Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 13 December 2016

4 pm

Watch the meeting

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 33 Heard in Public Questions 301 - 313

Witness

I: Rt Hon Jeremy Hunt MP, Secretary of State for Health.

Examination of witness

Rt Hon Jeremy Hunts MP.

Q301 **The Chairman:** Secretary of State, thank you very much indeed for finding time to come and address us. I know it is an enormous amount of time out of your busy life and we are extremely grateful to you.

As you gather, this inquiry is looking at the long-term sustainability of the NHS and social care, so looking beyond 2025, 2030. We do not want to focus on current or immediate issues, although we inevitably get into them; it is the future that we are more interested in.

We all know you, but please introduce yourself so we get it on the record. If you wish to make a brief opening statement, that is fine. Otherwise, I will go to the questioning.

Jeremy Hunt: Thank you very much for inviting me. I welcome the discussion. I will not make an opening statement because I am sure there are lots of questions but I think it is absolutely the right discussion to have.

The Chairman: Thank you very much. If I might kick off, as you might expect, it is about funding. We have heard considerable evidence that funding pressures are the most significant threat to the sustainability of the health and social care system, and that spending on health will need to grow considerably over the longer term if the health and social care systems are to remain sustainable. I do not know if you would agree with that. My supplementary to that is that there seem to be conflicting views on whether the funding requested by the NHS is forthcoming, and you might confirm whether that is correct or not. Also, looking beyond 2020, which is this Committee's main concern, we will inevitably have to look at different funding models. Do you think we should be doing so, or would you agree that healthcare should always be free at the point of need, and that you and future governments should not deviate from that?

Jeremy Hunt: Those are obviously three critical questions. Let me deal first with the very short-term one, and I am very happy to come back to it if you want. There is a slightly fake debate going on about whether or not the Government have honoured what they said in the spending review this time last year. We had a request from the NHS for what it thought it needed to kick-start its own plan, the *Five Year Forward View*, and we negotiated a spending settlement. It was a very long and difficult battle, in which I was negotiating on behalf of the NHS, for what it said it needed, and we received a settlement that the NHS said was sufficient.

It is a £10 billion increase for the NHS but some of that £10 billion, as you will know, is funded by cuts in central budgets held by the Department of Health. Under the new legislation NHS England is separate and independent from the Department of Health, but we have always been very open, as we were this time last year. When we negotiated the spending round NHS England was fully aware of where the extra £10 billion was coming from. The crucial discussion then was that they were

very clear that they wanted the settlement to be front-loaded; they wanted the majority of the settlement to come early in the Parliament, and that was a very difficult negotiation, because the natural thing for the Treasury to do would be to increase the extra £10 billion in a straight line, £2.5 billion a year for four years, but the NHS wanted the money to come early, so that was in the end what we did.

I do not want to pretend that means it is easy on the NHS front line. I think it is incredibly tough, for all sorts of reasons which we can go on to discuss. It certainly does not feel as though there has been a bonanza. Things are tougher than they have ever been and NHS staff are working harder than they have ever been.

On the question about sustainability, I think there is a rabbit hole that you can wrongly go down. Often the question is posed on whether the NHS is sustainable, and I think that is the wrong question to ask, because what the NHS stands for is a set of values that we will never abandon as a country—certainly I, as Health Secretary, and this Government will never abandon, which are very important principles, of which one—

The Chairman: Does that mean you will maintain free at the point of need in perpetuity?

Jeremy Hunt: Yes. Sadly, I am not going to be Health Secretary in perpetuity but as far as I and this Government are concerned, we are absolutely committed to that principle.

The Chairman: You might be in a higher office.

Jeremy Hunt: That is not said about me very often but I will take the compliments where I can.

The Chairman: The issue is whether in future any government should maintain that principle, which the public is clearly keen on maintaining.

Jeremy Hunt: I think the core principle of the NHS is that it should not matter what the size of your bank balance is; you should always be able to access high-quality care. That was the promise made in 1948 by a Labour Government that set up the NHS based on a Conservative Health Minister's White Paper in 1944. It unites both sides of the House of Commons and the House of Lords. I think it is very misleading and unnecessarily worrying to the public to talk about whether the NHS is sustainable, because they worry about those core principles.

The bigger question is how all health systems across the world will be sustainable in the face of the huge pressures of an ageing population, with advances in medicine and technology that are making us all live longer and are fantastic for all of us. There is a bigger question, which is not really about the NHS because I do not think we will ever change those principles, but is about how we will get more resources into healthcare systems, not just in this country but even in America, where they spend twice the proportion of GDP that we do. There you have to

have a strategic, long-term view, which is what I think this Committee is trying to do.

Q302 **Bishop of Carlisle:** You mentioned the growing demand on the NHS with the ageing population, multiple morbidities and so on. The Office for Budget Responsibility has suggested that after 2020 the proportion of GDP that will need to be spent on the NHS will need to increase, whatever happens. First, do you agree with that and, if you do, how do you think that could be funded?

Jeremy Hunt: Broadly, I agree that as we get older—I want the NHS to be the safest, highest-quality healthcare system in the world. I think that is what the British people want, and we are going to have to find a way of getting more resources into the NHS and the social care system as we deal with the extraordinary demographic pressures of 1 million more over-75s by 2020, and that will continue. I was quite relieved to read that some American researchers have said that our life expectancy will never increase beyond 115, which they have somehow identified as the highest it can go. I thought, "Phew!" Yes, we will have to find a way of devoting a greater share of our national resources into health and social care, without doubt. The point I would make is that this was a call that Tony Blair made in 2002, and it was also a call that George Osborne made when he decided to protect the NHS budget in 2010, and indeed increase it in 2015.

If I go back to the Blair analogy, where he very explicitly said that he wanted to increase the proportion of GDP to the European average, he was able to do that on the back of a strong economy. The biggest risk to the principles behind the NHS that we all hold dear is if the economy went pear-shaped. That is the thing we have to worry most about. I do not think it will; happily, we are doing better than many feared post-Brexit, but that is the biggest single risk. If the economy continues to grow, it is a choice for governments to continue with the current funding model. I personally think it is a sensible choice. It is probably the choice that is closest to what most British people want.

Bishop of Carlisle: Would you see that funding continuing to come primarily from taxation?

Jeremy Hunt: Yes, I would.

Bishop of Carlisle: Thank you. Can I ask one other thing: the *Five Year Forward View* talks about the importance of funding social care and public health. At the moment that does not seem to be happening, and obviously there are long-term implications of that. Do you think a forward-looking thing, which I know is difficult politically, say a five- to ten-year plan for public health and social care, might go some way towards resolving that problem?

