

Health Committee

Oral evidence: Brexit and health and social care, HC 640

Tuesday 24 January 2017

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Members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Dr James Davies; Andrew Selous; Maggie Throup; Helen Whately; Dr Philippa Whitford.

Questions 1 - 129

Witnesses

I: Rt Hon Mr Jeremy Hunt MP, Secretary of State for Health, and Paul MacNaught, Director of EU, International and Prevention Programmes, Department of Health.

Written evidence from witnesses:

– [Department of Health](#)

Examination of witnesses

Witnesses: Mr Hunt and Paul MacNaught.

Q1 Chair: Welcome to this afternoon's session, where we will be focusing on the process of Brexit. Secretary of State, I am sure you need no introduction. Thank you very much for joining us this afternoon. Paul MacNaught, because you have not been to the Committee on a regular basis perhaps you would introduce yourself to those who are following from outside.

Paul MacNaught: I am Paul MacNaught from the Department of Health. I am the director of international policy and prevention programmes.

Q2 Chair: Secretary of State, could I lead off the questioning? As you are not a member of the Brexit Cabinet Committee, what are you going to do to ensure that health remains firmly on the agenda? What kind of input will you have?

Mr Hunt: First, thank you, Chair, for holding this session. As I am sure you are going to tell me, we are very much affected by Brexit; it is very important. The reason I am not on that Committee is that under article 168, section 7, of the Lisbon treaty, health is a member state competence, so I do not need to be there for all the sessions, but I am invited every time a matter directly affecting health comes up. As I am sure we will discuss this afternoon, there are a number of areas. Broadly speaking, Brexit was unexpected; a lot of people here voted against it, but as in many areas of our national life, including our economic policy, it has become a catalyst for changes, some of which are necessary because of Brexit, but a number of which probably should have happened anyway, and the process of going through Brexit is causing us to look at them again and develop better policies than, frankly, we had before.

Chair: There are many policy areas that will have profound impact on both NHS staff and those who use NHS services and services abroad. I hope that this afternoon we will cover many of those. Ben has a particular point he wants to raise.

Q3 Mr Bradshaw: You say you are invited as and when. Can you tell us how many times you have been invited or attended?

Mr Hunt: I have not attended any of the Brexit Committees, but I have attended a number of Cabinet Sub-Committees that affect or are related to Brexit and health issues, such as discussions on immigration policy and social reform. All those things are linked. Of course, I am a member of the full Cabinet, where we discuss Brexit on a regular basis. I have raised issues affecting the NHS on numerous occasions.

Q4 Mr Bradshaw: I hope you won't take this as facetious, but I hope the fact that you don't have a briefing pack is not an expression of the level



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of engagement of your Department in this huge process.

Mr Hunt: I hope you will take it as mastery of my brief more than anything else.

Q5 Mr Bradshaw: You have it all in your head. Health and the NHS generally may not be an EU competence, but environmental legislation and food safety, which are issues of huge public concern, and the implications for public health are, so I assume you are involved in all the discussions in the relevant Committees on those issues.

Mr Hunt: Absolutely. The areas of health that have an impact or are directly impacted by Brexit are public health and things like the tobacco directive; the regulation of medicines and medical devices is another area. Obviously, immigration policy, with the end of free movement of people, has a direct impact. There are a number of important areas, and as a Department we are very actively involved in them.

Q6 Mr Bradshaw: There are environmental issues that have an impact, such as air quality and food safety. Yesterday on the radio we heard a representative of the US farming industry say that one of their conditions for any kind of trade deal with the UK would be, for example, that we have to allow hormone-treated American meat, or chlorine-washed poultry, into this country. I assume that is something you would fight tooth and nail as a representative of the consumer and of public safety and health.

Mr Hunt: It is very important to understand what the Brexit change is. The Brexit change does not mean that we are going to replace one set of rules with a completely new set the moment we leave the EU. It is a repatriation of sovereignty, which means that all the decisions we make with respect to what products we allow to enter the country tariff-free from the US or anywhere else will be made by this country, and specifically this Parliament. Those are issues we cannot prejudge because we are now in the very early stages of triggering article 50. Then there will be EU trade negotiations and then negotiations with other countries. We are clear that we want the lowest possible tariffs with our main trading partners, but we also want to continue with the protections that matter to British workers, in terms of the rights they have accumulated over many years, and to British consumers, where food safety is an important issue.

Q7 Mr Bradshaw: The negotiations and your Cabinet Committee discussions are currently around a divorce, and that will be the case until we leave. We do not start to negotiate trade deals until after we leave. Do you imagine that the machinery of government after we have left, when we negotiate the all-important new trade deals and the standards you have just referred to, will be the same, or do you think you will also attend those discussions and meetings as Secretary of State for Health only as and when you may feel like it?



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Mr Hunt: Let me reassure you that I will be attending all the meetings that affect my departmental responsibilities as Secretary of State for Health, but I would not characterise the discussions that are happening in the way you have done—that one does not talk about what happens after the divorce until divorce negotiations are completed. I would not use the word “divorce.” We want a new positive relationship with Europe, but it will be different from the one we have now. As the Prime Minister said last week, we want a strong, close relationship with our friends and partners from the EU, and there will remain a number of areas where we continue to co-operate closely going forward. It would be quite wrong to say that we cannot think ahead to what that relationship is as we have the post-triggering of article 50 discussions. It is a necessary part of those discussions to envisage what our future relationship will be in all sorts of areas.

Q8 **Chair:** Can I clarify that your status when you are round the table at those meetings will be an equal one?

Mr Hunt: Correct.

Chair: We will take a short break to vote. We will reconvene shortly.

Sitting suspended for a Division in the House.

On resuming—

Q9 **Heidi Alexander:** How do you characterise the risks posed to the health and social care system as a result of the referendum on 23 June?

Mr Hunt: First, welcome to the Committee. I think this is the first time we have met in this forum.

Heidi Alexander: Thank you.

Mr Hunt: There are risks and opportunities, and it is important to look at both. The biggest area of both risk and opportunity is around workforce. I will talk about the positives briefly. An area where it has been a catalyst for thinking that probably should have happened before, which I do not think we got right for decades in the NHS, is proper strategic workforce planning. That was what prompted me dramatically to expand doctor training places and important reforms to nurse training as well. That is the start of a much longer journey for the much more strategic workforce planning that needs to take place over a period of decades because of the time it takes to train medical staff.

Probably the biggest risk is around the morale and motivation of the brilliant EU staff who already work in both the health and the social care systems. The 90,000 staff from the EU who work in the social care system and the 58,000 who work in the NHS do a brilliant job. Frankly, we would fall over without their help. That is why it is a very early priority for us to secure, as quickly as we can, agreement for their right to remain in the UK and continue their great work.



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Q10 Heidi Alexander: Some of my colleagues have detailed questions on workforce. Do you see the workforce challenge being greater in social care than in the NHS?

Mr Hunt: I do not see it as being greater or less; they are different. In the social care system, of the approximately 90,000 EU nationals—it is harder to measure in the social care system—67,000 are lower skilled. Often, they are people working at low wages in care homes or in domiciliary care duties who provide absolutely vital patient care. As we have often talked about in this Committee, that area is under a great deal of pressure at the moment. Making sure not just that we maintain their morale and motivation but that we develop an immigration policy that recognises that we will need to continue to support the social care system with lower-skilled migrants is one set of issues.

When it comes to the NHS, there are more issues with higher-skilled workers—the 21,000 nurses and 10,000 doctors from the EU, all of whom do a very good job. We have no evidence at the moment of people leaving in droves. There is some evidence of a decline in applicants from EU countries for available job vacancies. That is why we are keen, as the Prime Minister said, to create certainty as quickly as we can about their continued rights.

