HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The Work of NHS England, HC 563

Tuesday 8 April 2025

Ordered by the House of Commons to be published on 8 April 2025.

Watch the meeting

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

Questions 175 - 273

Witnesses

I: Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care; Sir Jim Mackey, Chief Executive Officer, NHS England; and Sir Chris Whitty, Chief Medical Officer and Interim Permanent Secretary, Department of Health and Social Care.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Rt Hon Wes Streeting MP, Sir Jim Mackey and Sir Chris Whitty.

Q175 **Chair:** Welcome to today's extraordinary session of the Health and Social Care Select Committee, which has arisen after the recent announcement of the reorganisation of NHS England and the Department. First of all, I thank the Secretary of State for making the time to come and see us before Easter, as he promised at the Dispatch Box. I am grateful to him. With him we also have Sir Chris Whitty who, of course, is the Chief Medical Officer and Interim Permanent Secretary. Welcome, Sir Chris. Thank you for being here. An especially warm welcome to Sir Jim Mackey, for the first time in front of this Committee, having been in role for just a week now. Thank you so much, all three of you, for appearing in front of us on this beautiful day.

Secretary of State, you have been very busy and have made some announcements on mental health recently, so we will start on mental health and then move to the substantive questions on the reorganisation. There was a "Dear Colleague" that showed that mental health spending this year as an overall spend will be going down. My understanding is—correct me if I am wrong—that that is a reversal of a trend that we have seen since 2018 where it has gone up incrementally year on year since that point. It is the first time; what does this say about the Government's commitment to parity of esteem?

Wes Streeting: Actually, mental health spending is increasing in real terms for the coming year.

Chair: The proportion has decreased, though.

Wes Streeting: The proportion has decreased by 0.07%.

Q176 **Chair:** What is that worth in monetary terms?

Wes Streeting: It is worth probably £100 million or £200 million—in that order.

Chair: That is not small change.

Wes Streeting: However, it has to be seen in the context of the £26 billion the Chancellor allocated to health and social care, which kicks in this week, much of which is directed towards many things that we committed to at the last election, including the serious amount of investment going into our elective reform plan and the wider investment in the health service to help recover services.

The mental health part of our plan involves a real-terms increase in spending, delivering on the manifesto commitments we made. If you look at where we are in relation to recent years, as you mentioned, it is 8.71% of spending in 2025-26 NHS spend. It decreased last year under our predecessors. We are not in a bad position. For people who are

watching this closely and care about mental health investment, a real-terms increase in spending will mean real improvements for people accessing mental health services.

As ever, I don't want people to draw from my answer any hint of complacency. We are delivering the mental health investment standard through ICBs. With the investment in services, people should start to feel improvement in mental health services as well as improvement across the rest of the NHS.

Q177 **Chair:** You mentioned a previous figure and said that that was a decrease on the year before. Are you willing to publish the numbers for the years?

Wes Streeting: Yes. They are certainly available, and the Library would have those figures, but I am happy to share those with the Committee.

Q178 **Chair:** Are you able to write to us with those? My understanding was that this was the first year that there was a drop, not the second year. You will know that the Darzi report itself points out that 20% of the spend burden on the NHS is in mental health, and yet we are spending less than 10%. In the context of that report, that was very strongly stated as something that was unacceptable, and yet we are seeing an overall decrease in spend.

I see what you are saying—that, yes, the real-terms is increasing—and that continues to be welcome, but we got to this position because as the overall spend in the NHS increased, mental health kept lagging behind. That was reversed in previous attempts by the last Government, and this is the first time that trend in proportion has decreased. Is this an anomaly? Can we be assured at least that that is an anomaly and not a trend? Will the proportion decrease further next year?

Wes Streeting: We are committed to the mental health investment standard. That has been consistent and will be delivered for the coming year. On the overall proportion of spend in mental health as part of the overall NHS baseline, I hope to see it rise over the course of the Parliament, but—

Q179 **Chair:** What is the "hope" part of that?

Wes Streeting: That is all subject to the spending review. I will add the other caveat that if you think about the investment we have just put into general practice—the £889 million that is going into general practice—although it would not be classified in these numbers as mental health spend, it is an important part of the mental health pathway for lots of patients. Lots of people who require access to mental health services will benefit as a result of being able to see their GP or have follow-up appointments with their GPs for ongoing mental health conditions that are being managed in the community.

Q180 **Chair:** Which of course brings me on to waiting lists. The waiting lists for

mental health continue to be very concerning. The longest one is nearly two years, but that is more than twice the elective. I understand what you are saying about access to GPs, but are you concerned that this reversal of what was a positive trend in trying to tackle that, plus the changes in the planning guidance, means that you are deprioritising mental health in reality?

Wes Streeting: No, I really don't accept that at all. Mental health spending is going up in real terms. If it was not going up in real terms—if the actual spend in mental health was falling backwards—that would be a fair charge, but that is not the case. For 2025-26 we will be spending just shy of £179 million on mental health services. That is up considerably from 2018-19. You can see the trajectory of actual spend on mental health services: a real-terms increase for the year ahead. I think that puts us in a good position not just to deliver on our manifesto commitments but to deliver improvement in people's experience of, access to and impact of mental health services. Ultimately, that is the thing that matters most.

I accept the challenge you are putting to me about mental health as a share of the NHS. That is a fair challenge. As I said in my written statement to Parliament, we were up front about where that put us in the overall proportion, but it is a 0.07% decrease.

Q181 **Chair:** You are minimising the percentages, but you said yourself that we are talking about hundreds of millions of pounds here. These are not small amounts of money. As you know, we are running an inquiry on severe mental ill health and community services, and we are seeing in the evidence we have taken so far that this is not a productivity issue. It is simply that there is not enough out there to meet demand. Let's split the difference: £150 million-odd would make an enormous difference out in the community for mental health teams. Do you not accept that that would help the rest of the economy and their physical health? We know that there are comorbidities there. There is a virtuous cycle in that way, too, is there not?

Wes Streeting: Of course, whether it is mental health, general practice, dentistry, schools, prisons—across the board, if we had more money available, that would be quite useful, but we are making decisions against a very challenging fiscal background. None the less, we are committing to our manifesto. I think I misspoke earlier, so I should make sure I correct the record. For 2025-26 we are spending £15.6 billion on mental health. That is a real-terms increase from the previous year. I am not pretending that there will not still be challenges, but a real-terms increase in funding means a real improvement in services, and that is what we want to see.

Q182 **Chair:** You did that, but you also moved the targets. Why did you do both? You could have increased the spending and removed the targets, or you could have kept the targets knowing that the proportion of spending would decrease. Why did you decrease the targets at the same time?

Wes Streeting: On planning guidance, we felt it was important to subject the system to fewer centralised targets. That will be a key part of how we govern and lead the NHS over the course of this Parliament. The NHS has been overloaded with targets. The planning guidance and—this comes on to the changes we are making to NHS England—the number of targets being driven from the centre, from not one but two head offices, lead to duplication, waste, inefficiency, contradiction and the system being pulled in different directions.

Chair: We will come to that, Secretary of State.

Wes Streeting: We are asking the system to embark on big reforms over the coming years, and it is important that we give leaders freedom and flexibility.

Q183 **Chair:** As we know, the elective targets are part of—the missions are very important at a high level. Our concern is that you are prioritising some conditions over, say, bipolar. Is it right that someone who has a bunion—albeit a severe one—will get seen by a specialist first over someone who has a severe mental illness? Is that right, morally?

Wes Streeting: We want to see access and waiting times improve across the board, whether we are talking about physical health conditions or mental health conditions. That is why in mental health we see real-terms increases, and the same applies to physical health services. Let's not underestimate the link between the two. There are many people on waiting lists at the moment—despite the progress this Government have made in reducing waiting lists five months on the trot, including over peak winter pressures—who are waiting in pain and agony with anxiety and depression because of the debilitating impact of being on a physical health waiting list.

Q184 **Chair:** And vice versa, Secretary of State. The elective plan has been spoken about a lot in the context of the welfare reforms, but on the mental health aspect, can I ask you about a comment you made about overdiagnosis? What is the evidence for that?

Wes Streeting: We have certainly seen a debate since I was asked a question on Laura Kuenssberg's programme about this issue, and it is a welcome one.

Q185 **Chair:** What specifically has been diagnosed, and what evidence is there for that?

Wes Streeting: Let's look at some of the things that have been said and written since my comments. The total number of antidepressants prescribed in England increased by 36% between 2016 and 2023, with a concomitant 23% increase in the number of patients receiving antidepressants over that period. The BBC "Panorama" investigation found that patients are being offered powerful drugs and told they have ADHD after unreliable online assessments.

Professor Sir Sam Everington and Professor Aneez Esmail, both distinguished GPs, wrote in the *BMJ* recently, "Too many GPs are under pressure to issue fit notes rather than support and properly evaluate the request. There needs to be a cultural shift about mental health so that return to work is recognised as part of treatment except for severe mental health problems".

There are a number of things going on simultaneously here, and it is important to distinguish between a whole range of factors and pressures. The first is that there is anxiety in the medical profession about overdiagnosis and overpathologising of anxiety, day-to-day stresses, pressures and wellbeing issues that, by the way, do require support but there are concerns there. At the same time—I certainly felt this in the wake of my comments to the BBC—there are lots of people saying, "Overdiagnosis? I can't get access to a clinician who can give me a diagnosis, let alone access treatment".

I think that both of those things are true and are also related. We have to distinguish between people who should be on a mental health treatment pathway and those people where earlier intervention, with challenges in their lives early on, would stop wellbeing issues becoming mental illness or, worse still, mental health crisis. I think that is what we are seeing, and that is why we want to make sure we are intervening far earlier.

Q186 **Chair:** I was struck that in your answer, you said this had happened since you were asked the question. When you made the comment that there is overdiagnosis, had you not looked into that before? Was this based on evidence that you had seen before? Evidence from the BBC "Panorama" programme and a couple of articles in the *BMJ* are potentially canaries in a coalmine, but I don't understand this to be well-evidenced.

Wes Streeting: I think that those numbers on prescriptions of antidepressants should be cause for concern.

Q187 **Chair:** That could well be explained by the fact that there is unmet need out in the community, which we are investigating as part of our inquiry, could it not?

Wes Streeting: I welcome further debate on this, but I absolutely stand by what I said on the BBC to Laura Kuenssberg. I appreciate that I sometimes suffer with the affliction of answering direct questions honestly, and that is what I did on Laura Kuenssberg, based on the concerns that clinicians and lots of families have put to me about the anxieties of over-pathologizing of wellbeing issues.