Jeremy Hunt: We have a long-term plan for both social care and public health. I think they are both different. The long-term plan for social care is complete integration with the NHS. That is what is now starting to

happen in parts of the country. Frankly, it is crazy that people have to navigate the complexity of two different systems. It is not fair and it is expensive, so we need to bring those two systems together.

On public health, the first observation I would make is that we have one of the best public health records in the world in this country, and we are still going strong. We are one of the first, probably the second or third country in the world to have standardised packaging for cigarettes; we have teenage smoking rates down to below 5%, which is a lot lower than it was when I was a teenager, watching my friends go behind the bike sheds. The world has changed a lot. I think the UN did a report a couple of months ago that said we are the fifth healthiest country in the world. I memorised the countries: Iceland, Andorra, Sweden and Singapore were the only ones that are ahead of us, so we have a very strong record.

In public health I do not think it is primarily about money; it is about taking big decisions, such as we were hearing from Philippa Whitford, on obesity, standardised packaging, stopping smoking in public places, but that absolutely has to be an important part of the picture.

Q303 **Lord Warner:** Can I pursue this issue which has come out in the evidence of the longer-term smoothness of the funding for the NHS and social care? The evidence being presented to us—and this is not a party political point because it goes back over 20 to 25 years—is that you have these huge spikes in the way money is given out to the NHS, and there is no synchronisation between what is given to the NHS and what is given to social care. This makes the planning of these services very difficult for those trying to manage them, and probably fairly difficult for Ministers as well. What we are grappling with is how you start to smooth some of this out. We all accept that you cannot ignore the state of the economy in the allocations but we ought to be able to do a better job. One of the issues preoccupying us is whether you, as the Government, need more help to get that planning over the longer term right. The department's evidence to us was that you are stuck in a five-year groove; that is what the officials were saying. Do we need something like the OBR? Medicare has a set of trustees which are looking to the future. Do we need something which would help governments try to focus on a longer-term view around funding, workforce, and investment issues?

Jeremy Hunt: It is a very interesting point. I think I know you well enough to know that you are not party political anyway but perhaps I could say—

Lord Warner: I gave that up some time ago as a bad job.

Jeremy Hunt: I think it has been particularly lumpy in the last six years because of the economic context we have been in, which has made it particularly challenging. It was incredibly disappointing that we were not able to protect the social care budget in 2010 as we were able to protect the NHS budget, but the reality was that the economic crisis we faced in 2010 meant that it was an absolutely huge effort to protect the NHS budget, which is the second biggest budget in government, and meant

that other government departments had to have correspondingly bigger cuts, and it was not possible to give that same level of protection to the social care budget. Because of the 2008 financial crisis, we have been through a lumpy period.

I do not want to pre-empt your later questions but, broadly speaking, I think there is merit in the direction of travel of what you have said, for this reason. If you look at the positive lumps, if I can put it that way, if you look at the spike in funding in 2002, that was based on the Wanless report, and five years later Wanless concluded that 43% of the extra funding had gone into higher pay and prices and not into better services for patients. There was a lot of talk about that at the time but, if you went to the root of it, one of the reasons was workforce planning. You can put extra money in but, if you do not have the doctors and nurses there to deliver the extra care, what you end up doing is inflating the prices you pay to the current workforce, which is very nice for them but is not necessarily what the taxpayer intended.

We need to be better at taking a strategic view because if, as I suggest to you, over the coming decades we will need to spend a greater proportion of our GDP on health and social care, we will need more doctors and nurses. Doctors take six years to train and nurses take three years to train, and we need to start thinking about that now, because the truth is, even while we are in the EU and we can import as many doctors and nurses as we wish from EU countries without restrictions, we still have rota gaps; we still cannot find enough of them, because every country is facing the same problem. One of the most important reasons for taking a longer-term view is to be able to be more strategic about our workforce planning.

The Chairman: That is a very helpful comment.

Lord Warner: Can I move us on to social care, where the one thing which has been absolutely consistent in the evidence to us is that, putting it very crudely, the NHS is shooting itself in the foot by neglecting social care because of the effect it has had on discharges, sizes of A&Es, bed occupancy and so forth. What is the Government's longer-term plan for social care? We do not have a view, other than that it is very clear from the evidence that there has to be a plan. Do you have any views about whether there should be more discussion with the public about whether the family should do more, or whether we need a social insurance system of the kind in Japan or Germany? How would you see us approaching this? I am not talking about sticking plaster at the moment; I am talking about the longer-term game plan for social care.

Jeremy Hunt: First, we completely recognise that there is a serious issue when it comes to social care. I have always seen my job as being as responsible for the social care system as for the health system, even though it falls under local government and under CLG as a government department. For someone with dementia, it does not matter where the care and support they get comes from, but we need it to be good and we need them to be treated with dignity and respect. We are constrained by

our economic context but if you wanted some evidence that we recognise the pressures, as is well known, funding on social care fell in the last Parliament but in the first year of this Parliament has gone up by £600 million in cash terms. There can be a debate about whether that is enough but there is a definite change of direction in funding.

You are right to say there is a longer-term issue, and it is a complex one. In a nutshell, we need, as a country, to start saving for our social care costs in the same way as we save for our pension. It needs to be a normal, automatic thing for everyone to do, and we need to make sure there is a proper safety net there for those who have not been able to do that. It is a difficult issue because, on the one hand, you want to encourage saving, but we also want to live in a civilised country where there is a safety net below which no one falls. I think we need to do some radical thinking about how we tackle that problem, because at the moment we are not in that place.

Lord Warner: Do you think that your position as the Health Secretary for the NHS and the policy on social care but not, so to speak, the handler of the budget for social care, is an impediment to integration?

Jeremy Hunt: I do not particularly, because it is not as if there are big disagreements inside government. The issue is that we are constrained by our economic context, but we are very aware of the pressures. One of the things it is worth pointing out is that the pressures on the NHS which you have talked about vary a lot. You have places like Torbay, Peterborough, Rutland and Newcastle, where there are virtually no delayed transfers of care in hospital. The latest figure I saw was that half of all delayed transfers of care are in 20 local authority areas, so there is quite a lot of variation. As a short-term measure, we need to focus hard on the areas where there are problems and see what we can do to sort them out. I still think there is a longer-term problem. We need to get into the habit of saving more when we are younger in the way we do for pensions.

Lord Warner: Is Dilnot critical? Is implementing Part 2 of the Care Act a critical part of your longer-term agenda, capping those catastrophic costs?

