make progress against the backlog, but as long as it exists there is a problem that we need to address. We need not only to get back to where we were before Covid but to keep having earlier and earlier intervention.

In fact, I would say that one of the big lessons of Covid for the nation and the way we have run our health service is that there was not nearly enough focus on diagnostics before, and far too much on patching things up afterwards. This is true, obviously, in terms of the testing regime and testing capabilities that were available for coronavirus. It is also true for other infectious diseases, like the British approach to turning up at work; soldiering on if you have a runny nose is an outlier internationally and people should protect and look after their colleagues rather than do that. The same concept is true in diagnostics of cancer, where there was already a programme of work under way to try to expand diagnostics, because we need to be identifying earlier. That was started before my time, when you were Health Secretary, and is something we need to accelerate further.

Q200 **Chair:** Do you accept that one of the reasons why some cancer treatments have been delayed has been that cancer patients themselves



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have been nervous about going in for their treatment because they are immunosuppressed and worried that they could be particularly vulnerable if they catch the disease? As part of project Moonshot, which you announced, and which sounds very exciting, might it be possible to introduce weekly testing or twice-weekly testing of staff in cancer units, to completely put people's minds at rest that they are not going to catch the virus if they go in for their cancer care?

Matt Hancock: There are lots of things in that question. In response to the first part of the question, absolutely, we need people to come forward if they have a concern. In fact, we have put quite a significant marketing budget behind trying to get that message out under an NHS-led programme called, "Help us to help you". The concept is help us to treat you, and, if you have a lump, you must come forward. As soon as we got through the initial peak, we started working to get that message out.

The next point, about further reassurance through the use of testing, is absolutely an option once we get to the stage of having the rapid turnaround, next generation tests in huge quantity. We have been working on that project for some months and have been able to talk about it in the last couple of weeks. Operation Moonshot and the concept of mass testing is both about finding the virus, and therefore being able to suppress it, and, exactly as you say, about giving people the confidence to do other things that are important, whether social, economic or, indeed, looking after their health.

Q201 **Chair:** There are obviously some big problems in testing capacity at the moment, notwithstanding those big ambitions, and Sarah-Jane Marsh, who heads the testing programme, put out a tweet this morning apologising to people who cannot get a Covid test. She says it is not the testing sites that are the pinch point, but the laboratory processing. How soon do you think it will be before those issues can be resolved?

Matt Hancock: It will be in the coming weeks. We are working on it incredibly hard. Sarah-Jane Marsh is leading that; she is an absolutely exemplary leader and we are doing everything we can. We have had the operational issues that I have talked about. We have had a problem with a couple of contracts, and we have discussed some of that in the House of Commons. It is a matter of a couple of weeks until we can get all of that sorted.

In the short term, in the immediate term, we have already put in certain solutions to ensure that people do not have to travel more than 75 miles. I appreciate that 75 miles is far longer than you would want to go, and, indeed, the vast majority of tests are much closer than that. We have also successfully continued the roll-out of asymptomatic testing to care homes, even despite the pressures, because of the importance of that.

Q202 **Dr Davies:** Good morning, Secretary of State. I was pleased to hear you refer earlier to long Covid syndrome and what you are doing to tackle it. There was a paper in the *BMJ* recently suggesting that up to 10% of



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those infected, possibly 60,000 in this country, have the condition. You referred to the long Covid clinics that are being set up. Can you give some idea of the number of those across the country, the level of access to them and how we are going to make sure that professionals, particularly in primary care, are aware of their existence?

Matt Hancock: This is a project in England. I have had discussions with my colleagues in the devolved nations about it, but it is an area of responsibility that is devolved.

The short answer is that they are rolling out, and we need to get them rolled out as fast as possible. At the same time, as I said to Dr Evans, we have been communicating with GPs and other primary care professionals with the latest insight into how to support people, but, unfortunately, there isn't a treatment.

Q203 **Dr Davies:** It is a good opportunity to highlight the fact that many in the ME/chronic fatigue syndrome community feel that access to services is not always what it should be. I wonder whether this might form a template for improved facilities for them, too.

Matt Hancock: I will take that point away. It seems very sensible.

Q204 **Dr Davies:** Thank you. The Chair was discussing with you the provision of urgent care, cancer services in particular. I have a question about routine and elective provision because, clearly, the longer that is delayed, the more people suffer, and the system begins to break down in terms of attendances at A&E unnecessarily and so forth. What is your assessment of the provision of those services currently—out-patient appointments and elective surgery?