Q11 Heidi Alexander: What are your views about the amount of money that will be available over the next decade, for example, for the NHS and social care? At the end of March you wrote an article for *The Guardian* in which you said that Brexit would “inevitably mean less money for public services like the NHS. Those who want to leave need to explain how they could protect the NHS from this economic shock.” Do you stand by those views?

Mr Hunt: I think I was right on one point and wrong on another. I think it was in *The Observer* rather than *The Guardian*—it is the same family of newspapers—but the main point I was making in the article was that the most important thing for the NHS going forward, given that we will continue to need to invest more in the NHS because of the ageing population in the decades that lie ahead of us, was the strength of the economy. My main concern in that argument was the impact of Brexit on the British economy and, therefore, its ability to provide the funding we need for the NHS and the social care system. That was why I made that argument.

Where I was wrong—I was not alone in this respect—was that we did not see the immediate slow-down in the British economy that many of us feared would happen if we voted for Brexit. We have seen a British economy that is much more resilient. Indeed, last year we were the fastest-growing country in the G7, even including the post-Brexit months. That is why we can be more optimistic than perhaps I was in that article.

Q12 Heidi Alexander: Are you honestly saying that you think the outlook for public finances and the amount of money that will be available to fund



key public services, such as the NHS, is strong going forward, given what the Chancellor said in the autumn statement?

Mr Hunt: No one has a crystal ball. Of course, uncertainty is created by a decision as momentous as Brexit, but we now have huge opportunities. Rather like my comment about our workforce decisions for the NHS, when we look forward I think the Brexit decision will prove to be a catalyst for long-term changes to the British economy to make it more competitive. There are things that potentially we could have done within the EU but did not, and I think we will now do them, which is why we can be a lot more optimistic that the economic impact could be positive in the long run.

Q13 **Heidi Alexander:** My last question—I may want to come in on some questions later—is also about something you wrote in the national press, this time in the *Telegraph* on 27 June, at a time when you may have been dipping your toe in the water about potential future leadership in the Conservative party. You referred in that article to the forthcoming negotiations on Brexit and said that “we need to negotiate a deal and put it to the British people, either in a referendum or through the Conservative manifesto at a fresh general election.” Do you still stand by those views?

Mr Hunt: No. I was in a post-Brexit state of shock, as I imagine quite a lot of people here were. As you point out, that was written four days after the referendum result. I held those views sincerely at the time I wrote them, but the reason I think a second referendum would be a big mistake is twofold. First, it would mean that we got a worse deal from the European Union than we would otherwise get in any trade negotiations, because they would know that the worse the deal they offered us, the more likely it would be that a referendum would be lost. Secondly, as a result, it would create huge uncertainty. We have to respect what the British people have decided and go forward in the way the Government are now doing.

Heidi Alexander: That is a different debate that could probably go on for a long time, but I will not take up the Committee’s time this afternoon.

Q14 **Chair:** Can I clarify one point?

Mr Hunt: We are in clarification mode today, aren’t we?

Chair: You said you would be sitting in on Sub-Committees that had relevance to health. Will you confirm that you will be sitting in on the Sub-Committee on immigration?

Mr Hunt: I am. I am not sitting in; I am a member of it.

Chair: Excellent.

Q15 **Mr Bradshaw:** You said you had changed your mind on the economic impact of Brexit, although of course it has not happened yet. You do not dispute the latest prediction of your own OBR that we are going to take a



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hit of up to £60 billion as a result.

Mr Hunt: The OBR is an independent forecaster, and of course I respect its views in that sense. That does not mean to say that I do not hold the view that it is entirely possible that Brexit could be a net positive for the British economy over the coming decades, but that is up to us. In the past few months we have confounded people, including many of us who thought the British economy would end up tanking as a result of Brexit. We have to continue to confound those expectations, but it is in our hands to decide how we as a Government and a country respond to these very particular challenges. If we get it right, we can make it an enormously positive thing.

Q16 **Dr Davies:** You have already identified improved workforce planning as a potential benefit from our departure from the EU, but what other opportunities have your officials identified from Brexit?

Mr Hunt: Let me talk first about the areas we do not want to change. We have extremely good co-operation with our European partners, and with countries outside Europe, on things like disease prevention. That is something Paul MacNaught can talk to in more detail. We have very good relations. Public Health England is respected all over the world for its expertise in those areas. We were one of the leading three countries in the world in our response to Ebola, including close working with France and the United States. That area and the global campaign to reduce antibiotic use and combat antimicrobial resistance are absolutely ones we want to continue, and I am absolutely certain that other European countries will want to do that as well.

Another area where we have always had aspirations, but I think Brexit will be a catalyst to do better, is in our plans for the life sciences industry. As you know, of the world's top 10 medical research universities, four are in the UK. We have a hugely strong science base. We have 222,000 people employed in the life sciences industry and nearly 6,000 businesses. We are a global science hub, but can we do better? Because of Brexit I have taken it upon myself to meet the chief executives of the pharma global top 10. I have met four and should be meeting another five in the next month. When we talk to these people and understand their priorities in terms of where they are going to invest their research capabilities, we find that there are indeed things we can do differently and better. That is what I want to do.

Q17 **Dr Davies:** Some of my colleagues may want to come in later in relation to the mutual recognition of professional qualifications directive, language testing and the working time directive. Do you have any brief comments about those as a whole at this point?

Mr Hunt: With respect to the working time directive, Theresa May made it very clear in her 12 priorities that reducing what are loosely called workers' rights is not the direction of travel we intend to take. With respect to people working in the NHS, the working time directive was



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partly brought in at EU level to deal with excessive hours worked, particularly by doctors in training. We do not want to go back to that. The recent change to the junior doctors contract, although controversial, actually reduced still further the maximum hours they can be asked to work.

With the Great Repeal Bill that will be going through Parliament, the working time directive will be enshrined in UK law, but there will be an opportunity for the British Parliament to debate changing it in the future. There may be people who argue—as the Royal College of Surgeons does, for example—that we should put more flexibility into it in terms of Government policy. What we do not want to do is increase the total hours worked, because we think that would be a step backwards and not good for patient safety.

In terms of professional qualifications, we are about to negotiate a deal in trade and services with the EU following the triggering of article 50. Professional qualifications and their recognition may be an area of discussion in those negotiations. I cannot prejudge the negotiations, but, subject to that, the GMC and the NMC make a case about the inadequacies of the current system. For example, in 2014 we introduced proper language tests, but under EU law we can test only people's basic English, not their clinical English. Things like that do not seem logical and would be a natural priority for reform in a post-Brexit world.

Q18 Dr Davies: If the economy stays strong and there is a net financial benefit from the reduction or disappearance of EU contributions, do you think the Government have a duty to put more money into the NHS and social care systems as a consequence?

Mr Bradshaw: Three hundred and fifty million a week maximum.

Dr Davies: However much it might be.

Mr Hunt: I was about to say that is a very delicate question until, in his eloquent way, your colleague Mr Bradshaw chimed in. As the Committee knows—we have talked about it before—I have never used the £350 million figure because I do not accept it. Any Brexit dividend one might get from reduced contributions to the EU has to be weighed against the overall state of public finances and the British economy at that stage. I do not think we can start committing money we do not know we will have, but, if I can put it this way, I always welcome the opportunity to argue for more investment in the NHS and social care systems.

Q19 Chair: Secretary of State, you have confirmed that you will have a place at the table in the Cabinet Sub-Committees, but in the direct negotiations with the EU on areas entirely around health, will you be leading those negotiations directly or will it come under the Department for Exiting the European Union?



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Mr Hunt: I imagine it will be both. Clearly, the lead role is the Department for Exiting the EU, but I would feed very closely into any discussions involving health.

Q20 **Chair:** You say you will feed into them. Will you be there at the discussions themselves?

Mr Hunt: I am not aware that that level of detail has been decided for any Cabinet Minister whose role is affected, but I can absolutely assure you that I will be involved in all discussions as to what Britain's negotiating position is—what concessions we make, what our red lines are and all those areas.