Jeremy Hunt: I think Dilnot is one part of it. I am not sure it is the whole solution. We have found it difficult to persuade insurance companies to come out with insurance products, as we had hoped would happen, to cover the £72,000 that people might be liable for. One of the complexities in this area, as you will be very familiar with, is the fact that it is a sort of Russian roulette as to who has to pay care costs. One in four of us will pay more than £100,000 but a lot of us will pay absolutely nothing. In that context, it is quite hard to persuade people that they need to put aside money when they are younger.

Lord Warner: I should have declared my interest as a member of the Dilnot commission. I apologise, Chairman.

The Chairman: If I pursue the question that I think Lord Warner asked, and that you have partly answered, do you think we need a greater public debate about individuals' responsibility for planning for their social care? If we are going to do that, what funding model do we present to them? Lord Warner referred to other models, such as Japan and Germany, where people who are richer but do not pay any taxes such as insurance tax, national insurance, could begin to pay for their social care.

Jeremy Hunt: We need to have that debate but this is about long-term incentives in the system, which was the debate that we had in the 1940s and 1950s around pension savings, which in the end gave us a pretty robust pension system, but we also need to recognise that there are short-term pressures in the social care system that will need to be addressed before those longer-term changes kick in.

The Chairman: If the Government were to come out tomorrow or the day after and announce some short-term fix for the current problems for social care, would that not be an opportunity to say, "But at the same time we now need to have a dialogue about the longer term" and engage the public?

Jeremy Hunt: Yes, I think we need to have that debate. It is always easier to address short-term problems if you are also thinking about the long-term issues as well. The name of the game is to find a way of getting people in their 20s and 30s to think it is part of being a citizen to think about what will happen when you are much older in a more realistic way than is currently happening.

The Chairman: The Japanese system is that you do not start paying towards a social care tax till you are 45, and you pay for the rest of your life, if you are earning money, so it is not the younger but the older people.

Q304 **Lord Lipsey:** The reason you have given, as I understand it, is you had to put healthcare up because you had given a commitment and therefore social care was left behind, but is it really true that there was not money available that could have been put in the direction of social care? To give two examples, you have adopted the extremely expensive triple lock on pensions; some of that money could have gone into social care. To give another example, in the summer you put up the nursing care allowance, which is paid only to better off people in nursing care, by £190 million, and that would have come in very handy for better social care at the moment. Is it really a shortage of money or is it that you are not giving priority to social care?

Jeremy Hunt: I do not want to pretend that there are not pressures in the social care system. I am alive to those every day. The triple lock was a manifesto commitment made by David Cameron in 2010 because he felt very strongly that, when we were going into a recession, we had a big financial crisis, he did not want people who were not able to boost their earnings through work to suffer, so he thought it was right to protect pensioners as we went through that very difficult period. That is

why he made that commitment for two elections in a row, and we believe it is important to honour those promises, otherwise you destroy trust in the political system.

The broader point is that a promise you make on the triple lock and on the NHS has implications for the departments that are not protected. That does not only include the social care system; it also includes the police, the education department, the armed forces, and they have to bear a bigger share. My hope is that if the economy continues to grow, we can move away from this business of having certain departments that are ring-fenced and certain departments that are not, because we can be confident that we will be able to increase the budgets of all government departments. That has not been the case for the last two elections.

Lord Ribeiro: You slightly hesitated when you talked about the funding of the health service through taxation. Part of the evidence we have heard today was discussion around the use of national insurance. One of the problems about social care is how you encourage, as you have said, people over the age of 40 to invest in their future. Frank Field has come up with this proposal of looking at national insurance as a vehicle for doing this. Do you want to comment on that?

Jeremy Hunt: Frank always has interesting ideas but essentially, as I understand it, he is not talking about a new funding model; he is talking about ring-fencing an existing tax, which I do not think addresses the longer-term issue. I am a supporter of our current system. Lots of people say, "What about an insurance-based system?" The interesting thing is, if you look at the insurance-based systems that exist, they tend to be much worse at cost control. The NHS is very widely admired for its ability to control costs. An MRI scan costs three times more in America than it does in England, despite having the same machine and the same operators, because when insurance companies are paying the costs, no one has a motive to keep costs down, but with a single payer system you can. That is one advantage.

Another advantage, which might sound a bit surprising given the conversation we have had about lumpiness in settlements, is that taxpayer-funded systems tend to have more stable income. If you have a system funded through insurance, it tends to fluctuate a lot more when countries go into recession, but governments tend not to change health budgets too much through recessions. I am a supporter of the single payer system broadly. I think in the end the question is whether we are able to keep growing the economy as strongly as we need to be able to continue to put the extra resources in.

Q305 **Lord Bradley:** This is a very short question, for clarification on the timeframes that you are talking about. You have identified a short-term problem with social care funding and said that we need to move perhaps in the long term to people saving for their own care. Where do you fit the short term and the longer term together? How quickly do you think you can get to a funding position where people have saved against the short-term problems we have now? How long are you going to have to fund the

short-term problem?

Jeremy Hunt: I think there is a real commitment in the Government to address the longer-term funding issues in the social care system during this Parliament. I do not think we are saying that we want to wait until post-Brexit or until another Parliament. We recognise that this is a really serious issue that needs to be looked at sooner rather than later.

Lord Bradley: How long would that have to flow through for before you get an alternative in place?

Jeremy Hunt: The reality is that putting in place longer-term incentives so that people save more for their social care costs will not make a material difference for decades, but it is still the right thing to do, and that is why we still have the short-term pressures that we have to manage because we want to make sure people are treated with dignity and respect.

The Chairman: Am I hearing correctly that you are suggesting that in the short term the Government would have to deal with the short-term crisis in social care, but at the same time the Government intend in this Parliament to bring forward a proposal for a long-term solution for social care?

Jeremy Hunt: I would use the word "pressures" rather than "crisis" but, broadly speaking, I think that is correct. We need to find a way, through evening out the variations between different areas, pressing ahead faster with health and social care integration, doing what we can to relieve the pressure being felt everywhere, but I also think this is a time when we need to put in place a long-term settlement for the social care system, absolutely.

Q306 **Lord Turnberg:** I wonder if could pursue Lord Ribeiro's question a little further. Your suggestion is that people should begin to pay for an insurance system themselves, put away something for their likely care needs in the future, but what about a hypothecated tax, using the national insurance model, which incorporates the idea that as people age, they put in as much as they can according to their earnings? We know that people earn more in the last 20 or 30 years of employment, and we also know that people in retirement often have quite an income, which could be incorporated into that. Instead of making it more a voluntary thing for them to put away money, this is in the system and could be used for health, and particularly for social care. Do you not think this is a reasonable way forward?

Jeremy Hunt: I suppose the difficulty I have is that we are collecting and spending the money that is used for national insurance at the moment.

Lord Turnberg: But not necessarily for the NHS.