Particularly in the CAMHS space, young people are ending up on CAMHS waiting lists with wellbeing issues that should be dealt with far earlier and more quickly, which is why we have committed to the roll-out of IAPT in every primary and secondary school in the country so that the wellbeing issues that young people experience do not become mental health illness or, worse still, mental health crisis.

We have to tread carefully in this debate, because what I would not want—and what I think lots of people heard in that interview—is the Secretary of State for Health and Social Care saying that there is overdiagnosis at the same time as they felt they were unable to access a diagnosis. I think both of those things are true simultaneously, as is often the case with the pressures we see in our health service at the moment. I welcome the clinical debate on this. There are lots of clinicians who have seen this and supported what I have said, feeling the pressure, at the same time as people who are cautioning—again, quite rightly and understandably—not to underestimate the level of mental health pressures that exist particularly for children and young people but more generally in our society at the moment. I think that both of those things can be true.

Q188 **Chair:** Let us move on to the reorganisation. What are the Government seeking to deliver through these reforms?

Wes Streeting: A number of things. First and foremost, we want to make sure that the NHS is well led, and with the various layers of bureaucracy that exist in the NHS, we are reducing waste, inefficiency and duplication. Where we currently have effectively two head offices for the NHS, we will have one. Where we have duplication of functions across the Department of Health and Social Care and NHS England, we will eliminate that duplication.

That also applies down at ICB levels. We have too many checkers in the system; we could do with some doers. We will free up hundreds of millions of pounds in the process that can be redeployed to frontline services. I think that is welcomed by patients and by lots of frontline staff who agree with the diagnosis of too many layers.

I want to say up front that I am mindful that with the scale of the change we are doing and the level of headcount reduction, there are lots of people whose jobs are at risk. We do not take these decisions lightly and I do not for a moment suggest that, because there is waste, inefficiency and duplication or there are too many layers of bureaucracy, this is somehow a failure on the part of the people who are turning up for work every day and working extremely hard as dedicated public servants.

This is not their failure. It is a failure of the system they work in, and I do not pretend for a moment that people whose jobs are affected are happy about this change. They will be experiencing the same sorts of fears and anxiety as anyone whose job is at risk. I don't take that lightly, but many people working in the Department and NHS England and working in the system will recognise what we describe as duplication, waste and inefficiency. That is the first part.

The second part of what we are driving up is the biggest devolution of power in the history of the NHS. We need to move away from the absurd notion that a system this large, this diverse, and this complex can be micromanaged or commanded and controlled by the Secretary of State,

or the chief executive of NHS England for that matter, pulling a set of national levers.

It is our job to make sure that the system has the tools to do the job, to make sure that we have the right people and the right resources in the right place, and the right regulatory environment, and that we are unlocking the as yet unrealised potential of the NHS as a single-payer organisation on things like procurement, life sciences, data and the revolution we are going through with life sciences and medical technology.

We have to make sure that we have all of those national system enablers, but where is the best innovation coming from? The frontline. Where is the real change being delivered? The frontline. Where will patients benefit most from Labour's reform agenda? The frontline. That is what we are driving at with these changes.

Q189 **Chair:** What do you hope that you will be able to do as a result of this reorganisation, as the Secretary of State, as the politician pulling the levers, that you could not do currently?

Wes Streeting: Put even more money into the frontline, as the Chancellor already is. It is really important to remember that we were elected on a mandate of investment and reform. Even with the £26 billion the Chancellor has allocated, as you alluded to in your opening set of questions on mental health, we could always do with more money for frontline services, so we have to go hard after any waste, any inefficiency, any duplication.

As the Secretary of State, I am trying to do the most radical thing that you can do in national government, which is to win power and then give it away, and make sure that the people who are leading provider organisations and health and care systems have the tools, the freedoms and the flexibilities to do the job, drive innovation and be held to account for the outcomes they achieve rather than being centrally dictated to about the means.

Q190 **Chair:** What would success look like, Secretary of State? We ask this in the context of the 10-year plan, and maybe I should ask that question first. The timing of this is curious, because you would think that with the 10-year plan coming, form should follow function, and yet we are changing the form without knowing yet what the function will look like. I have ICBs telling me that they need to start redundancy packages by the end of April when we know very well that the 10-year plan will not be fully finalised and published until at least after the local elections. Why have you done it in this order? Why now?

Wes Streeting: We know where we are headed with the 10-year plan, which will be published in June around the spending review. I have been clear for some time now that I wanted more devolution of power in the NHS—more power, freedom, flexibility and responsibility closer to the

frontline, and indeed at the frontline. I made it clear in my NHS Providers speech at the tail end of last year that in that context, the roles of ICBs would be changing and becoming more focused on strategic commissioning. I made it clear that senior leaders would be given more freedoms and flexibilities but would also be better held to account for performance management and—

Q191 **Chair:** That is very top level. Forgive me, Secretary of State, because we are trying to stick very closely to time. You have ICBs trying to make these changes now. Sir Jim wrote a "day one" letter, which we have seen and is published on the website if people want to look at it. That, again, was very top level, but the detail of this will be predicated on the 10-year plan, surely. When will all the parts of the system get the detail they need to make the right redundancies so that we don't end up losing the good people and then not having the right form to follow the function that you want?

Wes Streeting: As with the planning round, that is under way and the ICBs will be sending their plans and their proposals for reducing cost and headcount, as they are being directed to by Jim, as the new chief executive. They will be sending their plans in to Jim and his team, who will be checking and evaluating them against our priorities to deliver better services for patients.

Ultimately that is where this Government's focus is, and how we will be judged. Are waiting lists lower? Are waiting times shorter? Are ambulances arriving faster? Is it easier to see a GP and a dentist than when we came to power? That is the yardstick the public will judge us by.

Q192 **Chair:** This is my last question before I move on. Just so the system is clear—perhaps Sir Jim will chime in quickly—if they are planning to make redundancies from roles that will affect the frontline, that will not be allowed, versus if they are combining comms teams, safeguarding and backroom or office staff, those will be fine.

Bluntly, I think what we want is reassurance that the teams that are delivering for the frontline—you will know I have a particular interest in place-based teams, which will be critical to delivering the neighbourhood NHS that you and I both want. How will you make sure that ICBs are not doing that to meet these numbers?

Sir Jim Mackey: As the Secretary of State has already said, we have set out a direction. We know where the 10-year plan is going. We have been clear in the letter and have followed that up with verbal briefings. We have some ICB colleagues working with us on the future of ICBs and the shape and the sort of functions they will have. It is our expectation that, by the end of May, they will have agreed with regional teams what that looks like, how they will move resource from certain functions into other functions—the functions they will not need in the future—and agree a plan that will be implemented later on in the year.

There are some checks and balances in it but, as you have already identified, the key is that colleagues have heard the message. We will need to pick up the pace of change, so this is not something we could have just waited for because of the financial position and other pressures that we have, but we are keeping an eye on and working with colleagues to make sure that we don't lose capacity and critical staff who are directly impacting patient care in this process.

Q193 **Ben Coleman:** Thank you all very much for coming in. Before we talk a little bit more about what we have just been talking about, I will throw in one thing that is much on my mind, which is about palliative care. Are we looking forward to seeing something in the 10-year plan about improving palliative care?

Wes Streeting: Yes, we are looking at palliative and end-of-life care in the context of the 10-year plan.

Q194 **Ben Coleman:** Do you think that will produce anything that is radically different from what we see now? Although we are better than many other countries, our palliative care is awful; it is just worse everywhere else.

Wes Streeting: You are tempting me to preannounce the 10-year plan. We want to see improvements in the quality of palliative care. Regardless of the different positions we might have as parliamentarians around this Committee about the merits of assisted dying, it has certainly generated a broader national conversation about palliative and end-of-life care, which I think is a good and important debate to have.

Ultimately, we should be driving towards everyone being able to have the best possible death and to break some of the taboos and conversations around what a good death looks like. I hope that, regardless of the views people might have on a piece of legislation going through Parliament, we can create the end-of-life care and palliative care that everyone in our country deserves.

Q195 **Ben Coleman:** It is good in a few places, but it is just not spread across the country the way it needs to be. You are optimistic that the 10-year plan will address that problem?

Wes Streeting: This is one of many areas where we need to take the best of the NHS to the rest of the NHS.

Q196 **Ben Coleman:** Thank you; that is very helpful on palliative care. Coming back to the reform that we are talking about today, we touched on quite a lot of detail about the fact that you were pretty much opposed to doing this reform initially. On 30 January you told the *Health Service Journal* that you "could spend a hell of a lot of time in Parliament and a hell of a lot of taxpayers' money changing some job titles" without making any difference to the patient interest.

Six weeks later you announced the move, shall we say, of NHS England into DHSC and getting rid of a lot of jobs. What happened in the six

weeks? Were there some particular changes that you tried to introduce, and you just thought, "This isn't going to work" and the shock was too great to try to deal with the current system? Were there particular things that changed your mind?

Wes Streeting: Yes; experience in office, bluntly.

Q197 **Ben Coleman:** Any particular experiences? What was the straw that broke the camel's back?

Wes Streeting: Even as someone who has paid close attention to how the system is run and led as shadow Health and Social Care Secretary, I was quite surprised at the extent of the duplication that exists between the Department and NHS England. I was taken aback by the extent to which policy and strategy—which I think should always have sat with the Department and I assumed had always sat with the Department—had become part and parcel of life over at NHS England. I think that blurred form and function.

NHS England was set up to be the delivery arm with policy and strategy still supposed to sit with the Department of Health and Social Care. I do not think that has always been the case, and it has led to litigation and relitigation of decisions that democratically elected Governments—I include our predecessors in this—have wanted to take. There is that part of it.

Secondly, there is the waste, the inefficiency and the duplication I have seen. It goes back to the Chair's question, in a way, of why now: why have we announced this decision ahead of the 10-year plan? It is because it takes time to do what we are embarking on. Reducing headcount on this scale and abolishing an arm's-length body of this size and complexity takes time. We don't have time to waste. If we are going to achieve hundreds of millions of pounds' worth of savings every year—foot down on the accelerator.

Q198 **Ben Coleman:** There was no particular straw that broke the camel's back for you, though?

Wes Streeting: No, not particularly. I had been talking with Amanda Pritchard, as chief executive of NHS England, about the changes that we needed in the relationship between the Department and NHS England. That is why from day one Amanda and I sought to build a new culture, a one-team culture, which I think, to the credit of people working in both organisations, has already begun to bear some fruit.