Q21 **Chair:** That is something it would be helpful to know. You have already touched on several areas, for example public health and reducing the use of antibiotics, where one would expect somebody who has acquired expertise and a deep interest in public health to be there. You are not sure whether you would be in the room or not.

Mr Hunt: If that answer is known I will let you know, but we have not even triggered article 50 yet. As to who is going to be in the room, I imagine that in all these things it will start with officials, but I will certainly let you know if those things have been decided.

Q22 **Chair:** Have you had any preliminary discussions about what your level of involvement would be?

Mr Hunt: The level of involvement for me on health issues will be extremely high. I will be there. I will have a major contribution in Britain's negotiating position and what we decide on all the important issues. You asked me about a very specific detail—who will be in the room. Ahead of even triggering article 50, that is not something I am able to tell you.

Chair: It has not been clarified yet.

Q23 **Luciana Berger:** We heard from the head of the civil service, Mr Manzoni, who has warned that Government Departments are overstretched. In that context, what steps have you taken to ensure that there is sufficient capacity in your Department to accommodate the demands of the Brexit negotiations?

Mr Hunt: We have a director who essentially is full time on Brexit. We have a Brexit programme. We have done a review of every area of departmental policy to see which ones are going to be affected by Brexit. We have weekly discussions at official level with the Department for Exiting the EU. The total headcount in the Department is currently around 1,800. It will fall to about 1,300 this year because, like all parts of the NHS, we are making efficiency savings to maximise the amount of resources going to the frontline. We are confident that we have enough resources to more than deal with the challenges of Brexit. Our estimate is that about two thirds of DH officials will have some involvement with



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Brexit policy at some level, but we are a Department where the principal competence remains with member states, so we are confident we have the resources.

Q24 Luciana Berger: That is very interesting, particularly in light of the fact that a recent survey across Whitehall, including your Department, found that additional resources were needed at the moment. As you rightly highlighted, by April, not over the next year, you will lose 30% of the staff of your Department. Perhaps you could elaborate a little further how you anticipate you will be able to contend with the demands of Brexit alongside all the wider issues we see and hear in the NHS that are going on at the same time.

Mr Hunt: I absolutely believe that we can. I went through a process of losing 40% of my staff when I was Culture Secretary. It is a very difficult process. They were long-standing staff who had given very distinguished service to the civil service over very many years, but, if you rethink people's roles and job functions, it is possible to do the same work, and even more challenging work, with a lower number of people, and I am absolutely confident we can do that.

Q25 Luciana Berger: You wrote to the Committee in December and told us about the work being co-ordinated in what was called the global and public health directorate—I believe it is still called that—and referred to a small team. Can you confirm to us how many people are in that small team?

Paul MacNaught: That is my directorate. There are about 25 posts in that directorate as a result of the restructuring we are completing at the moment.

Q26 Luciana Berger: Twenty-five people.

Paul MacNaught: We are not all focused on Brexit the whole time; we liaise with the World Health Organisation, the G7 and the G20, and we have bilateral liaison with other countries as well, but we are able to flex as necessary to make sure the Brexit work gets the focus it needs.

Q27 Luciana Berger: I do not know whether you share a concern that many of us round this table have. I was in Brussels a couple of weeks ago and heard at first hand about the number of people on the other side who are working and will be working on our Brexit negotiations, particularly in the area of health, yet we hear today that just 25 people in your directorate, who have other responsibilities as well, are focusing on Brexit.

Paul MacNaught: That is the directorate you asked about, but the way we have the work organised in the Department is that other policy directorates in the Department have the lead for work on specific areas—for example, workforce supply, medicines and devices regulation and health protection systems. Large parts of the rest of the organisation are focused on particular issues. Those teams existed before we had the referendum, so we have not had to stand up new teams to do that work.



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Q28 Luciana Berger: Are you planning to recruit additional officials or advisers to work specifically on Brexit?

Paul MacNaught: We may. We have some headroom, following the restructuring to which the Secretary of State referred, to recruit between 100 and 200 extra people over the coming few months. As we see what shape the negotiations are more likely to take, and when decisions about the role of particular Departments are clarified, we will be able to make sure we have the people we need. One of the opportunities of the restructuring we have done is that, because it has taken place since the referendum, we have been able to make sure the structure we have gone to is the right one not only for this work but for the rest of the work the Department has to do.

Q29 Luciana Berger: Perhaps you could elaborate further on how the work on Brexit is affecting the Department of Health's other priorities and what will not be done as a result of the time and the staff now being made available for Brexit work.

Mr Hunt: I do not accept that things will not be done that need to be done. In the health policy agenda, a huge amount of work is going on. It is important to note that, since the 2012 Act, 6,000 people who previously worked in the Department of Health are now working at NHS England, so a huge group of people with enormous expertise are helping to contribute to some of the big changes we see happening in the NHS.

We are seeing a huge transformation with the sustainability and transformation plans. We are looking very closely at our approach to winter pressures following the challenges of the last few weeks. There are big changes in mental health, which I know you follow very closely; there are big changes and improvements coming in patient safety, which is something I have been particularly focused on. There is a huge range of other activity. It is absolutely my responsibility to make sure that none of those slows down as a result of Brexit. In fact, as I said, Brexit has been a catalyst to putting some issues on the list that probably should have been there before, and making sure we address them as well.

Q30 Luciana Berger: Could I ask you to tease it out a bit further? I anticipate that further down the line this Committee will look at specific things you mention, particularly the STP process, but it is fair to say that the reports we get from across the country indicate that it is a very troubled process, and the fact that we might have officials diverted to other activities is not going to help that process in future.

Mr Hunt: But they are not going to be diverted to other activities; we are able to do both, and it is unfair to make a premature judgment on a process that could only be started after the spending review settlement of a year ago. It was a process that we consciously decided would be better if it was a bottom-up, locally driven process, which means that we need to allow time for people in local parts of the NHS to come together with



their plans. We think that is the way to get more lasting transformative change, and I am confident that it will be a successful process.

- Q31 **Heidi Alexander:** In the Queen's Speech last year, one of the things we were told the Department of Health would be focused on was a piece of legislation to do with charging overseas migrants for the use of NHS services. What has happened to that Bill?

Mr Hunt: We have continued to make progress on that, but we did not proceed with the legislation because of Brexit. There are wider issues to do with reciprocal healthcare that need to be considered, and we thought we needed to consider those in the round. It is incredibly important that the NHS gets better at recovering the cost of treating people who are not entitled to free NHS care. In the time that I have been Health Secretary the amount of money we have recovered has tripled, and we continue to look at further ways to make progress.

- Q32 **Heidi Alexander:** But there will not be a Bill in this Session in relation to that matter.

Mr Hunt: No.

- Q33 **Rosie Cooper:** Although the Prime Minister has made it clear that after triggering article 50 it would not be in our interests, nor the European Union's interests, not to reach an agreement before the end of the two-year period, none the less that is a possibility we must prepare for. If that were to happen, the UK would leave the EU without any legal agreement in place. In terms of contingency planning, what are you putting in place to ensure that we have continuity in health and social care?

Mr Hunt: I believe that we will come to an agreement. Obviously, we have to plan for all contingencies, but in that particular situation no one believes it would mean the end of trade with the countries of the EU. We would just fall back on WTO rules for trade, and those are the rules that apply in large parts of the world at the moment. Obviously, that is not the best-case scenario, but even in that case, although it would be bumpier, I think that in the end the British economy would still thrive and be very successful. In terms of the long-term impact on the NHS, I am confident we will be all right.

- Q34 **Rosie Cooper:** What about things like access to medicines, patients caught on either side of the argument—EU patients in England and British patients in Europe—and the reciprocal agreements we have? Myriad things will be caught. While I shared with you the hope, or view, that it was a situation we would not get into, and most of us did not believe we would be in the situation where we now find ourselves, we need to get on with the planning and know that it is there this time.