Jeremy Hunt: No. If you were to give all that money to the NHS and social care system, you would have to take the money away from somewhere else or you would have to put up taxes overall.

Lord Turnberg: The putting up of taxes to groups that no longer pay national insurance is what is being suggested by this method.

Jeremy Hunt: I think the judgment, which is obviously not my responsibility, about tax rises—I say this in a completely non-party political way—is what is consistent with a strong and growing economy. All tax rises take spending power out of the economy. One of the reasons why you have the challenge about the need, which was shared across all parties, to make spending cuts in both 2010 and 2015 was the recognition that we needed to allow consumption to take off and allow the economy to grow. That is the difficult territory you get into. If you are effectively arguing for a tax rise so that more money goes into the health and social care system, I think the Chancellor would say that his judgment is that, for the economy to be strong, the current fiscal envelope is the right one.

Q307 **Baroness Blackstone:** I do not think that is economically terribly literate, in the sense that older people spend much less of their income than younger people, because they have bought their house, their furniture, they have their small car that they keep for a long time, et cetera. Asking them to make a larger contribution to something that is hypothecated, where they can see the link between the extra amount of money they are paying and improved healthcare when they get dementia, or improved social care when they become very frail, they would find easier to understand than making an overall tax rise which would also affect many younger people, who have greater spending needs than those in the category that Lord Turnberg is talking about. I know this is not entirely your responsibility but I feel your response did not make much sense on what we know about people's spending behaviour.

Jeremy Hunt: With respect, I think you would find a lot of older people who would disagree with that, and who would say they spend a very high proportion of their income. A lot of older people are extremely poor.

Baroness Blackstone: Of course, but there are a lot of younger people who are even poorer and they have children.

Jeremy Hunt: We have to be careful here, because family budgets are very tight for people at all ages, and particularly now. I am not sure that well-heeled retired people in the Home Counties are particularly representative of older people across the country.

My broader point is a very straightforward one, which is that the level of tax an economy takes is directly related to economic growth and to consumption more broadly. The old people I know are great spenders of money. They do not secrete it away. I do not think there is a cost-free tax rise, if that is what your argument is. I think the judgment made in

2010 about the level of tax and spending to allow the economy to grow was the right judgment, and I think it is very important that we continue to set the levels of tax and spending at a rate that will allow the economy to go from strength to strength.

The proof of this argument is that by the end of the last Parliament we were able to make a big commitment of extra resource to the NHS on the back of a growing economy. In the end, the win-win here is to make the judgment that is right for the optimal level of economic growth. In the end, once you get that right, you can have all sorts of discussions about getting extra funding into the NHS and social care system.

Lord Warner: Can I go back and challenge you a little bit on this? There was a proposition that if we allowed people to pay more for their social care after they have died, you take no spending money out of the economy at that point. You milk an asset. Your party—I am not being party political but it is an unavoidable fact—

Jeremy Hunt: None of us is today.

Lord Warner: It is a historical fact that your party ran against that, and a deferred payment scheme was an integral part of the Dilnot commission. That has disappeared. That does not take spending power out of the economy at all. Is this pure politics, that we did not like to appeal to the *Daily Mail* or the *Daily Telegraph*, or is that still an option, that you could pump money into social care? There is a lag, it is not immediate, but you start to get more money coming into the social care system post-death.

Jeremy Hunt: I think that is a slightly unfair description of history, if I may say.

Lord Warner: I did live through it.

Jeremy Hunt: There was indeed a lot of politics around the 2010 election on that issue but, if you look at what happened in the last Parliament, the Government accepted Dilnot, introduced Dilnot, we are going ahead with Dilnot, but we have also legislated now for the deferred payment scheme, so that no one has to sell their house if they need to pay for residential care costs, and it is exactly the model that you are talking about; it becomes a charge on their assets after they have died. I think there is indeed merit in that approach and that is why we are doing it.

Q308 **Lord Willis of Knaresborough:** I was struck by your difference between long term and short term. Your short term for social care has now been described in decades, so I think you will need a long-term plan for the short term before it comes to pass.

I wonder if I could move on to the issue of workforce, which you were discussing with Lord Warner earlier. Nobody on this Committee, and I am sure you, would disagree that there has been a real failure in long-term workforce planning. All political parties are culpable in that sense. I want

to ask you, looking ahead to 2025, 2030, are you confident that you will have the right policies in place to have the right capacity, but principally to also have the right capabilities? I declare an interest as the author of *Shape of Caring* but it seems to me that it is not just a shortage of personnel at the moment; it is the fact that many of them do not have the right skills to perform what is required in both health and social care. On capacity and skill mix, assure the Committee you have got it right.

Jeremy Hunt: Thank you. You are absolutely right; this is not an area where any government have covered themselves in glory. We cannot wait until 2025, 2030 to get these policies and frameworks in place because of the time it takes to train people, so I completely agree with your point that we have to be strategic, and that means understanding what the skill mix will be for a very different population. I think that is absolutely right.

The interesting thing that has changed in this is Brexit—which I did not support; I was a "remainer". Brexit is happening, and I think that is prompting a very welcome and overdue strategic look at workforce requirements. It was Brexit that prompted me to look at the number of doctors that we were training, and we are currently training in England about 6,500 doctors a year. We need 8,000 doctors a year, but we have for many years been counting on being able to import doctors from other countries to fill the gap. Those international, overseas-trained doctors make a wonderful contribution to the NHS but I question whether that is sustainable given that the WHO say there is a shortage of, I think, 2 million doctors now across the world. We need to train as many doctors as we need; that is the truth of it.

That is one area, at the high end, the most well paid end, but Brexit also makes you ask about unskilled labour, particularly people in the social care workforce. We have 67,000 EU workers in the social care workforce, with no clinical qualifications, performing an absolutely essential job. If you go into a care home in London and the south-east they do a brilliant job and we would fall over without them, but you have to ask yourself why it is that so many British people do not want to do those jobs. My own view is that we need to create a career structure, so that if you are working in direct care in a care home, that can be a stepping stone to the next stage. That is why I announced last month that we are creating a pathway for people to move from direct care to nursing without going to university, so that people can work in a care home, perhaps do some rotations and evening study, get a degree, but they would not have to take time off for full-time study in a university.

What we need to do is make sure that in every part of the NHS there is real career progression as an absolutely vital priority.

Lord Willis of Knaresborough: If you take nursing, which I am obviously more familiar with, we have by legislation to train people in four particular brands, so that unless you do mental health nursing, the rest of the workforce are trained with scant evidence in mental health, yet it is now all-party policy to have integrated mental and physical

health. We have to radically change the way we train people, what we offer them as a curriculum. Are you confident that you will be able to help drive those reforms through and take people with you? If you do not take the current workforce with you, we will be no better off, because half of them will be here in 2025, 2030.