Matt Hancock: If we take the two in turn, in England, the goal for the standard of treatment, essentially, for elective surgery is to reach 95% of normal over the autumn. In many areas, we have nearly got back to normal, but of course that is really hard because of the need for infection control. Where there are aerosol-generating procedures, obviously it is yet harder. Using testing to give people confidence that they are safe and the recent updates to infection control advice that went out at the start of this month will help to get the elective rates back.

When it comes to out-patients, there is a good side and a bad side. The good side is that there has been a radical switch of out-patient appointments to telemedicine, which has been a very good thing and has actually increased access in many ways. Also, obviously, it has been harder to deliver face-to-face appointments, but that is coming back now as well. With out-patients, you can use telemedicine, which is much better for the patient and much better for the clinician, where it is clinically appropriate, and that has been able to take a lot of the strain. Surgery is much more challenging because you cannot replace surgery with telemedicine.

Q205 **Dr Davies:** Indeed. My final question relates to the uptick in infections



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more recently. Many people are concerned about whether we are heading towards a full lockdown again and what it means for Christmas. What would you say to people who are worried about the direction of travel?

Matt Hancock: I would say that it is for all of us to take this very seriously indeed. We have seen in other countries that, if you do not take a second spike seriously, it can lead to very serious problems down the track. I want us, if at all possible, to get to a position where we can all have the sort of Christmas that people yearn for, but that will require everybody to play their part, to follow the social distancing and follow basic hygiene. The “hands, face, space” concept has been developed as an easy way to remember the three single most important things that individual people can do.

Q206 **Sarah Owen:** I have a very specific question about women’s health and will then move on to a question predominantly on women in the health workforce.

One in four pregnancies ends in miscarriage. I know this from personal experience, having had two miscarriages before my rainbow baby. Women have shared their added stress and anxiety about going into hospital for scans and routine appointments during the pandemic without any personal support whatsoever. I genuinely cannot imagine what it would have been like without my partner beside me, so could you please explain to those women why it is safe for women to go to pubs with their partners but not have their partners by their side at what is one of the most anxious times for parents?

Matt Hancock: I absolutely agree with you, Sarah, and we have removed national restrictions on people having birth partners with them while they are giving birth, and the advice from the Royal College of Obstetricians and Gynaecologists supports birth partners being there. The decision in individual circumstances is down to the individual.

Q207 **Sarah Owen:** Secretary of State—I am sorry—that is fine for those who get to the stage of actually being able to give birth, but it is during all of the maternity services running up to that point that I think is in question. If it is a question of whether PPE is still in such short supply that this vital support cannot be offered, when do you think that will be rectified?

Matt Hancock: No, there is no problem of supply of PPE. In fact, on PPE we are now rebuilding the stockpile, so that is a problem that has been fixed.

Advice on the ability of people to go with their partners to a maternity visit is an incredibly important point. As I say, the questions have been devolved to individual institutions, taking into account the local director of public health’s advice on the risk in that area, but I have heard loud and clear the call for better access to maternity services both during pregnancy and at birth and I have also had discussions with the all-party group for maternity and maternal health. It is something that I have



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taken up with the NHS and I hope we will be able to make further progress soon.

Q208 Sarah Owen: Thank you. You talked a little earlier about the British sense of soldiering on if you have a runny nose, possibly putting colleagues at risk. Do you accept that by paying just statutory sick pay levels to care workers that you are forcing them to do just that, even if they are sick or have symptoms, putting themselves, colleagues and patients at risk? If you could not live on £94 a week, why are you expecting care workers to do so, particularly during the pandemic?

Matt Hancock: We are not expecting anybody to live on that level of income alone. For long periods of time, there is the important support that most employers give. We have made changes to do that in the health and care system, not least with the infection control fund in social care—£600 million of taxpayers' money. It is a really important area. It is a really important area of culture change.

Q209 Sarah Owen: You say that it is a very important area. You gave exactly the same answer on miscarriage support and maternal support. Is there going to be any action on these important areas?

Matt Hancock: Yes.

Q210 Sarah Owen: Okay. I will move on to another question. It is around bereavement. Too many people have lost their lives prematurely during this pandemic, and too many loved ones have had to grieve alone. That is having a huge impact on people's mental health. Are there plans for the Government to look into the option of bereavement bubbles?