Mr Hunt: I want to reassure you that we do very comprehensive contingency planning. In a way, your question revealed the answer: the issues affect European countries as much as they affect us. Just as we have British nationals living in countries like Spain, France and Italy, so



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too the EU has many hundreds of thousands of nationals living and working in the UK. That is why I am confident we will find an agreement that works for both sides.

Q35 **Rosie Cooper:** There is agreement that planning is taking place, but which areas do you believe will have priority? What work is going on now?

Mr Hunt: We absolutely plan for all eventualities; that is the job of all Government Departments, not just the Department of Health.

Q36 **Rosie Cooper:** You did not plan for Brexit, so most of us are a bit worried that that is continuing.

Mr Hunt: We have learned from that mistake and we are absolutely planning for all eventualities, but we are very confident that we will get a good deal.

Q37 **Chair:** You mentioned its being bumpy if we go back to WTO rules, but there are areas, for example the transport of blood products, where it is not just about the tariff; it is about how easy it is for them to flow backwards and forwards. Can you reassure the Committee that you will be setting out a very clear list of areas where we absolutely must have patient safety contingency planning?

Mr Hunt: I can absolutely reassure the Committee that we will do all the planning that is necessary to make sure that patient safety is protected, yes.

Q38 **Chair:** If you come back to this Committee before the end of the article 50 process, will we have a detailed contingency planning checklist?

Mr Hunt: I cannot commit that we will publish all our contingency plans, because we do not always as a Government publish contingency plans for every eventuality. There is a particular reason for that, which is that it could impact on the negotiations and mean that we end up with a less good deal than we would otherwise get. It is the job of Government Departments, and civil servants at the Department of Health are particularly good at it. As you know, we have had many discussions about the existence or otherwise of risk registers in the Department of Health. I can tell you that the Department is very good at producing risk registers, and sometimes they find their way into the public arena.

Q39 **Chair:** Indeed, but you could argue that with risk registers, having many eyes on the document would help you to identify whether there was anything that had not been identified.

Mr Hunt: You could argue that, but, if you will forgive the pun, there are also risks in risk registers. In this particular case, the risk we have to be careful about is that the publication of what might be called the worst-case scenario could itself have an impact on negotiations, and that is why we need to be careful that we do not do anything against the national interest.



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Q40 Helen Whately: You have already touched on the workforce. Following up on that, what do you see as the main implications of Brexit for the health and social care workforce?

Mr Hunt: The important thing is to look not just at the pressures on the NHS going forward, but the lessons we can learn on the basis of what happened in the past. On workforce planning, the previous Labour Government under Tony Blair did the right thing in increasing funding for the NHS, but when they announced the big increase in funding in the early 2000s what actually happened, according to Derek Wanless, the architect of the plan, was that nearly half the extra funding went into higher pay and inflation, not into better services for patients. That was a disappointment not just to the public but to the Government, and the architect of the plans did not want it to happen either. It happened because a lot of extra resources were put into the NHS without having the doctors and nurses who were able to increase the services available to patients, so there was a relatively inelastic supply of clinical workforce.

Going forward, we need to recognise that in the decades ahead we will need to invest more in the health and social care system, but we have to make sure that we have the workforce ready to provide the extra services we need. That is why we need a structured plan, the first step of which is to look at our doctor numbers. It is interesting that the Health Education England estimate is that we were depending on about 1,500 imported doctors every year. We were training about 6,500 a year and we needed to train about 8,000 a year to be self-sufficient. I believe we will always want to welcome the brightest and best doctors from all over the world, but none the less we should as a country be training the number of doctors we need. WHO thinks there is a global shortage of about 2 million doctors. Interestingly, even being able to import as many doctors as we want freely from the rest of the EU, as we currently can, we still have doctor shortages. That is why it is important to get our doctor and nurse training right.

The other aspect we have not thought hard enough about is lower-skilled workers. It has become a truism that people observe the brilliant work done in residential care homes by non-British nationals. If you go into care homes, particularly in London and the south-east but all over the country, you see fantastic work being done, but we probably have not asked ourselves why it is that even in areas of unemployment some British people do not want to do those jobs. One of the reasons is that often there is not a career structure that goes with them—a path whereby you can see the job as a way to progress your own career. That is why from September we have introduced nurse apprenticeships, which are a four-year way to get a nursing degree and become a nurse through a non-traditional and more hands-on practical route. We need to do much more work to continue that, but creating career structures is the way we can encourage people to take advantage of opportunities in the sector.

Q41 Helen Whately: That is all absolutely right. It is good that we are



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increasing the number of doctors and nurses, and having training and career structures for the care workforce. However, it all takes some time. It takes many years to train a doctor or nurse or an allied healthcare professional. What steps will be taken in the shorter term to make sure we continue to have the workforce the NHS needs? What options are being considered for the shorter term, particularly, as you said a little earlier, when we are seeing a decline in applicants for some positions?

Mr Hunt: In the shorter term, for example from this August, we are removing the cap on nurse training places through the nurse training colleges as part of a package of reforms—they are not easy reforms—which we hope will see around 10,000 more nurses being trained every year by the end of the Parliament. Across this Parliament we expect an extra 40,000 nurses to be trained compared with the previous Parliament. That is one aspect.

It is also important that immigration policy has a role. Nurses remain on the tier 2 shortage occupation list. We do not envisage that there will be any cliff edges in immigration policy going forward, so we need to recognise that any possibility of reducing the need for people trained overseas to come and work in the NHS and social care systems will be a gradual process, not an instant one.

Q42 Helen Whately: Can I nudge you particularly on the workforce in care homes and the domiciliary care system, which we know is under great pressure? In my area, I hear that there are challenges in recruiting. We know that many of those staff come from overseas—from the EU. Do you foresee any steps being taken in the relatively short term to try to support the supply of workforce in that sector?

Mr Hunt: The measures we have talked about are designed to make those jobs more attractive. For example, I am hoping that people in your constituency will from this year be able to start working in a care home as a route whereby, after four years, they will become nurses. That was not possible before. We are doing a lot of things to try to make it more attractive. At the same time, we recognise that there will be a need for immigration to fill some of the gaps in the short term, possibly longer than that, so we are not planning any changes that would mean that care homes and domiciliary care agencies were not able to recruit the staff they needed.

Q43 Chair: You mentioned a decline in applications from the European Union. Can you put any numbers on that, or give us greater clarity about how many?

Mr Hunt: I cannot, because we do not have hard data; it is just anecdotal. Anecdotally, it is not a large decline, but the information I get from NHS Employers is that there may be some decline in applicants, but not an exodus of people.

Q44 Chair: You mentioned that nurses remain on the tier 2 shortage occupation list. Are you going to press for care workers to be added to



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that list after we leave the European Union?

Mr Hunt: These are matters that we keep under continuous review, but a big priority for my Department now is to go through the process of establishing what will be the need for those lower-skilled workers in the NHS and social care sector. A high priority of our new immigration policy post-Brexit will be to make sure we get that absolutely right, and get the supply of workers we need.

Q45 Heidi Alexander: Currently, NHS England is running a pilot in Lincolnshire. In effect, it is running a training campus in Poland where it guarantees GPs a salary of £90,000 to come to the UK. The doctors participating in that scheme come from countries such as Poland, Croatia, Lithuania, Greece and Spain. NHS England has indicated that it is a blueprint for schemes in other parts of the country. Will those schemes still go ahead during the article 50 negotiations, and which other parts of the country are you considering for them?