I think about some of the teams that sit around my table in the Department. The best meetings are when you can't distinguish who is in the Department and who is in NHS England. Some of the worst meetings are when it is blindingly obvious who is sat on which side and it sometimes resembles "West Side Story", albeit a very polite version and less musical. That is not a really good way of working for anyone, and regardless—

Q199 **Chair:** Which side is on Wes's side?

Wes Streeting: It depends on the issue. I am glad you asked that question, because it is important for me to underscore this, as the person who has been in this chair for the last nine months. When I think of my team or the team I am responsible for, I don't just think about the Department of Health and Social Care. I think about the people who work at NHS England. That is the culture that Amanda and I have been building from day one of my coming into office. There are brilliant people working at every level of NHS England. I am determined that, as we bring these two organisations together, we are building what is effectively a new organisation with a new culture and new ways of working.

One of my metrics for success will be a few years down the line. As is sometimes the case in the Department and NHS England, do you still have people referring to themselves and their job functions based on where they used to work? It is not unusual to find people saying, "Oh, yes, I was with HEE", or "I was at OHID", even though they have been abolished. Those are signs that the culture of teamwork in one organisation has not always been achieved in previous mergers. That is something that I am mindful of as we embark on this process.

I do not want people to think that because we are abolishing NHS England, we think it is a terrible organisation filled with bad people doing a bad job—quite the opposite. Some of the most brilliant public servants I have ever encountered work at NHS England, and I hope that they will continue to work in the new merged organisation.

Ben Coleman: You are not intending to throw the baby out with the bathwater.

Wes Streeting: No. Certainly not.

Q200 **Ben Coleman:** Sir Chris, who is leading this? It is a big change programme. Who is leading it in the DHSE? Is it you?

Sir Chris Whitty: The political leadership comes entirely from the Secretary of State.

Q201 **Ben Coleman:** Operationally?

Sir Chris Whitty: Operationally, while I am in the interim role, I am leading this, but there is a transformation board across both organisations. Sir Jim and I both sit on that. It is co-chaired by the Chairs of the boards of NHSE and DHSE so there is a level of co-ordination between the two organisations. When it comes down to things that are specifically the role of the Department, I will be the person dealing with the operational side.

Q202 **Ben Coleman:** Good. Do you have a target date by which NHS England is to be formally abolished?

Wes Streeting: We are looking at this as a process over up to two years. That does not mean that that will be when everything is done. There is a process, of bringing teams and the organisation together, and reducing headcount, which will start in the coming months. Although there is much that we can do with changes to primary legislation, the process of abolishing NHS England will ultimately require primary legislation and, as we know, that takes time, and it is not just down to me. It is down to business managers and all of you as parliamentarians, and it will depend on how co-operative or otherwise you want to be.

Q203 **Ben Coleman:** Is there some thinking about the date for the abolition?

Wes Streeting: No specific date, but it will take up to two years. In the meantime, I am mindful that in doing something of this nature, when and how information is conveyed is a challenge. In any organisation I have ever worked in where I have either been part of a restructure or led a restructure, we would never have handled the process in the way that the Government inevitably have to.

In an ideal world, we would have embarked on this process with a change management plan already in place, with an organisational structure and new job descriptions and organograms in place and ready to go, when we started to brief staff about changes. However, of course, the moment we started to do that work—which is now well under way—we would have been reading about it in the *HSJ*, long before the Prime Minister announced it or Parliament was informed.

I appreciate that for people who are on the receiving end of some of these changes, this has been a difficult and challenging time. However, the Prime Minister and I have sought to ensure that we have handled announcements in the right way. Now that we are clear about the direction of travel, we will be keeping regular internal communication up with staff whose jobs are affected.

Q204 **Ben Coleman:** That is good to hear.

I want to ask about one more thing, which is the move to community and the funding of that. It is partly to do with accountability. In the move to community, are we going to have an NHS-typical, top-down single model? Or is it going to be different, sometimes led by GPs, sometimes by ICSs or ICBs where they survive, and sometimes led by hospitals? Will different models be permitted? Also, while that happens, is there going to be any double running funding for secondary and primary care? Or will secondary care be expected to lose money?

Wes Streeting: I will say a few things and then bring Jim Mackey in. First, ICBs are here to stay. There is not going to be an NHS reform bill that abolishes ICBs. As Jim alluded to in the *HSJ*, we have encountered a demand against the reductions that we have asked ICBs to make in the attempt to go after duplication and the challenge that we have laid down for them.

We have had demands from some ICBs for permission, effectively, to look at whether some ICBs should merge and be consolidated. We are very receptive and responsive to that kind of demand from below. I hope we see more of this kind of two-way interaction and leadership within the system. If it is always top-down command and control, we will fail.

The more we get that pressure from below and that hunger for change, the more we will succeed, whether it comes from system leaders in ICBs or frontline clinical teams that are changing the way that they do their elective surgery, for example, and having the support of executive leaders to do so. That is the first thing.

The second is in the spirit of devolution. One of the reasons why the NHS is not performing as effectively as it could, and why we see such variation in performance across the country, is because there has been too much top-down diktat about how services are configured. How we design and deliver community and neighbourhood services in my part of north-east London and west Essex will look very different from in Cumbria and Cornwall.

It is important that we give communities and system leaders the freedom and flexibility to do the kind of place-based planning and delivery of services that the Chair was referring to. We will take a test-and-learn approach and give more freedom, more flexibility and more powers to the frontline. We will be judging them on outcomes. Is access improving? Is quality improving? Are outcomes improving? Are we reducing health inequalities in our country at the same time? Those are the key tests.

Q205 **Ben Coleman:** On the double-running point, are we going to take from Peter to pay Paul? Is secondary care going to pay for primary care while this happens, or are you going to continue to fund both while the new community approach is developed?

Wes Streeting: There will be a bit of both. Against the backdrop of the challenges, we cannot afford the luxury of double-running things all over the shop. That is part of the reason why we are going after unnecessary duplication. In different parts of the country—you will have seen the front pages in recent days—we are beginning to see reports of some of the neighbourhood-based teams and the pilots that are running. There is a combination of approaches.

In some cases, we will fund pilots and take the test-and-learn approach to trialling new things. In other cases, system leaders and provider-leaders are looking carefully at how they are spending public money and configuring services, and they are concluding that rather than pouring more money into another set of secondary care services, it would be better for the secondary provider and their patient outcomes for some of their money to go into primary care, community services or social care. I want to see more of that system leadership and system thinking.

Chair: We will come to that. We need to move on. We will come back to

ICBs and community.

Q206 **Jen Craft:** Before I get on to the questions I have written down, I would like to circle back to some of the discussions around welfare reform. It strikes me that your Department has a particularly strong role to play in making sure that this is a success and delivers what it says on the tin. I am particularly interested in the fact that there seems to be a move towards PIP supporting those with higher needs and not those with lower health needs.

I note that the Green Paper, when it looks at the fact that some people will no longer be eligible for PIP but will still have health and care needs, states that everyone should have their health care needs met by the NHS, and that DWP will be working with the DHSE to make sure that this happens. I am interested in what kind of assessment your Department has done to identify people who might not be able to access PIP in future, yet still have those health and social care needs. How will DHSE pick up those needs and make sure that these people do not miss out?

Wes Streeting: I will say a couple of things. First, my Department and the Department for Work and Pensions have a good working relationship, including a joint health and work team, doing some innovative things—the WorkWell initiative and some of the work that we are developing together in the context of the forthcoming spending review—to better integrate health and work pathways.

We recognise, and I recognise as a constituency MP, that a brown envelope from DWP coming through the letterbox can often be a source of anxiety rather than a welcome approach. Often, when people hear terms such as welfare reform or getting people off welfare and back to work, they fear it means a stick approach and being penalised into finding work.

As we have seen in some places, such as the Maudsley Hospital in south London and some of the encouraging initiatives coming through WorkWell, integrating health and work pathways means that for people who do have ill health—whether mental or physical—that risks preventing them from being able to find work or stay in work, joining up employment and health support is a more supportive way of working. It delivers better outcomes, and it makes people feel genuinely supported back to work rather than penalised back to work. Liz Kendall and I have heard that first-hand from people who have benefited from that approach. We have also heard the pride of people in delivering those initiatives.

Regarding the impact of the Green Paper and the welfare reforms being brought forward by the DWP, the DWP is doing its impact assessments and reporting. Regardless of the welfare changes, it is up to us to make sure that people's health needs are met.

Q207 **Jen Craft:** You said it is up to you, but has there been any discussion

about where this lies budgetarily? I am aware that Westminster probably suffers from silo working as much as anywhere else. If you read the Green Paper in a certain light, it does feel very much like a pushback from DWP, saying, "we should not necessarily be paying for this". The phrase "people's health and care needs should be met by the National Health Service" seems to be speaking potentially about DWP having paid for things in the past that it feels it should not have paid for. Are these the kinds of discussions you are having about who should pay?

Wes Streeting: First, not a day goes by when a colleague in Government doesn't knock on my door and suggest something that the Department of Health and Social Care should be paying for, to help them with their goals and priorities, and vice versa. It is partly the nature of government. It is also true that some areas of health activity are provided by DWP, and we need to take a more team-based approach to making sure that those services are properly designed, delivered and funded.

The Secretary of State for Work and Pensions and I work closely, and so do our Departments. Fundamentally, we have to make sure that people's health needs are met. Take electives, for example. One of the reasons we launched the Further Faster 20 initiative was to target areas with high numbers of people off work, off sick and on an NHS waiting list—long waiting lists, and high levels of economic inactivity. I am mindful that it is our responsibility to get people back to health. In many cases, that will not just mean back to health but will also mean back to work, which is good for everyone.

Q208 **Jen Craft:** I do note that it is a cross-government initiative. I think that speaks to mission-led Government, but it usually comes down to the money.

I want to touch on the impact and some of the narrative around welfare reform. Have you had any idea of whether that has had a negative impact on people's mental health and whether you might see an increase in some of those waiting lists as a result?

Wes Streeting: No, not at this stage. It is partly on us, as Government and parliamentarians, to make sure that the detail of welfare reform is properly understood. For example, I met a constituent at the weekend who was very concerned about what the welfare reforms would mean for her. She is on universal credit, not PIP. I completely understand that, against the political backdrop over the years, there are lots of people for whom the welfare system is a safety net, a lifeline, and who worry when they hear "welfare reform". That is almost inevitable, given where we have been as a country. It is important, however, that we also get the facts and the details across and then, as Members of Parliament, begin to make judgments about cases of people who are impacted. Understandably, you will challenge us if you think that we are getting this wrong, or if we are drawing eligibility lines in the wrong way, or if there

are people or edge cases that we have overlooked. That is part of the process of parliamentary scrutiny and accountability.