Matt Hancock: I am so sorry. I missed the end of the question.

Q211 Sarah Owen: Are there plans for the Government to look into the option of bereavement bubbles?

Matt Hancock: The answer is that the rules around social contact for people who are bereaved need to take into account individual circumstances. I have been clear about how, for instance, we changed the rules around funerals to allow a more liberal approach for people going to funerals, because it is such a critical moment. The rules are clear that, where there are exceptional circumstances, people may be able to act differently. That is true around childcare as well. Having people behave in a reasonable and sensible manner to be able to support one another through bereavement is incredibly important.

None of these things is straightforward, because the nature of social distancing rules is that there are an awful lot of exceptional circumstances that you have to take into account. What really matters when it comes to social distancing is that people follow social distancing where it is necessary, especially around social events, in order for us to be able to act as a society with compassion when people need extra support in exactly the sort of way that you have described.



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Q212 **Sarah Owen:** Thank you for that answer. We have consistently heard evidence to this Committee that during the pandemic countries that have perhaps fared better than us have had very consistent, clear communication. Communication has been an issue throughout this crisis. It is very difficult to communicate why somebody might be able to go to the pub with a group of people, but not be able to be with a loved one when they are grieving or going through a very stressful period of their life, such as going to routine maternity services. I must stress that the ambiguity that you have just given in your answer demonstrates the problem.

This is my last question, because I know that others are due to come in. Over 900 healthcare workers have died during this pandemic. Do you plan to meet the families of NHS and social care workers who have lost their lives during the pandemic?

Matt Hancock: Yes, of course. I am very happy to meet them, and I have done so. I have written to some of their families as well.

Q213 **Taiwo Owatemi:** Secretary of State, you mentioned earlier that test sites should not be more than 75 miles away, but just yesterday a constituent of mine and his children were directed to a site that was 250 miles away, in Moffat, nowhere near Coventry. No parent should have to be put in that position. It clearly shows a lack of regard and poor handling of coronavirus in towns and cities outside London. Is that truly acceptable?

Matt Hancock: It is a challenge; it is an operational challenge. I would love to have the details of that example, because we have put in place a policy of people getting tests within 75 miles. That is the first I have heard of that happening since we put the policy in place.

Clearly, we have enormous testing capability. The vast majority of people get their tests locally and get the results back quickly. As we discussed earlier, there have been challenges, not least with an increase in demand for testing.

Q214 **Taiwo Owatemi:** That's fine. I wrote to you yesterday. I hope to get a swift reply from you.

Matt Hancock: I will look straight into it and get back to you as soon as I can.

Q215 **Taiwo Owatemi:** Thank you. My next question is about social care in England. Over the past 10 years, we can say that social care has been nothing short of woeful. Whether it has been the botched reforms or the lack of funding for local authorities like mine in Coventry, we have had to bear the brunt of the Government's failures. That has meant that older people and those with underlying health conditions are at even greater risk from the coronavirus than the rest of the population. After such a lengthy delay in bringing forward plans to address the level of care for vulnerable elderly people in England, what are the Government doing to



address the long-term deficiencies?

Matt Hancock: First, I do not agree with your characterisation of social care. Millions of people work incredibly hard to deliver the very best of care to people who are often vulnerable, including towards the end of their life, but of working age as well. We should support our social care workers and describe the amazing system of love and compassion that they deliver.

Over the last five years, national funding for social care has increased by £2.4 billion. That was before the pandemic. In the last year, we put in an extra £1.5 billion of funding uplift. During the pandemic, we brought in the infection control fund, which we discussed earlier, and gave extra funding to local authorities, in part to support social care.

One of the changes we brought in that has been very successful is the discharge fund—£588 million that runs until the end of this financial year—which allows the NHS to pay for the first six weeks of social care funding. I do not think that anybody should underestimate the importance of that particular change. It means that, when people are leaving hospital, the funding is sorted for six weeks. That means that a clinical decision on the appropriate care can be put in place, whether someone should go into a care home, a nursing home or into the community. Then, once they are in the right place, the long-term funding package is put in place.

It helps hospitals, because it means that people can get out of hospital when it is clinically right, rather than waiting for a package to be put together. Crucially, it means that people can go into the right type of social care. Previously, there was strong evidence that more people were going into care homes than was clinically advised. The change of policy that we put in place at the peak of the pandemic has had a very positive impact, both on hospitals and on people going into the right sort of care.