Mr Hunt: The commitment we have made is that by the end of this Parliament we will have 5,000 more doctors, or thereabouts, working in general practice, because we recognise that the heart of the change we want to make in the NHS is a move to prevention rather than cure, and that means strengthening the care we give outside hospitals. We will continue to recruit doctors from overseas as part of the way we deliver on that commitment, but it will not be the only way. We also need to look at retention rates among GPs, retirement rates and many other factors. The long-term solution is to be self-sufficient in the number of doctors we have. That is why we announced the second biggest increase in the number of doctor training places in the history of the NHS. That will happen during this Parliament, but obviously it will not feed into the number of doctors actually practising until the middle of the next Parliament.

Q46 Heidi Alexander: How many of the 5,000 will come from EEA countries?

Mr Hunt: I will have to write to you about that and give you a breakdown.

Q47 Heidi Alexander: But the pilots will be continuing.

Mr Hunt: They will be continuing.

Q48 Luciana Berger: You have just said that those doctors will not be ready until the end of the next Parliament. From what you announced last year, medical students will not become GPs until at least 2028 and consultants until at least 2032. Can you clarify how you will ensure that you have the appropriate workforce across the NHS before then?

Mr Hunt: I will have to look at the comment about 2028, but the increase in medical student places will start from 2018. It takes about six years before a doctor can qualify, so it will be in the middle of the next Parliament that we start to see the benefit of those increases.



Q49 Heidi Alexander: I have a final question on immigration. My experience, from dealing with constituency casework, is that it can take a hugely lengthy period of time to deal with the tier 2 process. Are you concerned about the speed of an immigration system for EU citizens that would be similar to the present one for people from outside the EU? As an open question, what sort of principles would you like to see in a future immigration system to provide for the needs of the NHS and social care workforce?

Mr Hunt: The principle we follow is not zero immigration; it is that we have the immigration to this country that we need as a country, and that is decided in the British Parliament by people elected by the British people. The principle is control of our immigration policy by people elected by the British people. As the Prime Minister has said on many occasions, we want an immigration policy that continues to attract the brightest and best from all over the world, and we continue to be one of the most open, outward-looking global countries on the planet. If we get that right, we can have a more relaxed national attitude towards immigration because people will feel that we have got back control. One of the causes of tension pre-23 June last year was that people felt that, even if they disagreed with high levels of migration from the EU, there was nothing they could do about it because we had surrendered that right as a country, so in part that was what they were voting to get back.

Q50 Heidi Alexander: Are you concerned that the speed of the process could, in effect, cause sclerosis in the ability of the NHS and social care system to get the staff they require? It could be a labyrinthine system that you are asking potential staff in the NHS and social care system to go through.

Mr Hunt: We need to make sure that it is not, but the point is that the people who will be in control of our immigration policy and the immigration processes to which you refer, post-2019 and post-Brexit, will be us—the British Government. It will be the responsibility of the Health Secretary and the Home Secretary to make sure that we have an immigration policy that, first, meets the needs of the health and social care system, and, secondly, meets them efficiently without the long processes you talk about.

Q51 Chair: You referred a minute ago to the 5,000 extra doctors in primary care. Do you feel that it will be more difficult to attract doctors to primary care if they continue to hear the kind of comments they heard last weekend in the press? Did you have any input with No. 10 before those comments were made?

Mr Hunt: The comments were in part a sense of frustration shared throughout Government that some GP leaders had talked about scaling back GPs' commitment to a seven-day NHS, despite the fact that the Government had made a commitment last year for a 14% real-terms increase in GPs' annual budgets by the end of the Parliament—an extra £2.4 billion—part of which was a carefully costed and agreed programme



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towards making sure that people are offered seven-day access to GPs. It is very important that, just as the Government must stick to their side of the deal when it comes to the additional funding for general practice, the profession also respects the fact that part of its side of the deal is meeting the manifesto commitments we made.

Chair: The tone of the comments was unfortunate. If we have time at the end, I might return to that issue, if that is all right with colleagues, but Philippa will stick to the main points for the moment.

Q52 Dr Whitford: I do not think there is anyone who does not welcome the idea of a 25% increase in the number of doctors being trained, but if we are talking about it starting only in 2018, the people who come out in 2023 will be raw recruits. They are at the stage of learning rather than giving, so from the point of view of being GPs, it will be towards the end of the 20s. That is where the 2028 comes from. We have had a 29% increase over the last 20 to 25 years, so the 25% does not even replace that. Secretary of State, do you absolutely commit that we will need doctors from elsewhere in the future? The problem is that there are people in society being given the impression that they will have a pure British medical service and they will not have to see a doctor from somewhere else.

Mr Hunt: That is wholly false, and I completely reject any suggestion that that is what the Government have been saying. I would say the opposite. At every stage when we were outlining the policy, I paid tribute to the fantastic work carried out by doctors trained overseas—about 20% of our doctors in the NHS. I think the phrase I used in my party conference speech when I announced the policy was that the NHS would fall over without them. They do a fantastic job, and I reiterate that today. The Prime Minister went further than that and said that one of our top priorities, as part of the Brexit negotiations, is to secure their rights to continue to live and work in the UK. We have huge respect and admiration for their contribution, which we hope will continue.

Q53 Dr Whitford: I think phrases like “in the interim” were used, implying that those doctors were “welcome to stay” until we had trained our own. Those phrases were used, and there is definitely concern among people in the profession. They may not be leaving in droves, but we will find it harder to attract them because people will think, “Why go there when we don’t know what our status is going to be, certainly in the next couple of years?”

Mr Hunt: It is very important that we are clear about language. The word “interim” was never applied to people who are currently working as overseas-trained doctors in the NHS—quite the reverse. We have been clear that we want to secure their rights to continue to live and work in the UK for ever. That is what we like. We think they make a fantastic contribution, so there is nothing temporary about our commitment.

Q54 Dr Whitford: How will that be done? Will they be part of the article 50



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negotiations?

Mr Hunt: Yes, that is what we said. The Prime Minister says she wants to make the rights of EU nationals living and working in Britain and the rights of Brits living and working in the EU one of the first things that we settle. She actually said that most EU states are happy to do that. Unfortunately, at the moment one or two are not, but it is a very high priority for us.

Q55 **Dr Whitford:** To go back to Heidi's point about the system for applying, it is quite expensive to apply for British citizenship. A lot of EU nationals are panicking at the moment and applying. People are being knocked back for permanent residency because they do not earn enough and are in a rest-of-the-world situation. Do you envisage that EU nationals, or at least the ones who are already here, will have a differentiated system, or will they pay £1,800 a head and have to earn above a particular threshold to be allowed to stay?

Mr Hunt: I cannot answer that question, because we have not yet triggered article 50 and the negotiations have not started.

Q56 **Dr Whitford:** What are you pushing for at the Cabinet table? Are you saying, "We can't lose them, so this is what we need to get to keep them"?

Mr Hunt: What I am saying is exactly what the Prime Minister said—securing their rights to continue to live and work here is our top priority. That is what we want to do before anything else. The first principle that she enunciated in her list of 12 principles with respect to her approach to this process was the principle of certainty. We recognise that, until we are able to secure the rights of EU citizens living in other EU countries who are affected by Brexit, it creates uncertainty. We want to eliminate that.

Q57 **Dr Whitford:** There is huge uncertainty at the moment. One area that will particularly affect social care is the fact that people within social care do not earn the kind of money that would bring them over the threshold to apply for British citizenship now. Are you in there arguing for something different, so that we can keep the 80,000 people who work in social care?

Mr Hunt: It is 90,000. I am in there arguing for their rights to remain here, but I do not need to argue for that, because it is Government policy. We want them to remain here. We recognise the fantastic work they do. We want to negotiate a sensible reciprocal arrangement that allows them to remain here, but also allows Brits who have retired in Spain, for example, to continue to live where they live currently.

Q58 **Dr Whitford:** People being able to stay where they are, whether here or in Europe, is not just around the agreement to allow it. It is about the techniques that you set up—the bureaucracy and the cost of applying. The earning threshold is up to us. It is not up to anyone in the EU. It is



our current thresholds that would drive people out of social care jobs.