Overall, what are the Government trying to do on welfare reform? We are trying to make sure that the system is sustainable; that it is there for people when they need it; that it is not just a safety net when people fall on hard times, but a springboard back to work; and that we are not writing off people who are ill or disabled when they want to work and are able to. Most importantly, we want to make sure that when people are so ill or severely disabled that they cannot work, they are provided with the level of support that they need to live as happy, dignified and independent a life as possible with their conditions. That is what is driving the welfare reform agenda.

Q209 **Jen Craft:** One final question on this before we move on, coming back to the comments about the overdiagnosis of mental health. I wonder if there is some pressure—a view that there are people who potentially have been overdiagnosed with a mental health condition and who are off work but could be in work. Is there any leniency in the system? I note again that the Green Paper points to people having to engage, and having an expectation of engagement with employment advice, and that includes signposting to mental and physical health services. However, you will know that these services simply do not exist in quite a lot of areas.

Has any thought been given to hypothetical examples such as someone who experiences a mental health condition and their mental health has become worse—if we want to argue overdiagnosis, we can—and their doctor has signed them off work and prescribed antidepressants, but there is a nine-month to two-year waiting list for talking therapies and in the meantime the person cannot go back to work? Is there some leniency? Or is it just that because they have been signposted, they are expected to get on and find that support?

Wes Streeting: Cases like that are why integrating mental health and employment support pathways is a good thing. It makes sure that people are receiving the holistic support that they need. Just because someone is suffering from mental ill health does not mean that they should be written off. It does not mean that we should assume that they are unable to work or that employers should not try to show a degree of flexibility, and that with the right support, people could not be supported to stay in work or to find work.

We have to handle these conversations sensitively. Many people, either from their own experience of mental ill health or through providing mental health support for other people, would say that if you can get a person back to work, it is good for their mental health. It gets them out of the house, socialising with colleagues and feeling like they are getting back on their feet.

In some ways, the people I worry most about in this context are those who, through a mental or physical health challenge, find themselves off

work, stuck at home and feeling increasingly despairing about their position. That may be because of a physical health situation added to by mental health anxiety, or because their mental health condition had them come off work for a time and they are struggling to take the initial steps towards going back. These things can lead to a downward spiral instead of the recuperation that people aspire to when they first take time off work. It is important that the welfare system is not just a safety net that people can fall into when they hit hard times, but a springboard that helps them back into work.

Q210 **Jen Craft:** I will move on quickly, because I know that others need to get in. Turning back to the reform of the NHS and NHS England, how are you going to make sure that the reforms are used to strengthen both clinician and patient voices and put them at the centre of the heart of what you do?

Wes Streeting: As people will see when the 10-year plan is published in June, it emphasises not just the devolution of power from national leaders to system or provider leaders, but devolution of power so that clinicians feel more empowered to innovate and do things differently, and, crucially, also put power in the hands of patients. There will be a number of ways in which we can achieve those outcomes through the 10-year plan.

Q211 **Alex McIntyre:** Secretary of State, several times today you have mentioned that there is a lot of duplication. What exactly is duplicated between the Department and NHS England?

Wes Streeting: Bearing in mind that there will be people working in these teams, I do not want any examples I give to be seen as a reflection on the quality of their work or their dedication to their jobs. That is not the case. However, there are some obvious examples. There are two HR departments, two finance departments and two communication departments. I have already mentioned the duplication in policy and strategy functions.

Starting to go down the system, you can look at NHS regions, ICBs, the different regulators and the regulatory landscape, and you can see lines of accountability and work focus beginning to look either blurred or, worse still, like Mr Messy with a number of lines of accountability and a lot of duplication.

Prior to her appointment as Chair of NHS England, Dr Penny Dash was working on the regulatory landscape. We will be looking at all of these things in that context and trying to make sure that nationally we provide what is most important in a system of this size and scale—clarity—followed by the tools that people need to do their job.

Q212 **Alex McIntyre:** Why do you think the duplication has been allowed to happen, historically?

Wes Streeting: I am tempted to suggest that you should invite my predecessors to account for that episode. However, I think there were a number of reasons. Thinking about the two organisations, there has been a lot of what I would call man-marking going on between the Department and NHS England. For example, there are two elective teams, and I can happily pick out electives as the example without offending anyone in those teams, because I often cite the elective teams as working effectively and well together. However, notionally those two teams have been set up for NHS England to deliver elective performance and recovery and for the Department to man-mark.

Thanks to our one-team approach, the team is working much more effectively. We now have a team of doers rather than a team of doers and a team of checkers. You can imagine how widespread that kind of duplication is across all the areas of health and NHS activity. A policy and strategy function currently exists throughout NHS England, filled, by the way, by some extremely bright and capable people, but that is not what NHS England was set up to do.

You would have to ask my predecessors, and Jim Mackey's predecessors and NHS England executives over the years, why that happened. However, I think it is due to the natural tendency towards expanding the state and empire building, and—thinking now about the broader regulatory landscape—when something is not going right, if there is a problem, introducing a new regulation. Then, when that does not work, you introduce more regulation. When that has not worked either, you might even introduce a new regulator. You can look at how the health and social care landscape has evolved over more than a decade. We have far too much duplication, and I think that is partly how we have come to this position and why we need to call time on it.

Q213 **Alex McIntyre:** A number has been bandied around of a 50% reduction in workforce. How has that number been calculated?

Wes Streeting: We know that there is duplication across NHS England and the Department. We have taken a few things into account. One is where we think there are duplications of function. Secondly, we intend to devolve more power and responsibility and therefore, in the spirit of what I said to NHS Providers, if you are giving power away from the centre, you should shrink the size of the centre. Thirdly, to demonstrate intent and direction to the system—the seriousness of our intent and purpose—we are about to embark on this process, with the establishment of the transformation team. Work on that front is well under way.

Whether we land on a 46% or a 52% reduction, it will be done through careful design, deliberation and consultation with staff, as you would rightly expect, not only in the spirit of treating people fairly but to make sure that the set-up is the right set-up for the longer term. We have announced the big-bang change. In executing it, we are proceeding in a careful and considered way. Even though the change itself is radical, and

it is a radical reduction of the centre, we are proceeding in a considered and thoughtful way in how we execute the plan.

Q214 **Alex McIntyre:** So, it is a direction of travel rather than a hard and fast target?

Wes Streeting: Yes. And we have been very clear that we want to reduce the size of the centre by 50%. I am not so dogmatic that if we ended up with just below or above 50%, I would feel we had failed. However, that direction is important. It is also important in the context of financial savings. I make no bones about that. One of the objectives of this exercise is, yes, to ensure better clarity and decision-making from the centre, nationally. It is also about freeing up hundreds of millions of pounds that can be deployed in frontline services, and I think that is a good thing to do.

Q215 **Alex McIntyre:** You have pre-empted my next question. It is a perfect segue. You have said that the savings will run into the hundreds of millions. Presumably, some of that is from removing some of the duplication directly. What are the other costs to the taxpayer in how the Department and NHS England are structured?

Wes Streeting: In what sense?

Alex McIntyre: In the sense of opportunity costs or the fact that you have people man-marking instead of doing.

Wes Streeting: That is exactly the right framework and is exactly how we are thinking. If we can free up hundreds of millions of pounds and deploy that resource to the frontline, investing in more frontline staff, and making sure we have the right care in the right places at the right time, we will deliver not only better care for patients but better value for taxpayers too. That, in a nutshell, is what is driving the Government's approach to NHS reform.

It is a conviction that we are not spending the money as effectively as we could and that is to the detriment of patient care and outcomes. It is also to the detriment of value for taxpayers. We must look at the growing ageing society, rising levels of chronic disease and cost pressures. If we do not act to bend the curve of cost and demand and spend the money that is already going into the NHS as effectively as we can, we risk busting NHS finances and putting into serious jeopardy the NHS model and the founding principles of a publicly funded service free at the point of use.

Our Government are unequivocally committed to the founding values. As a party, we are determined to make sure that the equitable founding principles of the NHS, which saw us through most of the 20th century, not only survive but thrive in the 21st century. However, that means reform. That is why it is existential and why, in opposition and now in government, I have consistently emphasised the importance of

investment and reform, which we are now demonstrating through our actions in government, not just the words we spoke in opposition.

Q216 **Alex McIntyre:** It is reassuring to hear that the savings will be making their way to the frontline. Two questions follow from that. First, the hundreds of millions is a relatively small percentage of the overall spend of the Department. What impact do you think the savings will have on the frontline? I am the MP for Gloucester. When can Gloucester residents expect to see the benefits from that investment in the frontline? We have already seen a reduction in the waiting lists, but when will residents be able to feel that? When will they find it easier to see a GP or get a dental appointment when they need one?

Wes Streeting: A couple of things: first—and this is not a criticism of your question, by the way—it makes my blood boil when people say, "Oh, but it is only hundreds of millions of pounds of savings. Is it really worth it?" I think that one of the cultural problems with the NHS and a Department that has a budget of the size it has—now in excess of £200 billion—is that there is a risk that because we deal so often in the billions, we lose sight of the hundreds of millions and the millions. Ask any one of my Cabinet colleagues what they could do with hundreds of millions of pounds, or how much greater a proportion of their departmental spend it might be compared with mine. Also, ask our constituents, the taxpayers, what they would do if they had more money in their pockets, and about some of the marginal decisions that families are making in the supermarket, between what they put in their baskets and what they put back on the shelf.

There is such a bad culture when it comes to treating taxpayers' money with respect and spending it as wisely as the mum or dad who puts back on the shelf in the supermarket something that they need in their fridge at home. Given that we are asking people to pay more in taxes and the tax burden in this country is high, we owe it them to make sure that taxpayers' money is well spent. I owe it to taxpayers and to my colleagues in Government to make sure that our budget is always well spent and that we treat taxpayers' money with respect.

To your constituents in Gloucester—if nothing else, against a backdrop of unprecedented anxiety about the future of the NHS and rock bottom trust and confidence in politics and politicians—I hope they have been able to see that in the last nine months, waiting lists have begun to fall, the number of GPs is beginning to rise, and that day by day, week by week, step by step, we have been putting the NHS on the road to recovery.

I would not overclaim. We are on the road to recovery, but the road ahead is long. We know there is still an enormous amount of work to do but we are delivering on the promises we made and beginning to improve services. That is because of the decisions that we have taken since we were put into power. I would say that change has begun, but the best is still to come.