Jeremy Hunt: We have commissioned the Centre for Workforce Intelligence to do some work on the shape of the workforce in 2035 and what we would need to do to make sure we can access those skills. I basically agree with you; it is something we have to do, and we have to do it a lot better. There are a number of roles such as physician associates and nursing associates which in other countries work extremely well. Physician associates leverage the time of doctors very effectively. They also create a way into medicine for people who do not have a degree or a medical degree. There is a lot we can do, and people want to work in health and social care.

Lord Ribeiro: We have heard evidence that there are quite severe staff shortages in the health and social care area, and your announcement of 1,500 new medical students is very welcome, although we know it takes 10 years before any of them will hit the ground running and we know that there will be a shortage of about 10,000 GPs by 2020. The Francis report highlighted issues around nursing numbers, and we have problems and issues over agency nurses as a consequence of that—very good-quality care but it comes at a cost. There is also the issue around GPs aged over 55 and retention, keeping the workforce.

While we do not enjoy a Soviet-style system where we can direct our labour, the problem we have is that doctors have a choice; they can choose what field to train in and where to go, and they may not necessarily follow a pathway that the public needs. How will we deal with all this? How can we unscramble this and get a flexible workforce that is able to deliver in 2030 or whenever?

Jeremy Hunt: I have discovered over four years of doing this job that, despite the appearance of Stalinist command and control in the NHS, in practice the Health Secretary has very little command and control at all. I think you are absolutely right, particularly with respect to doctors. It is very clear that we will need to train a lot more generalists. We are very lucky to have our traditional general practitioners in this country. They are perfectly positioned to look after growing numbers of older people who we want to keep healthy and happy at home. In fact, internationally people look at the NHS and say we have a huge strategic advantage because of our tradition of general practice. That is why, as part of our funding commitment to the NHS, we have said that we will increase the funding going to general practice by 14% in real terms, which is £2.4 billion a year by the end of the Parliament, which is a very significant increase, and we are aiming for around 5,000 more doctors working in general practice, which will be the biggest net increase in GPs in the NHS's history.

But you are right; it is not what we plan for. Part of this will also be talking to medical colleges and schools. To deliver that, we need around half of doctors to want to go into general practice when they graduate. We are not doing too badly. There is a lot of interest in that but that is something we have to bang the drum for. I think it will be the most exciting area of change. If we are talking about an integrated health and social care system, a GP will be an absolutely critical player in that. I agree with you. A very big thing that we have to do is persuade people that that is the most exciting area of the NHS to go into.

Lord Ribeiro: Is it important too to have in that mix the primary and acute care service that the *Five Year Forward View* suggested? Where you have an urban situation, for example, where general practices are not up to scratch, you provide the opportunity for a hospital that can deliver that care with general practice. In other words, we do not want one system, one size fits all. Is that part of your thinking?

Jeremy Hunt: Very much so. It is partly an urban/rural thing but it is also sometimes, frankly, where you have the best leaders. In Salford Royal you have an inspiring leader, Sir David Dalton, who has not only created one of the safest hospitals in the NHS but he has taken over all but one of the GP practices in Salford and is setting up a fully integrated health and social care system, with shared electronic health records. What he has done there is extraordinary. If you were going to transform the NHS in Salford, you would not want to back anyone other than Sir David; he is the right person to do that, but there are other parts of the country where you have brilliant local authority leaders. In Birmingham they have very enterprising GP groups. The NHS England plan is to essentially back the people showing the strongest leadership skills, and to recognise that there are parts of the country where that will be acute-led, and others where it will be primary care-led.

Q309 **The Chairman:** In one of the evidence sessions with the professionals and the regulators, particularly for doctors, we tried to pressurise them into agreeing about the need for more generalists and to have a generalist trained much faster. So far they have not been tempted to go down that path; it is always 10 years or 12 years, where other countries train them in three years. How are we going to make them reverse this issue?

Jeremy Hunt: I am afraid I need to plead clinical ignorance on that, because it is quite difficult for me, as a non-doctor, to make a judgment. I would want to talk to people like Bruce Keogh to ask whether that is possible.

The Chairman: Quite a few doctors around this table would be signed up to that proposal.

Jeremy Hunt: My experience of the doctors and the Royal Colleges I work with is that there is a lot more flexibility on those issues than there was even five years ago. If you had tried to introduce physician associates five or 10 years ago, you would have had headlines about

doctors on the cheap. The same thing with nursing associates. Now they are widely welcomed, and what is changing is that people on the front line realise there is so much pressure that none of these schemes is about replacing them but about supporting them to do their work better. These are the kinds of discussions we definitely should be having.

Baroness Blackstone: Picking up the point you made about supporting them to do their job better, coming back to GPs, we are told a lot of GPs are very demoralised. I wonder whether it is because they do not get enough professional support, and they are asked to do too wide a range of things, some of which are below their pay level, where their extensive training is not needed to do what they do, and other things are rather difficult for them, including some of the decisions they have to make on commissioning and so on, for which they have not had any training. I wonder whether we should not look at a primary care workforce which is more thought through, so that each general practitioner would be working with a mental health counsellor, a community pharmacist, nurses who do inoculations, so that some of this work—they have been trained to do more than these sort of things—is done by people with the right training. I do not think we have thought enough about how that skills mix should work.

The other small point is on training, and I agree with the doctors around the table: for somebody who has been in higher education, the length of training seems exceedingly long. The small point I have a chip on my shoulder about is that, if you are a graduate and you decide to do medicine, most of them are forced to start all over again and do a five-year, first-stage training—it is utterly absurd—including graduates with degrees in biochemistry, masters degrees, and sometimes even PhDs. Something is wrong and needs to be looked at, and it can only be dealt with by somebody in your position, who can try to shake it up and get people to think about this.

Jeremy Hunt: I think that is a very fair point. There is a lot of inflexibility. I think it is beginning to change. There is also a lot of inflexibility if a junior doctor wants to change specialty. We make it very difficult for them to do that. We shoot ourselves in the foot, because then they decide they want to become a locum.

With respect to GPs, what you are talking about is exactly what the strategy is. That is what the GP Forward View talks about. It has been widely welcomed by the Royal College of GPs, the BMA, and all the industry leaders. I think it is very striking. If you look at some of the most forward-thinking American healthcare organisations, such as like Kaiser Permanente or Group Health, and how they do primary care, it is a completely different model. We have one size fits all at the moment in general practice in most places, with 10-minute slots for appointments, and GPs absolutely exhausted after seeing 30 to 40 people in one day. What they need with their more complex patients is to spend 30 minutes, 45 minutes, getting to the bottom of all the issues that a patient is grappling with.