That is a long answer to the question. We have put in extra money and have made changes that we should not underestimate, which have improved where people end up in social care. It is incumbent on all of us to support the staff who work in social care who have done such an incredible job.

Chair: Thank you. Taiwo, do you have any more questions, or are you done?

Q216 **Taiwo Owatemi:** I want to follow up on that. I agree that social care workers are very hard working and passionate. What I was referring to was the past decade of cuts to local government, which have been about £7.7 billion. When can we expect long-term funding settlements for social care to be announced, together with the Government's plan for reform? What is your Department's estimate for the level of additional funding that social care needs? How does the Department aim to reach that estimate?



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Matt Hancock: It is absolutely fair to ask about that last point. However, it is really important do so on the basis of the increase that we have seen over the last five years, especially in the last year, with the £1.5 billion of extra spending power—£1 billion from central taxpayers' money and half a billion from an uplift in the social care precept. There are demographic pressures, which are going to increase the costs. As I discussed with the Chair at the start—

Chair: We are looking forward to the letter.

Matt Hancock: I am not yet able to give you a figure for those. That is part of the spending review discussions.

Q217 **Chair:** We will be grateful for any guidance that you can give us, because we will be finalising our report in the next couple of weeks. Obviously, if we do not get any information from you, we will have to use the external numbers we have been provided with.

Matt Hancock: Of course. A lot of the analysis of the various different cost pressures is in the public domain.

Chair: Barbara has a quick follow-up question on the pandemic. We will then finish with two brief non-pandemic areas.

Q218 **Barbara Keeley:** I am in the local lockdown area of Greater Manchester this morning. Like people across other areas with local lockdown, I am sure, my constituents are growing weary of not seeing their loved ones at home and not seeing friends and family members. To be able to lift local lockdown restrictions safely while we have the higher case numbers that we are seeing now, our local leaders in Greater Manchester have asked for two things: extra resources for testing and contact tracing, most importantly with teams led by local directors of public health, who are doing a much better job of getting through to the contacts; and proper financial support for people who are asked to self-isolate. Will the Health Secretary agree to that? If he does, how soon will it happen?

Matt Hancock: Yes. I am very glad to say that all of that is already happening. We have put in place support for people to self-isolate in parts of Greater Manchester and east Lancs. We are watching very closely how effective that is in increasing the numbers of people in the contact tracing system.

We work very closely with one seamless contact tracing system across national and local areas. The way it works is that the national system, essentially, goes first and contacts people and manages to get hold of a large proportion of the contacts. When we have not been able to get there through the mass national system, contacts are passed to the local authority, which, exactly as you say, with the director of public health, has boots on the ground and will have local knowledge and intelligence.

Q219 **Barbara Keeley:** I understand how that works, Secretary of State; I have talked about it endlessly with our director of public health. But it is



not happening in the way you describe. What our Greater Manchester local leaders, and those in other parts of the country, are asking for is for the directors of public health to lead the effort, not to wait to be passed contacts, but to have the resources in our local area. You have seen the spikes that we have had, with seven out of 10 of our Greater Manchester boroughs now in the red. We need those extra resources locally, because our local teams are much more successful.

Matt Hancock: As I said, there is one system. It is a system that works with both the national system, where very large resources can be brought to bear on one individual area, and then locally. Then, of course, there are the institutional settings, where we need to do contact tracing as well—for instance, the care homes that may have a case, where you need to go into the institution, as opposed to contacting the individual person. I think we are violently agreeing that the local element of that is incredibly important. The combination of the two, where you can get both the scale and the local boots on the ground, is what makes it work effectively.

Q220 **Barbara Keeley:** Will you transfer resources so that we can have more local boots on the ground? With the peaks we are seeing, that is what we need.

Matt Hancock: We have done that. We absolutely have a policy to do that, where we see the spikes.

Chair: We will wrap up briefly with two other areas not directly related to the pandemic. Dean Russell will ask about mental health. Laura Trott will then ask about maternity safety.

Q221 **Dean Russell:** I have two questions related to mental health, but I also want to ask about one specific group, the deaf community, which has been very anxious throughout the pandemic and moving forward.