Q217 **Alex McIntyre:** Finally from me, I appreciate that you will not be able to comment specifically, given that consultations will be ongoing, and I would not want to prejudice any of them. However, we saw reports at the weekend that the redundancies and the packages that might have to be paid to staff may end up costing the Department up to £1 billion. Do you recognise that figure? Have the costs of this transformation programme been assessed and, as a result, will they impact some of the investment we can make in our services?

Wes Streeting: We will not know the numbers until we have confirmed the ultimate size and shape of the organisation, the impact of the headcount and how much it will cost to treat fairly people whose jobs are at risk and may not be carried forward. However, that is not an unreasonable ballpark figure. I justify that cost on the basis that we will more than pay for it with the savings we achieve year on year.

One of the reasons why we sometimes end up with a bloated state is because people start to look at the costs of change and transformation, and they think, "We won't bother. This is in the 'too difficult' box". The country just cannot afford to do that any longer. I would argue that we should have done this a long time ago.

Sir Jim Mackey: Can I add to that? There will be a business case. It will have to demonstrate a payback. It is public money. It will have to be agreed with Treasury and so on. As the Secretary of State said, on the face of it, it is a significant and quite rapid return on investment if you look at it as an investment. It should not put us off. It has put us off making these kinds of changes in the past. That is part of why the financial position is as tight as it is now, and we have to break through that.

Q218 **Chair:** Where is money coming from in year?

Sir Jim Mackey: We have just started a discussion with Treasury about how the redundancy costs are managed, but that is not complete yet.

Q219 **Chair:** So the money may not come from within budget—from the current allocation?

Wes Streeting: It is subject to discussion with Treasury, whose servant I am.

Q220 **Joe Robertson:** So, NHS England is disappearing. ICBs are definitely staying?

Wes Streeting: Yes.

Q221 **Joe Robertson:** Will they be central to commissioning and developing what you call good neighbourhood health services, and central to realising the ambitions in the 10-year health plan?

Wes Streeting: Yes.

Q222 **Joe Robertson:** Why are you cutting their operating budgets by 50%?

Wes Streeting: Because we are going after waste, duplication and inefficiency. If we are asking ICBs to focus on strategic commissioning, by definition that also means asking them to stop the duplication, which I think has been allowed to build up unnecessarily and avoidably.

Sir Jim Mackey: Can I add to that? The variation in pay spend per ICB per head ranges from £49 to just short of £21. Throughout, and in response to one of your earlier questions, we are trying to go at the variation here and for this to be fairer, to be more equally distributed and to maximise the resource at the frontline.

Q223 **Joe Robertson:** Can you show us the analysis that helped you to arrive at 50% as the right level of cut to their operating costs?

Wes Streeting: It was about reducing duplication and inefficiency, bringing the NHS under financial control and making sure that we have the right spend in the right places, which is closer to the frontline.

Q224 **Joe Robertson:** Are you sure that the figure is about a 50% cut for the ICBs? Are you sure that is right?

Wes Streeting: That is what we are going at. Those are the plans that will be coming in. We will look at the plans that come in on their merits.

Sir Jim Mackey: The extent of the variation gives us confidence in that. Looking at the variation in spend, there is little correlation between performance, outcomes and impact.

Coming back to how the numbers were derived, we needed to move more quickly, and we needed to send a signal. It had to be dramatic. We have been improving slowly. We are trying to communicate that we need much more rapid and significant change to deliver what we need in future.

Q225 **Joe Robertson:** Jim, as the boss of NHS England, you wrote to health leaders just last week saying, "We will share with you soon what we think is a reasonable running cost for ICBs per head of population". Hasn't the Secretary of State just given you the answer? It is 50% of the current cost.

Sir Jim Mackey: Yes. However, because there is variation between ICBs, we did not want a blanket 50%, which would just continue the variation. We have calculated the cost per head. Some will have to spend more than others to get back to a more level playing field. That has been shared informally with colleagues in the service before we land the final numbers.

Q226 **Joe Robertson:** Some ICBs will be asked to save more than 50% and some will be asked to save less?

Sir Jim Mackey: Yes.

Q227 **Joe Robertson:** Will it be based on their performance so far, their health

outcomes?

Sir Jim Mackey: It addresses the overall running costs, trying to get everybody to the same running cost per head of population.

Q228 **Chair:** Will demographics be considered?

Sir Jim Mackey: A good point. They are generally on a formula. We are going to get back to the formula and move the allocation of resource away from the pattern that has developed in recent years. The running-cost formula is simply the cost per head to run those ICBs. I do not believe that there is a strong argument that demographics are a significant driver.

Q229 **Joe Robertson:** Do you know what is in the 10-year health plan?

Wes Streeting: Certainly the draft, yes, but it is not only subject to internal kicking of the tyres; I also need to take it to colleagues across government, not least the Prime Minister, to make sure that they are happy with it. Yes, I am very clear about where we are going with the 10-year health plan.

Q230 **Joe Robertson:** When will ICBs see what they need to see in order to decide how to save money?

Wes Streeting: That work is already well under way, as Jim Mackey has reported, and plans will be submitted and considered on their merits and viability. I have been very clear, right back to the NHS Providers' speech that I gave towards the tail end of last year. We want ICBs to focus much more on strategic commissioning and making sure that we are delivering the neighbourhood health services that people need to reduce demand on secondary care, and that people get the right care in the right place at the right time.

Q231 **Joe Robertson:** Will NHS England powers be coming down to ICBs, or is it all about powers going up to the Department?

Wes Streeting: We want to devolve power, resources and responsibility from the centre and closer to the frontline, and indeed at the frontline. I can understand why, when we announced that NHS England would be abolished and rolled into the Department, there was a cautious welcome from some quarters, saying that they got the case on duplication and that this would be a good thing if it is also about devolution and not simply about concentration of power in the hands of a Secretary of State, let alone this Secretary of State. I can reassure people that this is very much about devolution and not about centralisation—quite the opposite.

Q232 **Joe Robertson:** If powers are coming down to ICBs, how are ICBs expected to deliver that with half the amount of money, and some of them with even less than half, given that you are prepared to have variation?

Wes Streeting: And to provider organisations, and rationalising the regulatory landscape and making sure that we are measuring the right

things in the right way, doing quality assurance and improvement in the right way. There is not just devolution of power to ICBs but more freedoms and flexibility closer to the frontline across the range of NHS provider organisations.

Sir Jim Mackey: The intention is to move towards a rules-based system where people can understand the rules and comply with them without central approval mechanisms for lots of things. The more centralised process has developed naturally over the last few years. This is about reversing that process, so those things do not need to be replaced anywhere else in the system. We will remove the approval process and replace it with a clear set of rules and criteria.

Q233 **Chair:** Are you going back to foundation trusts?

Sir Jim Mackey: There are similarities in a lot of the approaches—

Q234 **Chair:** What about the regulator that went with them. You have mentioned the regulator a couple of times now. Are we looking at a new regulator in a similar model to what we had before?

Wes Streeting: In the sense of a Monitor?

Chair: Yes.

Wes Streeting: No, not necessarily. These are all subject to where we land in the 10-year plan. Do I believe fundamentally in more freedom and more flexibility for frontline system leaders and provider leaders? Absolutely. Do I think we need to make sure that that freedom comes with appropriate quality assurance and accountability? Certainly. Do we have a far too crowded regulatory landscape at the moment? I think certainly. Penny Dash—

Q235 **Chair:** We know that report is coming.

Sir Jim Mackey: That report is coming shortly. I want to see more freedom and flexibility for provider organisations. I would add one cautionary note: a point of reassurance to the Committee, to Parliament, to the system and to the public. I am proud of what the last Labour Government did—shortest waiting times, highest patient satisfaction in history—but we also have to make sure that we get the balance right in the right places, especially on patient safety.

I always keep in mind the lessons of the Francis Report. I always keep in mind some of the patient safety scandals that have arisen since then. To put it mildly, in some cases, we have seen shortcomings in patient safety, under successive Governments. In some cases, we have seen some horrifying failures. The worst meetings that I have had in the last nine months have been with victims of various NHS scandals in maternity, mental health and so on. We have to make sure that patient safety is at the forefront, but I say that by way of reassurance that as we are giving

more freedom and flexibility, we are not losing sight, in that context, of patient safety, accountability, quality assurance and standards.

Q236 **Joe Robertson:** One of the criticisms of ICBs, broadly, is about the lack of representation or lack of strength of representation for primary care, community care and the interests of social care. Will you bring about any reforms to strengthen that representation on ICBs?

Wes Streeting: That is an interesting governance question. On any board you want a range of experiences, perspectives and insights to make informed judgments. I always resile a bit when people start demanding a representative structure where you have to have a person from this background, that background or the other background. What you need is a range of skills, experiences and perspectives.

One of the encouraging things that Jim has done with his transformation team is in the context of the National Medical Director. Now we have two—one for primary care and one for secondary care—and I think that was a good innovation. As well as being practical, which is the most important thing, it also sends the right signal. I would definitely expect ICBs to have on their boards people who have a good understanding of the system that they are responsible for leading.

Q237 **Joe Robertson:** It might help your shift from acute to community if ICBs had better expertise and representation of what good community and GP primary care looked like.

Wes Streeting: I certainly expect any board of any ICB in the country to have people with skills, experience, knowledge and insight of the breadth of the system that they are responsible for leading.

Q238 **Joe Robertson:** I will turn to dementia. Dementia was taken out of NHS England's planning guidance at the beginning of this year, so it is not mentioned at all. Will you put it back in the planning guidance for NHS England, Department of Health and Social Care or whichever organisation produces that planning guidance for next year?

Wes Streeting: No. I totally understand why, and not just on dementia but on a number of other fronts, we had voices particularly from the voluntary and community sector saying, "Well, hang on a minute, something that we care about has not appeared in the planning guidance". I genuinely think that one of the problems that we have had with the planning guidance is it has become overloaded with every campaign ask, and it starts to turn into a Christmas tree on which everyone hangs everything.

Q239 **Joe Robertson:** Dementia is the biggest cause of death in the UK.

Wes Streeting: I think it is more like Buckaroo, where the more and more you hang on it, at some point the thing buckles, and I am afraid that is exactly where we have been. Certainly, as you have seen in the

Government's health mission, we want to reduce the number of lives lost to the biggest killers.

You are absolutely right about dementia, and that is why in some of the things like dementia research and dementia treatment, that continues to be an area where we are making progress and will continue to make progress over the course of this parliament. Because something is not in the planning guidance does not mean it is not happening. Because something is not in the planning guidance does not mean it is not important. We have to get used to this new world if it is going to work. The idea that we do top-down command and control on every single front for every condition is not a way to lead a health system that this is large and diverse.