What happens in those different models of care is that, when a patient arrives, they will be seen, typically, first by a nurse, who will look at all their long-term conditions, go through their notes, check they are completely up to date, and would only page a doctor when that initial assessment is complete; that nurse can have a fairly brief conversation with a doctor, who can make the critical clinical judgments on the basis of all the evidence that has been gathered by the nurse who does that.

A lot of those organisations have medical assistants who go round with the doctor everywhere. These are often people without degrees, the equivalent of A-level students. They fill in all the medical notes, and take the admin work from the physician, as they call them there. The people who organise that system say the biggest single benefit is the elimination of GP burn-out; people go home happy, feeling they have spent the day using the skills they have. I think we strongly want to encourage this. I went on that trip with the then President of the Royal College of GPs, and since then she has been a very strong supporter of that kind of change in approach.

Lord Warner: We had evidence from the GMC that what is holding a lot of this up is the inability to make the regulatory system adaptable enough to approve, in the interests of public safety, the physician assistant, and the nurses were saying some of the same things. That is totally within the Government's control, to adapt this 1983 regulatory system, which really rather controls the GMC about how they can do their job. What are the Government's plans for accelerating that reform?

Jeremy Hunt: We have committed to introduce legislation for regulatory reform. It is a question of finding a parliamentary slot. I agree with that but I also think there are lots of things you can do without changing the regulations, and we should get on and do those as well.

Q310 **Lord McColl of Dulwich:** Secretary of State, preventive medicine: you mentioned life expectancy improving. In the States it has started to fall, and it will be falling here too, because of the obesity epidemic. Of course, as you know, it is increasing vastly the number of diabetics, people with dementia, people needing joint replacements, and so on. This arose because of false advice by unscrupulous scientists, and NICE, and the Department of Health, who kept saying all the calories we eat go on exercise, which was not true. Mrs Thatcher used to say, "Don't bring me problems, bring me solutions". What do you think about this solution: that this Committee suggest that we have an all-out campaign throughout the country, involving everyone, informing them of the facts about obesity—not telling them what to eat but at least telling them what the scientific facts are? What would you say to that?

Jeremy Hunt: I think it would be an excellent idea. We have looked very hard at the scientific evidence, and there has been research done by people such as McKinsey as to what policy interventions make the biggest difference. I agree with you that obesity is rapidly overtaking smoking as the biggest public health threat. There is a big issue about equity as well, because it affects poorer people much more than it affects wealthier

people, I think essentially because a lot of the cheaper food that you can buy in supermarkets is less healthy. It would be an excellent idea to do that.

Lord McColl of Dulwich: Even if we suggested that poor people ate less of the wrong food, it would still be better than what they are doing at the moment.

Jeremy Hunt: I think everyone needs to be equipped with the knowledge as to what it is healthier to eat. I think that is very important.

Lord Bradley: The *Five Year Forward View* makes it clear that a significant investment in mental health is crucial if we are going to have long-term sustainability in the National Health Service, however you define sustainability, particularly own intervention and preventive work. What is your assessment of the progress that has been made to deliver on the commitment to parity of esteem between physical and mental health, and the integration of physical and mental health that you mentioned earlier?

Jeremy Hunt: I think we are making good progress but there is a long way to go. When you have an ambition such as parity of esteem, you are being dishonest if you say this is something you will achieve overnight. At the start of the Parliament we asked Paul Farmer, the chief executive of Mind, to come up independently with a plan that he thought would be good progress towards parity of esteem over this Parliament. He came up with the mental health Forward View, which involves treating 1 million more people every year for mental health conditions than we are currently treating, a transformation of CAMHS, a transformation of our suicide strategy, and a huge number of extra people going through talking therapies. We have committed to that, and we are going to fund it. I think we are broadly on track with our objectives in meeting the commitments we made to do that.

That is not to say there are not lots of things we should be doing now that we are not. We continue to do our best.

Lord Bradley: What would be your estimate—difficult question—of when we might get to parity of esteem? How are you defining it?

Jeremy Hunt: He says in that report that he thinks it will be a 10-year process to get to parity of esteem. He is more knowledgeable than I am about these matters, but I would hope by the end of the next Parliament we would not be having these discussions. I think there are some early encouraging signs, incidentally. If you look at the proportion of CCG budgets spent on mental health, last year it was 12.5%, now it is 13.1%, and even in the last two years, around £1 billion more is projected to be spent on mental health this year compared to a couple of years ago, so I think people are putting their money where their mouth is.

Lord Bradley: But on that percentage increase, it would take somewhat longer than 10 years to get to parity of esteem.

Jeremy Hunt: I do not think parity of esteem is about 50% of funding going to mental health. Parity of esteem is about people's mental health not being the poor relation, and always getting the priority it deserves alongside all the physical illnesses.

Baroness Blackstone: Because local authorities have been under the cosh and had their budgets cut quite extensively in recent years, I wonder what assessment your department has made about its impact on public health. Public health expenditure has certainly gone down. You were very bullish earlier about our performance in some international league tables as far as public health is concerned, I think. It is news to most of us probably that Andorra, Sweden and Iceland are the only ones who are ahead of us.

Jeremy Hunt: And Singapore.

Baroness Blackstone: That is one part of public health. Obesity is also a public health issue, and I think we are the second worst in the world after the US there, so clearly there is a need to spend money on public health. If you back what Lord McColl was saying about a national campaign for people to understand much better what causes their obesity and what the consequences of their obesity will be, we cannot sit in a situation with public health budgets being cut any longer, can we?

Jeremy Hunt: I am afraid I do not accept that a public health budget being cut automatically means that we are unable to make progress on the big public health issues of the day. There are some efficiencies that can be made, but there are some big things that you do in public health that happened under the last Labour Government, such as banning of smoking in public places, that have a huge impact on public health which are not about expenditure.

In the case of obesity, Duncan Selbie, the head of Public Health England, which every now and then issues reports that are quite critical of the Government, says he does not know of a country with a more ambitious obesity strategy than we have. If you look at the evidence base on obesity, the single biggest impact that you can have on obesity is getting manufacturers to reformulate their products, so that the amount of sugar in a frozen pizza, for example, comes down. If you can do that in a clever way, people do not notice the change, just as we have done very successfully in reducing salt in the products that we all buy. We have a plan aimed at reducing the amount of sugar in food consumed by children by 20% over the next four years. That is a very significant ambition, and we have said we are taking nothing off the table if we do not make progress towards that goal, and Theresa May has said the obesity strategy is a first step. We will go further. We also have the sugary drinks tax, which again is a pioneering thing, which will see a huge amount of extra resources going into school sport.