As you know, one of the biggest challenges is that there are 150,000 British Sign Language users across the UK. I understand that the cost of the basic service to provide BSL for those who engage by telephone, via an app, is around £10, so it is a cost of about £1.5 million over the course of the year. I was reached out to by a charity called SignHealth. They say that at the moment that service is not being covered by the NHS. They are having to try to cover it as part of their charitable donations, and they are getting close to running out of money. Can you confirm whether, moving forward, it will be possible to enable sign language to be available to all who need it and that the NHS could fund that?

Matt Hancock: I am very happy to look at that. It seems very reasonable. Let me see what I can do.

Q222 **Dean Russell:** Thank you. The second question is around mental health, particularly children's mental health. I am conscious that for many years there has been a challenge around support and children's ability to get mental health support through the NHS and more widely. An awful lot of



work has been done on that. Claire Murdoch has given excellent evidence to this Committee.

Looking forward, we are going to have mental health challenges for children who have been in lockdown and their families. What provisions have been put in place for the rise in mental health need and to ensure that that provision is as robust and strong as possible in the coming months and years?

Matt Hancock: It is an incredibly important area. Within the increase in funding that the NHS is getting over the next three or four years, the fastest increase in NHS services is in mental health. Within that, children's mental health is getting the fastest increase. It is not just about the money, but the money is very important, of course. At the same time, we need to develop and improve access to services, including, where appropriate, and where it is best used, digital technology. That will help, but it is not the solution to all of the problems.

Q223 **Dean Russell:** I have another question about mental health provision. At the moment, if people need physical health support with medicines and so on, they walk into their local pharmacist. Is it possible to look at whether pharmacists could also be a frontline for mental health, with regard to mental health first aid training, and to be a signpost to additional services? Is that something we could potentially look at? Has it been looked at over recent months, as times have changed?

Matt Hancock: It is not something I have looked at specifically. If we could make it work, I would be open to it. The focus, especially for paediatric mental health, has been to put support into schools, so that they can have a mental health co-ordinator who can make sure that connections are made between the school and local children's and young persons' mental health services. We have done it through schools, but I am always open to ideas.

That ties together two things that are very important to me. One is the importance of having high-quality mental health services that are easy to access. The second is the importance of putting more services through pharmacies, which are there in the community, rooted in the community and readily available. I want to support pharmacies and I want to support mental health. You have brought the two ideas together. It is the first time anybody has put that idea forward, so I want to reflect on it.

Q224 **Dean Russell:** For any parent whose children are just going back to school, anxiety may be high. If they feel that their child needs some mental health support, what advice would you give them right now?

Matt Hancock: In the first instance, they should contact their GP or one of the widely available and excellent charities that provide mental health services, in particular Mind, to get support. The single most important message from all of us is that there is help and people should ask for it. That is often the first and most important step in treatment for mental ill health.



Q225 **Laura Trott:** Secretary of State, has there been a rise in either maternal mortality or infant mortality during the pandemic?

Matt Hancock: The Office for National Statistics publishes the data on that. In fact, it published more data this morning. That is on mortality across the board. Of cases notified to the UK obstetric surveillance system of women who have had coronavirus, there were 1,434 women admitted to hospital with confirmed Covid-19 during pregnancy. Of those, 1,399 included additional case data. The pregnancy outcomes for those women were very slightly higher than, but similar to, the outcomes for the rest of the population, as a proportion. This is something that we monitor very closely. I have a concern to ensure that we get the very best information out and published, so that pregnant women and those who support them can take the best possible decisions.

Q226 **Laura Trott:** You mentioned ongoing monitoring. What exactly is being done to monitor the effects of this disease, because we know that it is very new, on pregnancy and birth? How is that being fed into clinical outcomes and commissioning?

Matt Hancock: Dr Jenny Harries, the deputy chief medical officer, is an expert in this area. The advice she gives me is that in the first two trimesters there is no evidence of any particular impact of Covid that is different if you are pregnant. In the third trimester, it is worth being cautious. There is not conclusive data, but there is a precautionary principle, as there is with respect to many things in the third trimester of pregnancy.

Q227 **Laura Trott:** In May this year, the Committee took evidence from Gill Walton from the Royal College of Midwives. At the time, there were concerns about redeployment of key staff, including dual-skilled nurses, obstetricians and anaesthetists, and the effect that has had on maternity safety. Have you taken action to address that? Are you satisfied that it has been dealt with?