Mr Hunt: With the greatest respect, I do not think that is a logical position to take. If we have said that securing the rights of, for example, the 90,000 people from the EU who currently work in the social care system is a top priority and that we want them to continue to live and work here, of course we will do the things that are within our control to make that happen; but it needs to be part of a deal that, equally, secures the rights of Brits who are living in other EU countries.

Q59 **Dr Whitford:** You would envisage some form of reform around applying for permanent right to remain or British citizenship, to make it affordable for people who do not earn—

Mr Hunt: Of course we need to make sure that they are practically able to stay, having secured their rights to do so. If that means that changes need to be made, of course we will consider those changes. The point is that we think they do a great job and we want to keep them.

Q60 **Dr Whitford:** You mentioned the nurse apprenticeships in social care as attracting people into social care. Through that, they become a nurse, which will attract them out of social care. Do you feel that we require a career structure within the care system itself, so that someone can become a middle-grade and advanced care leader, rather than it always being seen as a basic job, with those who develop moving somewhere else?

Mr Hunt: That is a fair point. We want to look at all career structures. Yes, we want to look at the career structures within social care—how you can progress to be a manager, but also how you can progress to be a nurse in the social care system, rather than necessarily a nurse outside the social care system. As you know, there is a growing need for nurses inside the social care system. Giving people a sense that there are progression opportunities is something we need to do better than we currently do.

Q61 **Dr Whitford:** Do you see things like the mutual recognition of registration and qualifications changing as we go forward? That is what has allowed us to attract people.

Mr Hunt: That echoes the point I made to Dr Davies. Of course, part of our negotiations for access to the European single market includes services as well as goods. Professional qualifications could be part of the discussions on services. I do not want to prejudge the negotiations, although I recognise that there are some anomalies in the way we recognise professional qualifications in this country at the moment; for example, we are able to check the standard of clinical English and some of the clinical standards of non-EU nationals to a higher standard than we can for EU nationals. I recognise the cogency of the argument made by the NMC and the GMC in that respect. I do not want to prejudge the negotiations going forward. We need to see the outcome of those before we take any decisions.



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Q62 Dr Whitford: You might see it as an opportunity to introduce competency testing of clinical ability or knowledge.

Mr Hunt: The professional regulators make a powerful case in that respect.

Q63 Dr Whitford: At the moment, when there are concerns about a doctor's practice—whether to do with their clinical practice or their non-clinical behaviour—they are flagged up across the EU. Do you expect that we will try to remain attached to that?

Mr Hunt: That seems to me an obvious area where it is in everyone's interests to continue to co-operate across national borders. All those things are subject to negotiation, but I do not imagine that that particular one will be controversial.

Q64 Maggie Throup: Can I come back on the language issue? You acknowledge that it is a problem at the moment. To me, it raises concerns about patient safety if clinical staff cannot communicate at the right level with their patients and colleagues. I know that you cannot talk too much about negotiations, but there is a difference between its being a priority and being able to change it as quickly as possible. How do you see that happening? To me, anything that affects patient safety must be a priority and must be done sooner rather than later. We cannot wait two years when patient safety is at risk.

Mr Hunt: Unfortunately, because we will remain a member of the EU for two years following the triggering of article 50, legally we have to wait two years before we can upgrade the current requirement on doctors coming into the NHS, which is that they pass an IELTS test. We have to wait for that time, but at the end of the process we will regain full control of our immigration policy and our borders. We will then have the opportunity to make those changes, which I recognise make a lot of sense.

Q65 Maggie Throup: You say that you will "have the opportunity." That is still a bit wishy-washy.

Mr Hunt: I am trying to be as un-wishy-washy as I can.

Q66 Maggie Throup: Having the opportunity and saying that you will do it are two different things.

Mr Hunt: I am trying to give an indication that I have a great deal of sympathy with the case being made by the GMC and the NMC. This has to be subject to the negotiations that are happening, which could involve the issue of the recognition of professional qualifications. I do not want to tie anyone's hands ahead of those, but I want to be open with the Committee about where my instincts are, which I think is very close to yours.

Q67 Dr Whitford: The Prime Minister said in her speech that the UK may seek to remain in certain EU mechanisms, agencies and schemes. Do you



expect those to include the European Medicines Agency? Are you aware of a mechanism whereby that might be possible? At the moment, it covers only the EEA. Is that something you will be pitching for?

Mr Hunt: I do not expect us to remain within the European Medicines Agency, but I am very hopeful that we will continue to work very closely with the EMA. This country has a closer relationship with the EMA than any other member state of the EU. The MHRA, which is our national regulator, does around 40% of the testing for the EMA, and it is not just the easy 40%; it is often the most complex and difficult cases. We have the foundations for a sensible, strong partnership, which means that, potentially, we could have mutual recognition between the EMA and the MHRA going forward. I will be open to having the closest possible relationship on those things, but I cannot prejudge the negotiations.

Q68 **Dr Whitford:** Are you suggesting that, if the EMA licensed a drug, the MHRA would automatically license it—that it would not be a separate process?

Mr Hunt: I do not take that possibility off the table. As I said, I will argue for the closest possible regulatory equivalence between the regime we have and the regime that currently exists in the EMA. I am sorry to be a cracked record, but it is all part of the negotiating process, so it is difficult to be more specific.

Q69 **Dr Whitford:** You recognise that, if we cannot do that, we might move into the second rank for drugs being launched. Canada and Australia get access to new drugs six months to a year behind the EU and the US. That is just market science. There is an awful lot to play for.

Mr Hunt: That is precisely why I would like to have the closest possible relationship. The EU has as much to gain as we do from that close relationship, because of the scientific expertise in this country and the extraordinary expertise inside the MHRA itself. We have a very strong scientific base. Around 30% of EU clinical trials have some of their work done in Britain, so we play a very important role.

Q70 **Dr Whitford:** The EMA leads and directs on rare disease research. Will that also be on your shopping list for trying to remain in some form of relationship with it?

Mr Hunt: I hope that it will be on their shopping list as well, because the UK leads on a lot of rare disease research. Our genomics project is world beating. That is something that the EU will want to be available for EU citizens, just as we want to benefit from scientific advances that happen in EU countries.

Q71 **Dr Whitford:** You are hoping for a close relationship, but you do not see a mechanism whereby we could remain within it, in the sense we are now.

Mr Hunt: I would like the closest possible relationship.



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Q72 **Dr Whitford:** We will probably lose the headquarters.

Mr Hunt: It is difficult to speculate on that, but it is unlikely, given Brexit, that the EMA headquarters would not move outside the UK.

Q73 **Mr Bradshaw:** Unlikely that it wouldn't?

Mr Hunt: It is likely that it will.

Q74 **Mr Bradshaw:** Can you explain why you have given up on that so easily and at this stage?

Mr Hunt: I have not given up on anything—if you were listening to the exchanges. I have just said that I am arguing for the closest possible relationship with European—

Q75 **Mr Bradshaw:** Why not stay inside it?

Mr Hunt: As I have explained, it is likely, in a post-Brexit scenario, that the EU will decide to move the headquarters of the EMA outside the UK. That does not mean that I will not argue for the closest possible relationship.

Q76 **Mr Bradshaw:** But we can lose the headquarters and still remain members. It is vital for the whole functioning of our medicines industry.

Mr Hunt: We cannot remain members of the EU. We are leaving the EU. That is why there will be separate regulatory arrangements. As I tried to explain earlier, I would like to have the closest possible partnership—

Q77 **Mr Bradshaw:** We have just had a session with one of your ministerial colleagues, who said that we will remain members of the European Patent Office. It is vital to our national interests to be members of all sorts of agencies and organisations. You seem to be giving up this one without even a fight.