Q240 **Joe Robertson:** I welcome those comments; I do not welcome you not putting it back in the planning guidance. It is such a significant document for where the NHS is heading for the year in advance that not to have the biggest cause of death in the UK in that document for the first time in ages seems to me a tragedy for those living with dementia. I will finish by asking whether you would like to see a national prostate cancer screening programme for men at high risk of the disease.

Wes Streeting: I would like to see that but—and this is such an important but—decisions in this area do need to be evidence-based and evidence-led, and that is why we have a National Screening Committee. I have asked the National Screening Committee to look at this and they are. There is an even more compelling case around groups that are at higher risk of prostate cancer.

Politicians have a responsibility to resist the temptation to sign every petition or to sign up to every campaign. We have to make sure that decisions we make are evidence-led and evidence-based.

Sure, I would like to see screening in this space, not least because—I was questioned on this on BBC Breakfast this morning—I can go on BBC Breakfast as the Health Secretary and say, "Great news, I am backing Chris Hoy's campaign. I am doing what everyone wants" and people will say, "Great, good to see the Government doing this". But I will only do that if the evidence base suggests that is the best use of valuable, constrained resources. I know that is not always the most popular answer, but it is the right answer. All of us as politicians need to show that restraint and discipline of not signing up to the latest campaign unless the evidence tells us it is the right thing to do.

Q241 **Danny Beales:** Thank you very much, Secretary of State, for your answers so far. In your letter to the Committee previously, you outlined the need for legislation primarily to formally abolish NHS England, which was established by legislation. I want to press you a bit more on the timing of possible legislation. Are we likely to see it in the next King's speech?

Wes Streeting: It is a sacking offence now if I say it will be in the next King's speech. First, it is His Majesty's speech, so it is certainly not for me to preannounce it.

Q242 **Danny Beales:** Would you like to see it in the next King's speech?

Wes Streeting: I will definitely not fall foul of the Leader of the House of Commons or the Leader of the House of Lords by saying what I would like or not like to be in the King's speech. Suffice it to say that in order to conclude this process in its entirety, it will require primary legislation, and I have already begun to socialise that issue with business managers, as you would expect.

Q243 **Danny Beales:** Diplomatically done. We know that that will be brought in legislation, but what other aspects of change to the system are you considering being part of that legislation, as well as formally abolishing NHS England?

Wes Streeting: This goes perhaps to some of Mr Robertson's questions; one of the challenges we will have as a Bill goes through Parliament is that I am sure lots of people have lots of ideas about NHS structural reform.

Danny Beales: Are there issues that you—

Wes Streeting: Rather than adding to it, I think it will be my job to try to fend off various attempts by different hobbyhorses, campaign groups and corners of Parliament to try to hang more reorganisation on this Bill. I will do my best to proceed in a very disciplined way to make sure that the Bill delivers this change, rather than every other change that people might like to see at every other level of a system. We do not want to do Lansley mark two.

Q244 **Danny Beales:** I note the desire to resist reorganisation of the NHS, but we kind of are undergoing a major reorganisation of the NHS. Having opened the box of NHS reform, is now not an opportunity to finally grasp some of the nettles that have not been grasped? Obviously, there is Baroness Casey's review of social care taking place.

My colleagues have touched upon the fact that ICB structures are very much focused on healthcare but not integrated with decision makers on social care or public health, as in local authorities. ICBs are very loose bodies, and there is no formal budget sharing or shared decision making. Are those the sorts of issues that we should be looking at as part of legislation that will now have to come before the House?

Wes Streeting: There are certainly lots of specific duties of NHS England that would need to be dealt with through primary legislation: commissioning services, oversight of ICBs, oversight of trusts and foundation trusts, provider licences, digital and technology products and services, the data that supports the health system, planning of workforce recruitment and education.

There are lots of things that are defined in statute as roles and responsibilities of NHS England, which we want to transfer to the Department of Health and Social Care. If people have ideas and particularly compelling examples of things where they think the law is out of date, getting in the way or out of touch, by all means, we are open to those representations. I would urge Parliament to resist the temptation to do unnecessary reorganisation. Your point, Danny, about the opportunity of a reform Bill is why I thought very carefully before opening this box and going in this direction.

Q245 **Danny Beales:** There has been discussion of a national care service, there is—

Wes Streeting: I am doing my best to put you off hanging any more things on this Bill, and I am worried I am already failing.

Q246 **Danny Beales:** In your own comments, you talked of the importance of having one HQ for health. Could you not argue that having one HQ for Health and Social Care locally and nationally is an important step forward in reducing overlap and regulation? Is this Bill an opportunity to do that?

Wes Streeting: If you had asked me when I was appointed Shadow Health and Social Care Secretary a few years ago, "What are your thoughts on where social care should sit? Should it be folded into the NHS and have a national health and care service? Should it remain primarily with local government?" I think I would have said I was open minded or agnostic. I am now even more strongly of the view, as the Secretary of State for Health and Social Care, that social care has different roles and responsibilities than the National Health Service.

Of course, in that Venn diagram there are big overlaps and relationships between the two, which is why there will be some reference to social care in the 10-year plan for health. It is a different type of service meeting different types of need, which are not all about treating or preventing ill health. It is about promoting dignity, independence, and quality of life, and a range of caring functions that not only are not delivered by the NHS today but are better delivered and commissioned through local government than through the NHS.

That does not mean there cannot be more integration of health and care services in some cases. It does not mean that the NHS cannot or should not spend more of its resources through social care to deliver better outcomes for patients and better value for taxpayers, but I think these are distinct services. They have an interrelationship, but I would not want to see the NHS and social care merged.

Q247 **Danny Beales:** That is clear, thank you. In terms of the functions that are currently performed by NHS England that could be transferred to the Department, in your earlier answer you talked about these enablers of the whole system that are crucial at a national level, I inferred from that: procurement, data and AI, digital infrastructure, potentially life sciences

and drug procurement. You are envisaging that those national enablers will simply move from NHS England to the Department of Health?

Wes Streeting: Yes.

Q248 **Danny Beales:** Do you envisage other, broader changes to the national landscape? We are talking about NHS England and functions moving to the Department of Health, but obviously there are other national bodies and infrastructure—NHS Property, the CQC, the MHRA; the list of acronyms goes on longer than your arm. As well as changes into functions in the Department, are we likely to see functions move or shift within the broader landscape nationally?

Wes Streeting: Yes, you have heard what the Prime Minister and the Chancellor of the Duchy of Lancaster have said about the number of arm's length bodies. We are committed to reducing them overall as a Government. I am certainly committed to reducing the number of arm's length bodies attached to my Department during my tenure as Secretary of State, and we have started with the biggest.

We are treading carefully in terms of looking at the ALB landscape in the Department of Health and Social Care to make sure we are doing two things. The first is not missing any opportunities. If we think there are other ALBs that should be folded into the Department, I would not want to miss the opportunity to do that now, at the expense of integration down the track. If we could effectively do more than one now, and that is the right thing to do, then we should seek to do that.

The judgment we have to make, though, before taking those sorts of decisions, is to make sure that we are not biting off more than we can chew and not trying to do too much reorganisation at the same time. It is important to bear in mind in the discussion about ALBs that there are and will always be arm's length bodies for good reason, and there are and will always be arm's length bodies discharging responsibilities on behalf of Government and the public because they are better set up to do that or necessarily set up to do that as arm's length from Government.

We should not assume that all ALBs are bad. There are some obvious ALBs that I would not want to get rid of, but this morning I am resisting the temptation to say, "Well, yes, but we will obviously get rid of X, Y or Z", because in omitting to reference every other ALB I might end up causing unnecessary anxiety amongst people who—

Q249 **Danny Beales:** I think we have heard that there is a general view that they should be looked at and assessed by case.

Wes Streeting: Yes. We are looking at this strategically but, as I say, I am conscious that we are doing something quite big now and I do not want to bite off more than we can chew.

Q250 **Danny Beales:** Presumably, on that basis, we will not see any new bodies established nationally. You said there is a desire to reduce them,

so, on that basis, we will not see any new national bodies created?

Wes Streeting: I definitely want to see the number of ALBs reduce during my time as Secretary of State and, therefore, there is a very high bar for someone to persuade me that a new ALB is required.

Q251 **Danny Beales:** Lastly, NHS England is a source of significant clinical leadership and clinical expertise. It hosts specialist clinical networks of various sorts and has national clinical directors. What is the future of those? Are they likely to shift to the Department? Are you seeing more of a local leadership model rather than national co-ordinated clinical networks and specialisms?

Wes Streeting: We already have clinical leadership across the NHS, quite rightly, in system leadership and provider leadership. I think we will always want to make sure that there is good national clinical leadership as well. I have one of those national clinical leaders sat to my left. There are many others who will be housed in the future in the Department of Health and Social Care, but we have to make sure we have that clear distinction between political leadership and official civil service leadership of the system as a whole, and clinical leadership.

It is one of the reasons why, despite political pressure to intervene politically—whether, for example, on implementation of the Cass review, or on reorganisations of particular services or pathways that providers or systems have proposed—I have resisted calls to intervene politically. That is because I believe in clinically led and evidence-based decision making, and people do not want—for understandable reasons—the Secretary of State for Health as a politician making decisions that rightly belong with clinicians. In fact, I see it as part of my job to protect clinicians from political interference.

Q252 **Danny Beales:** Those clinical leaders at a national organisation presumably must drive clinical leadership.

Wes Streeting: I rely all the time on good clinical advice because there are occasions where the Secretary of State has in statute powers to intervene or powers to take decisions, and there are Bills going through Parliament presently that propose to give the Secretary of State more powers in this respect. It is important that Secretaries of State are making decisions based on good clinical advice and evidence, and crucially that they protect clinicians from political interference.

Q253 **Danny Beales:** In terms of highly specialised services, NHS England has traditionally taken a lead. There has been some movement back towards a local level, but many patients with highly specialised conditions sometimes worry that local leadership ultimately means local variation. If your ICB do not prioritise your specialised condition or do not have a specific high population of that specialised service in your locality, that will mean maybe the service is not there, and national service specifications have ultimately led to a higher bar for quality for specialised services. How do you envisage specialised services evolving?

Will there still be a role for national leadership and expectations being set, or will it purely be local decision making?