Matt Hancock: Yes. One of the areas of what you could call the restart of the NHS that has, essentially, fully recovered is in maternity. It is not a restart, of course, in maternity; maternity services cannot stop whatever the depth of a pandemic because there is a time limit, obviously. This is an area where there has been an awful lot of work to make sure that the full quality of service is available, and was available as soon as possible. Clearly, there is the need for infection prevention and control and the precautionary principle that I mentioned, but it is an area on which the NHS has been doing a huge amount of work.

Q228 **Laura Trott:** Sarah mentioned the very important issue of fathers being allowed to attend scans and early labour. I am glad to hear that is something you are taking action on. You very kindly met the neonatal APPG to talk about parents being allowed access to neonatal care on an unfettered basis. Can you confirm again that action will be taken on that, so that we know that mothers and fathers, often in very desperate



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situations, will be able to access the neonatal unit without any obstructions?

Matt Hancock: Yes. You are right, and Sarah was absolutely right earlier, to raise the issue. It is incredibly important. It really matters to me and is something I have taken up with the NHS. I am very happy to write to the Committee within a fortnight with an update on progress, to make sure that we take whatever action is needed not only to support mothers and their chosen partner through the process, but to support parents in neonatal intensive care, which is very important. I heard loud and clear the message from the APPG, which is that parents are not visitors. Throughout, we have had a different policy for visitors from parents of children who are ill, especially those who are seriously ill, but we need to make sure that we get the guidance and advice right.

Q229 **Chair:** I have a couple of quick follow-ups on maternity safety. In the House last week, you talked to me about HSIB, which has a very important role in the independent investigations they do into maternity incidents. Obviously, you could not say what will be in the Queen's Speech, but do you think that it is possible that we will see the HSIB Bill in the next year?

Matt Hancock: I very much hope so. I think that is as far as I can go without breaking some convention.

Q230 **Chair:** I will pin my hopes on your hope. Secondly, last month I wrote to you about the concerns of baby loss charities—Sands, Baby Lifeline and the Lullaby Trust—about data protection law changes that could potentially mean that MBRRACE, who, as you know, are the people who collect the crucial data on maternity safety, might not find out about baby deaths if people have opted out. Have you been able to look into that?

Matt Hancock: I am looking into it. I am very happy to write back within a fortnight, if that is reasonable.

Chair: Thank you. Last but not least, it would not be a Select Committee if we did not hear from Rosie, so I will hand over to her. She will ask the last question this morning. Rosie, you need to unmute.

Rosie Cooper: Oh, not again.

Matt Hancock: I want to hear the last question.

Q231 **Rosie Cooper:** Covid has encouraged rapid change in the way NHS services are provided, much of it good but some of it with dreadful downsides. For example, face-to-face appointments with consultants are converted to telephone appointments. Quite often that works well, but recently a consultant from Clatterbridge NHS Trust told a patient that chemo was not working, that it was terminal and nothing could be done. Nothing was done to ensure that that patient was not on his own. Do you think that it is appropriate that we deliver that kind of news over the telephone without ensuring that there is some support?



Matt Hancock: It is a really important question. The natural instinct of everybody would be to say that that should be given face to face. I am also aware that there is some evidence from the use of videoconferencing that patients prefer to hear bad news when they can be with their family at home, when that is well prepared for and organised. I am certainly not endorsing the individual example that you gave. Clatterbridge is a very good trust, and the staff there are excellent. We should not automatically reject the use of telemedicine even in this scenario, because some people find that receiving bad news at home is better, rather than in the unfamiliar circumstances of a hospital.

Of course, it should be done in a sensitive way, where people have support around them. We need to learn from how this has been done, with an open mind as to what works well, what must return to being done face to face and where we can use advances in technology. Even as a huge enthusiast for technology, I would not have expected any evidence that people prefer to hear bad news over a videoconference, rather than face to face. When I saw that, I was surprised, but, once you think about it, you can understand it, if it is done sensitively. I hope that is a reasonable and nuanced answer.

Q232 **Rosie Cooper:** Absolutely. The objection is not to the telephone call. Keep it safe as well. The difficulty is that the consultant knows the message that they are going to deliver, but the patient does not know what they are getting, so you need to check that they are with their family. This actually caused grave mental health issues—a great drop in the person's ability to deal with their illness. It was awful.

Matt Hancock: I think we are on exactly the same page. I can absolutely empathise.

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

Matt Hancock: It was a pleasure. Thank you very much.