Mr Hunt: It is not giving up. The EMA is an EU institution. I think it is the biggest EU institution that we host in this country. I am just telling the Committee what I believe to be the case, which is that it is likely that EU countries will want to move its headquarters outside the UK.

Q78 **Chair:** The question is not about the headquarters—the physical location of the building. It is about whether we could remain within it, even if it is moved to somewhere else in the EU. Is it your preference to press for us to remain within the organisation or to be separate?

Mr Hunt: Mr Bradshaw's question was a specific question about the location of the EMA—

Q79 **Chair:** Yes, but there was a further question.

Mr Hunt: In answer to your question, I would say what I said to Dr Whitford. One of the possibilities is that we continue to recognise in this country approvals done by the EMA in a post-Brexit world.



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Q80 **Chair:** As a member? Presumably, one could see a scenario where you could retain your membership, even though the organisation is not physically located in the country; or is that not possible, in your view?

Mr Hunt: We will not be subject to the European Court of Justice. That was the clear decision made by the British people. It depends on what your definition of membership is. I do not rule out an agreement by us, as a sovereign state, with the EU on the mutual recognition of medicines and medical device approvals. We will argue for the closest possible relationship. We think that is in both sides' interests.

Q81 **Chair:** Does that mean that you have been given advice that, if we remained a member, we would be subject to the jurisdiction of the Court? Is that your understanding?

Mr Hunt: I am certain that we would not agree to anything that meant that we were subject to the jurisdiction of the European Court of Justice.

Q82 **Heidi Alexander:** I want to press this issue further, to understand why we cannot remain part of the EMA. You talk about seeking the closest possible relationship. It seems that there is an issue with the ECJ. Is one of the reasons also a fear that we may have to contribute financially in order to be part of the EMA?

Mr Hunt: No. It is a matter of sovereignty.

Q83 **Heidi Alexander:** Which Government Departments have you discussed our membership of the EMA with? Have you discussed this matter with No. 10? Has there been a discussion with the Department for Exiting the European Union? Is there a list in Government of the agencies we will seek to remain a member of? Could you explain? The Committee is at a bit of a loss to understand the reasons why you are seeking the closest possible relationship, but not seeking to remain a member of the organisation.

Mr Hunt: I shall try to explain it in a different way. A good analogy is with our membership of the single market. There are two concepts that are widely debated. One is membership of the single market, which we have ruled out because it would mean that we were subject to rulings of the European Court of Justice. We would not have control over a number of rules that would apply inside the UK, because they would be decided by EU member states without our being involved. That is not the same as access to the single market. We want access that is as close as possible, for both goods and services. We think that is in both sides' interests.

It is exactly the same with the EMA. We are not going to be subject to single market rules and the European Court of Justice, but that does not mean that, as an independent sovereign country, we cannot negotiate a working relationship with the EU, when it comes to medicines and medical devices regulation, that is as close as the one we currently have. That is what we will seek.



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Q84 **Mr Bradshaw:** That will also require some mechanism for resolving disputes. You do not want it to be the European Court of Justice, but there has to be some mechanism for resolving disputes.

Mr Hunt: Yes.

Q85 **Mr Bradshaw:** You talk about sovereignty. We cannot decide these things on our own. If we want to participate, or to have access to the EMA that is as good as we currently have, there will have to be some dispute resolution mechanism, so what is the difference? Why not stay in?

Mr Hunt: Because on 23 June the country voted to leave the EU.

Q86 **Mr Bradshaw:** I don't mean the EU, but the EMA. In your introductory statement, Mr Hunt, you said, "I think it improbable that we will stay inside the EMA". You now seem to be backtracking and trying to get out of what you said at the beginning.

Mr Hunt: No, I think I have been extremely clear. When we leave the EU, the arbitration mechanisms for any dispute that we might have will be subject to international law. That is what happens when countries sign treaties. That is what will happen with any future trade deal that we sign with the EU and, indeed, any agreement that we have on medicines regulation. I was simply saying that, when it comes to medicines and devices regulation, we will seek a relationship that is as close as we have now, but the legal mechanisms for enforcing any agreement made will be different.

Q87 **Dr Whitford:** In a way, has using the term "single market" all the time as shorthand for the basket of gains we have had from the EU misled people, and people have overlooked the benefits we have had for all these years?

Mr Hunt: I thought for a fleeting moment that you were going to say something I agreed with.

Q88 **Dr Whitford:** What did you think I was going to say? I want to see whether I might agree with you.

Mr Hunt: I thought that you were going to say that use of the phrase "single market" has been misleading because it has encompassed two potential concepts. One is tariff-free access for goods and services, which I think we all agree with. The other is being subject to EU law and the role of the ECJ. That is something the country has decided that it does not want to be part of. I am arguing for the former, not the latter.

Q89 **Dr Whitford:** The problem is that that is how it has been talked about—as being subject to other things. What did not come out prior to the referendum is the gains we have had in the last 40 years. Predominantly in the health world, a lot of them have been positive. The issue is how to get through Brexit while hanging on to as many of them as possible. I have real concerns that, along with the consultation on NICE and the new



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NHS England process around rare diseases, the £20 million limit and so on, pharma will simply see the UK as a hostile market. It is not just that we will be there with Canada and Australia, six months to a year behind; we will slide further down. We do not want research done here eventually to become a drug that is not available here. Therefore, it is crucial that we get it right.

Mr Hunt: Given that you clearly feel that the benefits of the Union and being part of a single market were not fully understood before 23 June, I hope that, going forward, you will actively make the case in Scotland for the huge benefits that Scotland receives from being a member of the Union and the single market that the United Kingdom—

Q90 **Dr Whitford:** I am sorry, but it is the European Medicines Agency and being in the EU that gives us that benefit, not being in the UK.

Mr Hunt: All these markets give us huge benefits. That is the only point I am making.

Q91 **Dr Whitford:** “Markets” makes it sound as if it is just about trade. The European Medicines Agency is not just about trade. That is the thing. The EU has had no credit for all those things—on public health, on research and so on.

Mr Hunt: There have definitely been benefits from being part of the EMA, but the EMA and the EU have also benefited massively from the British scientific base, the role of the MHRA and British expertise in this area. That is why I think we have the foundations for a sensible discussion that would allow both sides to continue to reap the benefits of what has been a good partnership.

Q92 **Andrew Selous:** Secretary of State, I want to take you back to the issue of reciprocal healthcare, which we touched on briefly in our earlier discussion about contingency planning. I want to look at it from two sides, starting with the position of UK nationals in the European Union. Most of us carry a European health insurance card with us, whether we are going on holiday or whether we are retired permanently in Spain, France or wherever else. A lot of British nationals are very exercised about what is going to happen to them and their ongoing care after we leave the EU. What are you aiming for in terms of those British nationals?

Mr Hunt: We have made it very clear that it is an absolutely top priority to create certainty for all individuals who are affected by the Brexit vote. There are the big strategic questions that exercise us in this place—Britain’s role in the world, the competitiveness of the British economy, immigration policy and the kind of society we want to be going forward—but we must never forget that, as you rightly say, there are many individuals who have retired to Spain or France and built their future in another country, despite having paid their taxes here for many years and being British citizens, just as there are many European citizens who have contributed hugely to this country. Access to healthcare locally where they live, free of charge, albeit in a different EU country from the one



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they are a citizen of, is among their rights. We want to secure those rights as part of an early negotiation. We cannot guarantee that we can do that, because negotiations have two parties, but the Prime Minister could not have been clearer last week that securing those rights was a top priority for her.

- Q93 **Andrew Selous:** If, in the Prime Minister's worst-case scenario, we had no deal, because we did not like what we were being offered, what would be the default position for British citizens in the European Union in terms of their healthcare?

Mr Hunt: That is impossible to predict. In that situation, EU countries would have to decide what rights they were going to give people who had settled in their countries. We have absolutely no way of knowing that. I hesitate to speculate, because that risks scaring people. Personally, I am very optimistic that we will secure a deal, because it seems to me that it is in everyone's interests to do so.