Wes Streeting: No. I think there still is a national role on specialised commissioning, but again you have to get the balance right. This is something we are considering very carefully in the context of the 10-year plan, because we want to make sure, in terms of how we set the system up, that we are taking the right decisions in the right places. Clearly in lots of cases you want more freedom, more flexibility and more innovation at the frontline and at system level as well as provider level. In other cases, it will be more desirable and effective to have national decision-making clinically driven and clinically led. But those are the sorts of edge cases and tensions we are considering in the context of the 10-year plan.

Q254 **Danny Beales:** Thank you, Secretary of State. Lastly, the shift of this clinical knowledge, expertise and capacity is obviously evolving, but how will we ensure, in this time of change and flux for expertise and capacity, that work currently under way on specialist areas—the National Cancer Plan, the HIV Action Plan and other areas—is not diluted, delayed or ultimately sacrificed as part of this broader change?

Wes Streeting: First, I am left in no doubt by the Prime Minister and the public that, regardless of the reform agenda we are pursuing to deliver better outcomes for patients and better value for taxpayers, that cannot be an excuse for not delivering consistent year-on-year improvements in NHS services on the manifesto we stood on at the election and the plans that we have committed to. I have a sharp eye on delivery.

This is one of the reasons I am delighted to have Jim sat to my right. One of the reasons we have appointed Jim as the Transformation Chief Executive of the NHS is because he has that combined experience of organisational change, transformation and improvement, and also a track record of not only good financial management but good delivery, particularly on elective recovery.

My eye is very firmly on the ball when it comes to the delivery of improved outcomes for patients. I see what we are doing in terms of the wider system change and organisational change at the top at NHS England as being in pursuit of improved services for patients, not being contradictory to or a distraction from it. If we get this right, we will deliver better value for taxpayers and better outcomes for patients, and that is why as we have embarked on this process we have sought to learn the right lessons from where previous reform agendas have and have not been very successful.

Chair: Thank you. We are failing miserably at keeping to time, which is my fault. We will go now to Josh Fenton-Glynn.

Q255 **Josh Fenton-Glynn:** Hi, Secretary of State. I will talk a bit about NHS Digital and the NHS workforce more generally. It will not surprise you

that the NHS England workforce is of particular interest to me, being a West Yorkshire MP. NHS England has a particularly large footprint in West Yorkshire; effectively we have a second NHS HQ in Leeds. Everyone in this Committee is persuaded by some of the logic of the changes that are being made, but I am also a bit concerned about some of the skills that we might lose, particularly under NHS Digital.

Could you give me some assurance that the skills—particularly around that digital infrastructure piece, which needs a lot of change, but we need some skilled workers to do that—will remain, and ideally will remain in West Yorkshire?

Wes Streeting: I will say two things about functions and skills specifically, and then about Leeds. First, we are still in the foothills of one of the most exciting revolutions taking place in the world, which is the revolution in life sciences and medical technology, as the Prime Minister announced this week with the establishment of the Health Data Research Service. We want the UK not only to be benefiting from that revolution but to be actively driving it.

We have a competitive edge in this country that is in danger of being lost. We will only achieve it if we have the right policy direction but also the right team and skills to deliver it. Whether it is on the security and integrity of the NHS's digital systems, the rollout of new digital capabilities, or our ability to marry the best scientific minds in this country and around the world with our National Health Service, we will need more of this capability. We will need people with the best skills. That function of NHS England, which is driving that digital transformation, breakthroughs in life sciences and technology as well as big productivity improvements and gains in the NHS, remains extremely important and will be part of the new Department, but we absolutely do not want to lose that functionality.

Secondly, this Government and I are absolutely committed to Leeds, not only in terms of the Department's base in Leeds, which is effectively our headquarters in Leeds. Over a number of years now that has been part of a strong ecosystem for health and science in Leeds. We often talk about the Oxford-Cambridge arc, a big part of the Government's plan for growth. We have a strong science powerhouse here in London and the south-east, with respect to my alma mater and the Chair's city, and the city I represent and live in here in London. We have some brilliant science strengths outside of London in the south-east, particularly in Leeds. It also applies to places like Stevenage and Liverpool.

This Department is absolutely committed to Leeds, absolutely committed to the capability that we have in Leeds, and being part of that wider Leeds health and science ecosystem, which I think is a big strength not just for West Yorkshire, but for our country.

Q256 **Josh Fenton-Glynn:** In West Yorkshire we have the health innovation village in Leeds. There is some anxiety about the delays in the rebuild of

the hospital. I understand why that has happened, but can I have the assurance that we will work on an NHS that is a good place to invest for and a good place for life sciences and that kind of work?

Wes Streeting: Absolutely. I had a deputation of the Leeds mafia to see me, or ambush me, here in Parliament only recently. That was a delegation of MPs from the city and the region but also from the NHS Trust and the city council. As you would expect, Tracy Brabin has been banging the drum very loudly for her region and its science base and health strengths.

It is important for me to signal very clearly not only our current but our future commitment to Leeds and West Yorkshire. I think there are opportunities for us to leverage in more partnership, particularly with the life sciences sector and the med tech sector, and to look at what we can do together to invest in and build that strong health and science footprint in Leeds for the benefit of the country. In terms of the hospital, I will take this as another representation in the context of the new hospital's programme.

Q257 **Josh Fenton-Glynn:** Moving back to that workforce point, what is the timetable for the NHS workforce plan now?

Wes Streeting: We are reviewing the workforce plan in the context of not only the 10-year plan but, frankly, the blindingly obvious problems that we have in the NHS today in terms of workforce planning. Some of the complaints that we have heard from resident doctors in particular about their future career prospects, the lack of speciality training places and some of those bottlenecks are well made.

Following the publication of the 10-year plan in June, there will be some technical work under way to make sure that we have a long-term workforce plan that we can have genuine confidence in and that can survive the transition from one Secretary of State to the next, which I am afraid to say the current workforce plan has not.

Q258 **Josh Fenton-Glynn:** We have a lot of change for NHS England, NHS Digital and various parts of the structure of the NHS. How will you ensure that the culture for people working for the Department of Health will be anything decent after they have seen a lot of their colleagues moved around and moved out of jobs, and seen that much change?

Wes Streeting: I will say a few things on this front. This is why we do not take these decisions lightly; I am very conscious that there are a number of people now who are anxious about their jobs and their futures. I am genuinely sorry about that, because I do not want people to have to worry. We would not be doing this unless we genuinely thought it was in the public's interest.

In terms of how we are handling the next steps of this process, we are proceeding with the degree of care, consideration and fairness with which you would expect us to treat people. We are engaging with the staff trade

unions, and we are keeping staff informed as the Transformation Board does its work, so that people know where they stand.

As I said earlier, in an ideal world if I was leading a restructure in any other walk of life I would have put my transformation board in place, had a look at the organogram, the job descriptions and functions, and I would then at that stage make the announcement. Unfortunately, in the world that we live in, the moment I commissioned that work to put together that plan it would have immediately leaked, and I would be reading about it in the *HSJ*.

We have tried to proceed in a way that is fair and transparent to staff, and also meeting our obligations to Parliament and to the public. The headcount reductions were known ahead of the Prime Minister and I announcing the abolition of NHS England, but I do not want to minimise for a moment the fact that that will have come as a shock. Even where there are people in the Department and NHS England who recognise what we are describing, the problem we are trying to solve and the impact we are driving towards, if your job is at risk it does not make you feel happy, even knowing that is the direction. We are proceeding with that in mind.

I must say that, regardless of the anxieties that people feel, my sense is that people are continuing to go about their work with the same professionalism and commitment that has driven them to now, so we will proceed on that basis.

The final point I want to mention is on culture. It is crucial that when we bring the two organisations together, we have one team, one culture, better ways of working and an environment where people feel happy and fulfilled at work and productive at work. You do not build culture by imposing it from the top; there will be lots of work done with staff to make sure they feel like they are part of that one team approach.

Q259 **Josh Fenton-Glynn:** Thank you, Secretary of State. Because you mentioned unions, I want to put on record that I previously worked for the Public and Commercial Services Union.

Wes Streeting: I should also mention I am a member of UNION, GMB and Community.

Q260 **Andrew George:** What lessons have been learned from previous reorganisations? I was around on the Government benches—opposing all the way through to the bitter end, I have to say—at the time of the Lansley reforms, which David Nicholson said could be seen from outer space, as we all will remember. If you were looking at those reforms and the major restructuring that happened then, what one lesson would you say you have learned from that, which you are seeking to avoid on this occasion?

Wes Streeting: Proceed carefully, even if you are acting radically. We came into office with a whole set of things we wanted to do and where we have hit the ground running, and we are beginning to see some of the

fruits of that with falling waiting lists, increasing GP numbers and the impact of the decisions that the Chancellor made in the early weeks of our time in office, as well as at the budget that will begin to kick in, in the new financial year.

I was also criticised at the same time because we said we would consult on our 10-year plan, and I came in sceptical and resistant to doing structural reorganisation. I would strongly defend that approach and those instincts because the challenge, as I saw it, with the Lansley reforms was that he had done a huge amount of work in opposition and he came into Government with a ready-made reorganisation and a plan that was then imposed in a very top-down way. Even when people were expressing criticisms and concerns, it was just sort of steamrollered through. I think David Cameron even acknowledged that he had not quite realised what Andrew Lansley was up to, and if he had realised, he might have put a stop to it.

What we have done is a to take a different approach, which is to consult on our 10-year plan and engage extremely widely so that when we publish a 10-year plan, it should be broadly welcomed. People will understand the direction and understand the part they play in it.

In terms of the changes I am making to the Department and NHS England, that has been done after consideration of how things are working in practice. The next step of the process will be consulting and engaging on how the setup is established. Although it is a radical change—I make no bones about that, and I think it is the right thing to do—we are delivering that radical change in a thoughtful and considered way.

Q261 **Andrew George:** As you say, although Lansley might well have had these plans in advance, the coalition agreement in fact announced that there would be no top-down reorganisation at the time. But moving on, the public and patients will be bemused by this, will they not? They are not as concerned about the backroom plumbing and wiring of the NHS; they are interested in what is delivered at the front door. How will you make sure that the inevitable disruption that this will cause will not distract from the delivery of the 10-year plan, and indeed onward to patient safety and improvements in patient services?

Wes Streeting: I will say two things in response to that. One of the interesting things in the aftermath of the announcement about NHS England, aside from one or two people—my favourite one was the anecdote of someone who was in A&E sat next to someone who turned to them and said, "Enjoy this while it lasts, because Wes Streeting is getting rid of the NHS". I think they had taken the abolition of NHS England as the abolition of the NHS.