I think we are doing a number of things. I recognise the fact that a number of campaigners would have liked us to have gone further, but I

think there are a number of things happening which we need to see through.

Baroness Blackstone: Is your assessment of the cuts in public health one where you are quite phlegmatic because all these other things you mention do not cost that much money?

Jeremy Hunt: No. I think it varies from council to council. I am very concerned when I hear stories about sexual health services and addiction services being cut, because local authorities have a statutory responsibility to provide those services and that should not happen. I think sometimes, in fairness, the issue with those addiction services is the same issue we have in other parts of the NHS, that, frankly, services are not joined up. If you talk to nurses in addiction services, they say it is very frustrating because there will be an NHS nurse commissioned by the local authority, but to solve the problem of someone who is a drug addict they need to talk to the housing department to sort out their accommodation, or they might need to talk to the local Jobcentre to sort out getting someone a job. What we need is a much more joined-up approach to some of our most vulnerable people.

Q311 **Lord Kakkar:** Secretary of State, I should at the outset declare my interest as chairman of UCL Partners, which hosts the national Innovation Accelerator. Can I pursue the question of how important you think it is that there is uptake of innovation and technology at scale and pace across the NHS to secure its longer-term sustainability, and how that might be achieved, particularly a fully digitally matured NHS at a time of some financial constraint, and how in that context there will be a strategy to fully optimise the use of patient data to drive an NHS and health informatics strategy?

Jeremy Hunt: It is a really important question, and I think the short answer is this is an area in which we have been behind but we are hoping to leapfrog the rest of the world due to a very remarkable thing that our GPs did about 10 years ago. They decided to ignore the Government's plans for a national IT programme in the NHS and exercise their right to go their own way. The government programme collapsed, but they set up fantastic electronic health records, some of the best primary health records anywhere in the world, where the software is done by two British suppliers. Amazingly, without anyone murmuring about this, without any request for funding from the government, they have digitised people's lifetime records, going right back to the pre-internet era, and we have complete medical histories we are now able to use. What we do not do at the moment, but it is starting to happen, is allow those records to flow around the NHS, but we have complete histories of people, which is a fantastic asset. If you are trying to set up electronic health records in America, you simply do not have that asset to use, because they have very good electronic hospital records but those are episodic records, not people's lifetime records.

Now we have around two-thirds of A&E departments able to access people's GP medical records, and next year we will go a step further and

introduce what we are calling the Blue Button scheme. At the moment you can access your own record if you go to your GP surgery and get a code, so you can go online and access your record, but from next year we will have a system where you can go online and identify yourself online without having to go to your GP surgery. That will be very significant, because people will be able to download their record on their phone. People with long-term conditions will be able to get engaged in their own treatment. What it will mean is, for example, if you call 111, we will have the 111 app and ask you questions electronically. It will be able to quiz your medical records, so if you are a diabetic, it will ask you questions about your diabetes. This means that if you need to talk to a doctor, the doctor will be a lot further down the road in understanding your situation than is currently the case. It will save a lot of time.

In short, I think there are some very exciting things happening.

Lord Kakkar: Do you think that we pay sufficient attention to that area and that we are making sufficient progress, with regard to this Committee's question about long-term sustainability, the consensus view that innovation and technology will play a vital role; that that part, in addition to finance, workforce and so on, is being properly addressed and planned for?

Jeremy Hunt: I am confident that it is being properly addressed and planned for, and I was very careful to secure the funding necessary for that in the spending review a year ago. I have made big, bold statements about it. I perhaps rather bravely said I wanted the NHS to be paperless by 2018 in my first few months as Health Secretary, and I am quite relieved that most people seem to have forgotten that I made that promise.

The Chairman: To remind you, it is now on record.

Jeremy Hunt: I think we are making good progress. There is definitely lots to do. We are weak at the moment on hospital IT systems. Professor Bob Wachter of the University of California, San Francisco, came over and looked at the state of hospital IT systems, and has given us some very good advice. He does not think 2018 will be possible, it will not surprise you to hear, but he has given us some very good advice about how we can get our hospitals to world-class levels over the course of the next five years.

Lord Kakkar: Going to the conclusions of this Committee, would it be fair to say that you would share a view that, if there were a failure to optimise on these different domains, whether it be health informatics, the adoption of innovation or digitisation of the NHS and the health record, the longer-term sustainability of the NHS may be jeopardised?

Jeremy Hunt: Absolutely. I think this is a completely necessary condition to get this right.

Q312 **Lord Scriven:** I have been listening very carefully and quietly to what

you have been saying throughout your presentation to the Committee. On future trends, what is happening, human behaviour and how this is adapted into the NHS, the NHS is being particularly slow at adapting disruptive technology, for example, which will change significantly not just the way in which healthcare is provided but health itself potentially in the future. What is happening regarding a systematic approach to the use, planning and policy changes that will be needed in the uptake of this kind of adaptive and disruptive technology and how it is implemented into the NHS? It is not just about the planning; the NHS falls down quite a lot in the implementation of some of this.

Jeremy Hunt: I think it is a very fair criticism. If you look at innovative new medicines, our uptake is far too slow. That is partly because we have a national system, which is respected across the world, the NICE system, but it is also quite clunky. We do not have the nimbleness that we need and we are looking very closely at what we could do to deal with that.

Lord Scriven: Could I push you there? What are you looking at in making it more nimble?

Jeremy Hunt: The essential problem with the system that we have at the moment is that, when you have a new drug that NICE says is good value and therefore should be adopted by the NHS, that creates a financial problem for NHS England and for me—that is inevitable—but we do not allow a situation where a willing buyer and a willing seller can come to a commercial agreement about the price at which that drug is distributed in the NHS. We make that impossible with the NICE system. Many of these pharmaceutical companies would give us huge discounts, well below the NICE price, to get their drug taken up across the NHS, but our system does not allow that to happen. That is obviously greatly to the disadvantage of NHS patients.

More broadly, we do not have financial structures that incentivise smart decisions. One of the things that the CCGs are in the process of doing, and through them the STPs, is for the first time tracking the total cost of each of their patients. That is really important, because if you have a piece of disruptive technology that can help a diabetic improve adherence to their regime, you would be able to say to a CCG, "If you spend £100 on this little machine, you will reduce the annual cost of your diabetics from £5,400 to £4,200", and it is a no-brainer for them to buy one of these devices for every single diabetic. Because they do not have that data at the moment, which we are in the process of sorting that out, they look at that device and say, "That is £100. That is going to cost me money. I do not want to spend money on that because I am already overspent." That is what we need to change.

Lord Scriven: Could I ask one more question? Clearly, the NHS is a very large organisation, and you are talking about devolution and working more locally. Disruptive technology tends to be more—not big bang but small issues, and there is an issue about culture and access into the NHS for disruptive technology. Is any work being done on how you access and use generic disruptive technology and implement it in an NHS-type

approach?

Jeremy Hunt: There is a lot of thinking going on about this, but the conclusion we have come to, or at least that I personally have come to, is that, when it comes to disruptive technology, the old model which says you have a single payer, who is the Health Secretary, and he or she decides the best technology for people with dementia living at home, and then we adopt it and roll it out across the whole system, is too slow and clunky. This is a very big system, and we need to free up the CCGs to purchase innovatively and to experiment. I think that would be a quicker way to get new technologies adapted than if we rely on national bodies to do all these processes. National bodies can assess for safety and value for money, but I think we need to free people locally to experiment more.

Lord Willis of Knaresborough: I was struck last week when we had Baroness Cavendish in front of us looking at the speed of roll-out of new technologies. For instance, I was in St Mary's hospital last week looking at their patient record system. It is totally paperless, automated, and is now in something like 200 hospitals across Britain. Unless you have a system whereby those who are slower to adopt can be encouraged to adopt a proven technology which is working, you will not get the fast roll-out.

The other critical part is it being able to talk to GP systems. One of the problems with GP systems—and you are right that they have moved ahead at pace—is that quite often they are on disparate systems. They have now started to change all that. I wonder if you have that bit in hand as well to drive things, as well as waiting for brilliant ideas to come up from the ground.

Jeremy Hunt: I think the second more than the first. On the second I am very confident; we have been thinking very hard the whole time I have been Health Secretary about how to get GP records to flow freely around the system. That is really happening now. They are certainly flowing as far as the A&E department, but they are not yet flowing inside the rest of the hospital. I think that is well under way, and is pretty impressive by international standards.

The business of getting hospitals with good IT systems to help those with less good IT systems is slower, because we have some reasonable it systems in this country but, according to Professor Wachter, we do not have any that are world-class anywhere. That is his view. He comes from the University of California in San Francisco, where they have 300 robots going around the hospital delivering medicines from one side to the other, so he has high standards. We have found when we have put trusts into special measures the quickest, lowest hassle way to improve an ICT system is for it to be taken over by a hospital which has a good IT system, and they do not have to do any procurement and just roll out a better system. That has happened very successfully in one or two places.

I think we have a long way to go when it comes to hospital IT systems.

Q313 **Baroness Blackstone:** You were admirably clear at the beginning about the need for much more long-term strategic thinking in the health service, yet all the evidence we have had is that there is not very much of it going on. We were particularly disappointed in what your officials had to say about this, where there seemed to be very little going on in the department post-2020. I wonder what you are going to do to close this gap. It seems to be particularly lacking anywhere in central government.

The other thing you said was that you recognised that economic growth is absolutely central to being able to spend more money on the health service, and nobody would disagree with that. You said that Brexit could be a problem but that so far the economy was doing pretty well post-Brexit. That is very short-term. All the economists are saying that in the long term the economy will be hit very hard by Brexit. That seems to me yet another reason why you might want some modelling to be done on what will happen as far as the pressures on health service expenditure are concerned if we are going to go into a period of very low, or, indeed, no economic growth, or even a recession post-Brexit. Could you tell us a bit about what ought to be done in this area?

Jeremy Hunt: I think the picture you paint of the strategic thinking that has been going on is not entirely fair. I do not think any of us predicted Brexit, which obviously creates all sorts of uncertainty as far as the future is concerned, but the Government are absolutely committed to making a success of it, and I believe we will.

Of the things that you talked about, I would say that workforce planning is an area where we have failed, and successive governments have failed to get this right. Brexit will be a catalyst to get this right, because we are going to be standing on our own two feet and we will have to start thinking much harder without the automatic access to the European labour pool that we have taken for granted for many years. That is an area where we need to be much more strategic than we have been. Being able to announce 1,500 medical places is only a start, but that was four months after the Brexit vote. I think that shows there is a serious effort going into being more strategic in our workforce planning, but there is lots more to do, as Lord Willis correctly says.

When it comes to funding, my own view is that the current model, as I said earlier, is sustainable, providing the economy keeps growing. I think the record of the Government over the last six years is that we have been taking strategic long-term decisions for the growth of the economy. We now have to go back over those decisions in a post-Brexit environment, but I do not believe the fundamental principles of the NHS that we all hold dear should be or ever will be compromised by Brexit or the changing economic situation. I think it should give us even more impetus to make sure we get the economy right, and that we are able to carry on increasing funding for the NHS, and indeed, in the decades ahead, increasing the proportion of GDP that goes into health and social care.

On strategic change, you have spoken to Simon Stevens today. You have not talked about it much with me, but he has been responsible for a hugely important strategic change in his time as chief executive of NHS England, which is essentially moving the whole NHS to an accountable care organisation model. He could not really start that process until he had his funding settlement, which was last year, and there is a process now of engaging the NHS. You have the 44 STP areas, with some places going better than others, but that is a very big and important strategic change, and I do not believe he could have gone much more quickly than he has in making that happen.

The only other thing, which we have not talked about very much today but I want to mention, is quality and safety. One of the things I have put most effort into is transparency about quality, with the new CQC inspection regime, but also transparency on mental health, diabetes, dementia, cancer and so on. We are by far the most transparent system in the world in quality and safety. Why is that? Because I think our simple objective is that NHS care should be the safest and best in the world, and the starting point for that is to know how good you are. That means being honest about the hospitals in difficulty and the ones doing brilliantly well, and doing something about the ones in difficulty.

This is the last thing I will say on this. I think it is important to say it, because there is not enough credit given to the NHS for how brave it has been. This autumn the CQC finished its round of inspections of major hospitals and has published its State of Care report. It has said that 54% of hospitals are good or outstanding. We had the usual media stories: nearly half our hospitals are not good; another "woe is me" day for the NHS. That was an extraordinary day for the NHS. We are the only healthcare system in the world that can say that 56% of our hospitals are good or outstanding, which ones are not, and what we are doing about the ones that are not. That is a very important journey to go on in becoming the safest and highest quality, which is what we all want.

The Chairman: Secretary of State, despite enthusiasm for more, I am having to call it a day because I promised you we would let you go. Thank you very much for coming today to help us. We appreciate it very much. In return, we will through our report try to help you identify issues that will make the NHS and social care sustainable in the long term, and I hope you will pay it as much cognisance as we have done in listening to you today. Thank you very much for coming.