For the avoidance of doubt, so long as I am the Secretary of State, the NHS is here to stay—a publicly funded public service free at the point of use. But I think one of the things that patients and NHS staff have in

common is frustration with what they see as layers and layers of bureaucracy. I think the public will be pleased to see that we are going after that and looking to redeploy more resource to the front line, which is where it can make a difference.

My focus, and the Prime Minister's focus in terms of holding me to account to deliver on behalf of him and his Government, is on services for patients, the quality of care, the speed of access, and most importantly the outcomes. In terms of how I spend my time and where my focus is, my first and foremost focus is always on are we bringing down waiting lists, and whether we are improving patient care year on year. There are some encouraging signs already, but as I keep on saying—

Q262 **Andrew George:** You do not think that this reorganisation will distract you from the progress made so far. Do you not think that is the key thing?

Wes Streeting: It is disruptive, certainly. Is it necessarily a distraction? No. We have to remember that the reorganisation of two entities, the Department and NHS England, which have just under 20,000 people working there, is in the context of a system where more than 1 million people work.

On the day we announced the abolition of NHS England, and indeed the day after, there would have been people going to work in GP practices, in the community, in hospitals and in social care, going about their work as they did the day before. We should not think that because we are spending quite a bit of time on a change management process with senior officials in the Department or NHS England, the rest of the system has stopped and is waiting with bated breath for the next missive coming on the reorganisation.

Q263 **Andrew George:** You were saying earlier that you keep in mind the Francis report. One of the things in the Francis report was that any major reorganisation should be subject to a risk and impact assessment. You say that you are confident it will not have an impact. Has any impact or risk assessment been undertaken? If not, when will it be undertaken and when will it be published?

Wes Streeting: In the way that the Government normally do, we will certainly do an impact assessment of changes, and we will be looking at impact through a range of lenses.

Chair: When?

Wes Streeting: Throughout the process, but I can report back to you in more detail down the line.

Q264 **Chair:** At the beginning of the process? The end is a bit late, isn't it?

Wes Streeting: We are at the beginning of the process now, but in terms of what the impact of the changes will be, that will depend very much on how we constitute the new organisation and what it looks like.

Q265 **Andrew George:** Finally, you seem to at least keep the door open with regard to the possibility of PFI within the capital spend. Now that you have Alan Milburn, who is an evangelist for PFI in some people's minds, where are you on that? Are there not lessons that you surely will have learned from the catastrophic impact that has had on NHS finances in past?

Wes Streeting: I will say two things about this. One is that with the level of capital underinvestment, which was identified very starkly in the Darzi Report, I constantly feel pressure from parliamentarians, who are constantly under pressure from their constituents about not only the new hospital's programme but the crumbling hospitals and the primary care estate, the mental health estate, the community health estate, and the new kit we need. Not only is there historic undercapitalisation of the NHS, but there are also ongoing and emerging capital pressures.

Even with the biggest capital allocation that the NHS has had since Labour was last in Government, which the Chancellor delivered in her budget, I do not see how you deal with the scale of that challenge without some private investment. The challenge though—this is why I tread extremely cautiously in this area, and it goes back to the earlier point about pride in the last Labour Government and what we achieved, but also humility about things that did not go so well—I am mindful that PFI came at a significant cost.

Many trusts are still repaying those costs, and that is not an inconsiderable cost for a number of trusts. But there are also different models of private financing. The Welsh Labour Government have been doing capital investment through private finance in a totally uncontroversial way. Many of the LIFT schemes that we saw in the primary care estate have been extremely successful.

It is with that caution and nuance in mind that we will look at this, but I want to reassure people that as we do, we are mindful not only of the good things the last Labour Government did, but also of the things we got wrong.

Andrew George: So, learning lessons, and hopefully there is still the institutional memory to learn those lessons.

Q266 **Dr Beccy Cooper:** I am aware that we are running out of time, so I will be quick. Chris, you have sat there silently and stoically for two hours, so perhaps I might address a question to you. With all the changes that are going on—NHSE being abolished, ICBs being cut by 50%, HSA presumably continuing as it is—where does public health and population health sit in this landscape?

Sir Chris Whitty: There are two answers. The first one is within the Department. That is obviously separate in large part. If I could divide population and public health prevention into two bits, the primary prevention bit—the thing that Government does, both local and national, broadly—will not be affected by the changes in terms of bringing in the NHS, because that has always been a separate function.

Q267 **Dr Beccy Cooper:** By that you mean that the local authority functions will remain as they are with the DPH. We will come to devolution in a minute—that may be for Jim—but carry on.

Sir Chris Whitty: Let's complete the answer, and then I will come back to that. Secondary prevention, which is what happens when a clinician sits in front of someone and says, "Look, here is a risk factor, can we reduce it?" may be affected in operational terms by the bringing together of NHS and DHSC, but in practical terms it will not.

I go back to a point that the Secretary of State has made repeatedly in different ways, and I will repeat it. For every clinician on the frontline, for almost all the technical people and for most of the policy people, their day job will not change from one day to the next as a result of these changes. What they are doing is working for patients and working for the public, and that is what they should be doing. They should not be spending their time thinking about reorganisations.

Q268 **Dr Beccy Cooper:** Understood, Chris. If I can perhaps direct your thinking to the Department known as OHID, presumably that is obsolete now, or continues as is but will no longer be. Where does that health inequality mandate sit moving forward?

Sir Chris Whitty: No, I do not think there is any reason to think that will change. Although PHE was abolished, OHID—

Wes Streeting: I think I said OHID had been abolished, and it was the other way around.

Dr Beccy Cooper: Excellent. Good to clarify.

Wes Streeting: I do not want to set any new hares running.

Sir Chris Whitty: Those functions are still very much present in the Department. They are broadly divided into the group of things that are on the primary prevention I talked about, the secondary prevention facing NHS, primary care, secondary care, and then research and data, which is off to one side. But the functions are still there and will still be needed.

Q269 **Dr Beccy Cooper:** Excellent. Do we foresee a world, not anticipating the 10-year strategy, where the functions of PHE—so the Health Security Agency, OHID, and perhaps that sort of strategic level thinking—are all brought closely together again?

Sir Chris Whitty: Without in any sense prejudging the 10-year plan, I think the Secretary of State has made it clear repeatedly that the shift

from treatment to prevention is a key part of this. He said in several of his answers today that he wants to push things further out to the periphery, but all of that can work with a public health system that is working. There will still need to be some central functions, which will include data and research, which is much more efficiently done centrally, and primary prevention, which has to be done by Government under democratic control.

Q270 **Dr Beccy Cooper:** Excellent; thank you, Chris. To Jim, then, devolution has been mentioned several times in this session. As we are aware, concurrently local authority is undergoing a process of devolution. For those areas in the country that do not have devolution and are mandated to undertake it by the end of this Parliament, how is devolution in health working alongside devolution in local authority? Do you foresee areas of synergy or areas of issue arising?

Sir Jim Mackey: It is a big part of what you do locally when you are running trusts or ICBs, you are trying to work well with local primary care, local council and increasingly combined authorities where they exist. It is absolutely a big part of what we want people to be doing, getting close, joining up public services wherever possible and maximising the value for the public.

Q271 **Dr Beccy Cooper:** In terms of resources and responsibilities, do you foresee a point where integrated care boards are working so closely with combined authorities that there is a level of accountability into those combined authorities, perhaps looking at some of the accountability that currently comes to central Government?

Sir Jim Mackey: If you are thinking about it from a structural governance sense, a lot of this has still got to be worked through, and I would agree with what the Secretary of State said earlier on about being careful not to end up in a position where we are loading people into boards for the sake of representation. But the principle of being very aligned, very joined up in terms of strategic planning and impact for the population—I absolutely expect that. With some ICBs, coterminosity with combined authorities is a big thing for them in the discussions we have had over the last few weeks, and others less so, where it is less developed.

Wes Streeting: There is different appetite from some of our mayors as well. Andy Burnham recently put out some interesting ideas and is doing some interesting work, particularly in the prevention space, that I think we should look at. One of the many interesting things about Andy is that he has sat in my chair before and is now driving population health and prevention work as a mayor. I think that is good and interesting, and I suspect if given the chance he would probably take on greater responsibility in this area.

Oliver Coppard is doing a similar agenda with a similar ambition. I am not sure every mayor would have the same level of enthusiasm or appetite,

but we are certainly up for trying things differently and testing and learning. Certainly, with some of the public noises that Andy has made about different approaches he would like to try in Greater Manchester, we are open to trialling and testing different things and seeing what works.

Q272 **Dr Beccy Cooper:** That aligns with the White Paper that came out around devolution, where it says it is expected that the mayor will be appointed to one of the relevant integrated care partnerships, so that aligns closely. My final question, Secretary of State, is for you. We are often accused in politics of using health as a political football. In terms of the changes that are now being undertaken, how will you ensure that for future Secretaries of State these are seen as positive—nothing is ever apolitical—sustainable changes that are not simply undone by your successor or future successors?

Wes Streeting: No Parliament can bind its successor, but I thought it was encouraging how many of my predecessors—Labour and Conservative—were, to different degrees, welcoming of the changes we are making, some more cautiously than others, and some emphasising different opportunities or risks to different degrees. Broadly speaking, we have achieved broad consensus on this, and I do not think that is a bad thing at all.

I know there are some people who say, whenever someone from the other side says something positive, "This is proof that you are not being puritan enough or ideological enough". As far as possible, especially when it comes to the overall system architecture, it is a good thing if people know that from one Government to another and from one party to another, although there will be different policies and different choices—we have to make sure there is that genuine choice and contest—it is a good thing if overall you are building a national consensus towards the same overall direction.

Q273 **Dr Beccy Cooper:** Would you say that this is the right balance between recovery and reform?

Wes Streeting: Yes, I think so. I think we are seeing some signs of the NHS's recovery, and we are seeing radicalism from the Government in terms of reform. We are seeing that welcomed across the party political divide. That is a good thing, and we will continue to work in this spirit. I have been delighted, informally as well as formally, to bring in people who might not share our party colours but care about the NHS and want to help this Government. In that spirit I was delighted, for example, to have on the Department's board Camilla Cavendish. She worked for the last Conservative Government—I do not want to say literally the last Conservative Government; there are so many of them, but a Conservative Government over the last 14 years. She has great ideas on social care, and she is a committed public servant.

Why would we not try to bring in people with that level of commitment, skills and experience? We will not always agree on everything across the

party political divide, but against the backdrop of very fractious politics, it is a good thing to remind the public that we have more in common than the things that divide us.

Chair: That is as much an advert for Select Committees as I have ever heard. That is a good place to end. Thank you, all three of you, for appearing in front us this morning.