- Q94 **Andrew Selous:** Turning to the position of European Union nationals here in the United Kingdom, after we have left the European Union, I suppose that their status will be broadly similar to that of other foreign nationals at the moment. How, legally, will we be able to treat them differently from nationals from outside the European Union?

Mr Hunt: As a sovereign country, we are entitled to give them any rights we wish going forward.

- Q95 **Andrew Selous:** It would not risk a discrimination challenge from the judges, in terms of the advice you have been given.

Mr Hunt: My understanding is that we could decide to do what we wished, as a sovereign country, with respect to our immigration policy. We do not have the same immigration policy with respect to every country in the world. Currently, we have different immigration policies with respect to different countries. I hope it does not come to that. Rather than wait until we have left the EU, which will be at least two years away, we could avoid the uncertainty for EU nationals here and British nationals living overseas by coming to a quick deal. I hope that is something we do, for all their sakes.

- Q96 **Andrew Selous:** From what you have said, I take it that at the moment there is no planning for GP practices or NHS foundation trusts to put in place charging systems for EU nationals.

Mr Hunt: No.

- Q97 **Andrew Selous:** Excellent. I would like to move on to public health, looking at it from both sides. In the evidence the Committee has had, there are two differing points of view on the impact of Brexit on public health. What do you see as the possible negative consequences for public health—the things we need to be concerned about and to guard against—from our leaving the EU?



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Mr Hunt: I do not really foresee a negative consequence for public health. The first thing to say is that we have one of the best records on public health anywhere in the EU. When it comes to things like smoking rates—getting teenage smoking to below 5%—big reductions in teenage pregnancies, alcoholism rates and drug use rates, we do very well. There are aspects of European health systems where their outcomes are better than ours—cancer survival rates and so on—but public health is normally an area where we are looked to as a leader. Obviously, we want to continue all aspects of co-operation with our partners and friends in the EU post-Brexit in order to reduce public health risks. It is incredibly unlikely that they will not want to do that, because it is as much in their interests as it is in ours.

Q98 **Andrew Selous:** On the positive side, are there areas you are looking at where you think that, as a result of leaving the EU, we can make further improvements on what you said is already a good record on public health?

Mr Hunt: There may be some. I would not want to overstate it, but I can give you one example. When we were looking at the sugary drinks tax and what we could do to reduce sugar consumption, one option that was proposed by Members of this House was to ask food manufacturers to put the number of teaspoons of sugar on the food labelling of every package sold in supermarkets. We discovered that that was against single market rules and that it would not be possible to do it. That said, we found a way around the problem. We have the traffic-light warning system, which was introduced as a voluntary scheme by the supermarkets. It could be introduced because it was a voluntary scheme. I do not think there will be any big changes in public health policy.

Q99 **Andrew Selous:** Can I ask you specifically about the issue of air quality, which is getting increasingly topical at the moment? The European Union has a primary position on environmental legislation. Is that an area you have given much thought to so far, in terms of the impact on public health?

Mr Hunt: Improving air quality is extremely important from a health point of view. I am very confident that we are able to take those decisions on a sovereign basis, as an elected UK Parliament. The UK Parliament will continue to do what it takes to make sure that we have good air quality.

Q100 **Mr Bradshaw:** You have just lost two legal cases because of the poor quality of our air. Air quality is one area where we lag behind the European standard. Why on earth do you think that a British Parliament will be able to persuade a British Government to do better on air quality when we already face huge fines for breaking air quality requirements?

Mr Hunt: Overall, this country has one of the best records on public health of any EU country—

Q101 **Mr Bradshaw:** I am asking specifically about air quality.



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Mr Hunt: I know, and I am specifically answering you that I have confidence in the British Parliament—

Q102 **Mr Bradshaw:** What is your evidence?

Mr Hunt: At the moment, what happens on issues like air quality is that you have a framework set by the EU, but we keep these things under review, and once it becomes our responsibility, if people want the laws on air quality to be changed, they will be changed. That should be something that is decided by the people of this country.

Q103 **Mr Bradshaw:** We have a framework now, which we have signed up to and supported. People across this House campaigned for that. We have lost two court cases and numerous Select Committee meetings have condemned the Government, but still nothing has happened. Why on earth should people expect anything to improve when we do not even have pressure coming from Europe for us to do anything? Surely the car manufacturers and everyone else will have much more clout in those circumstances than they have at the moment?

Mr Hunt: I have much more confidence than you have in the good sense of the British people. As an elective democracy, I think we will take sensible decisions on air quality and other aspects of public health, as we have done for many centuries.

Q104 **Mr Bradshaw:** There is no evidence to suggest that will be the case. On food, the NFU has made it clear that if we have to fall back on WTO rules, which your Prime Minister has said we might have to do if there is no deal or a deal that she does not like, we will have to accept things like hormone-treated American beef and chlorine-soaked poultry. We will not have a choice—that will be forced on us. Given that, I assume that you would oppose falling back on WTO rules as absolutely catastrophic for public health.

Mr Hunt: I do not think there is any point in speculating on the outcome of the negotiations.

Q105 **Mr Bradshaw:** Mrs May did. She said she would fall back on WTO rules if there was no deal.

Mr Hunt: She said that no deal is better than a bad deal, but I think we will get a deal. I do not want to speculate on the basis that we will not.

Q106 **Luciana Berger:** Could you expand on this a bit further? You said that you anticipated that our European neighbours would still want to work together on public health, but there are some very specific issues that affect our country and our neighbours around emerging and re-emerging infectious diseases and antibiotic resistance. Could you say in some detail, not just aspirationally, how you envisage us continuing to work with those neighbours on those specific and serious issues for the health and wellbeing of our nation?



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Mr Hunt: If you look at antimicrobial resistance and antibiotic use, the international campaign was led at official level by Professor Dame Sally Davies, our chief medical officer, who galvanised opinion across the world. The political campaign was led by David Cameron, when he was Prime Minister. We have taken a global leadership role on antimicrobial resistance, to the extent that it is now being talked about all over the world. When I go to meetings of other Health Ministers, it is completely understood. When we first raised the issue, there was very little understanding of it. It is to the great credit of both those people, and indeed of Theresa May, who continued the campaign at the United Nations when she became Prime Minister.

People recognise British leadership in those areas. They recognise that we did this not out of narrow national self-interest, but because it was the right thing to do, and they want us to continue to play that role. People co-operate when they recognise that your motives for doing things are right. As I said, we have one of the best records on public health of any country. Not only is it an area where we will continue to show leadership, but I am very confident that we will get international co-operation on it.

Q107 **Luciana Berger:** Are there any public health measures that originated in Europe that you will seek to repeal?

Mr Hunt: Not off the top of my head.

Q108 **Luciana Berger:** I am thinking specifically of the tobacco products directive.

Mr Hunt: As you know, we will put the tobacco products directive into law here when we have the Great Repeal Bill. That will be the law. Whether we wish to change it will then be a matter for Parliament. There are no current plans to do so.

Q109 **Dr Davies:** In response to this inquiry, we have had submissions from a wider range of stakeholders than we would normally expect for a Select Committee inquiry, which clearly demonstrates the interest in the topic. You told us in a letter recently that you are engaging with external organisations. How do you intend to do that to a greater extent?

Mr Hunt: I am not sure that we are going to do it to a greater extent, because we are already engaging extensively with all the external stakeholders with which we need to engage. That is the responsibility of Paul's directorate. Obviously, there are huge issues. There are probably issues that we have not yet discussed in a huge amount of detail that will emerge as people begin to see the opportunities of Brexit and not just the potential downsides. They will begin to see that this is a moment of great change that can be a catalyst for positive change if we do it in the right way, which is what I think is being done.

Q110 **Dr Davies:** Do you have any thoughts as to formal processes of consultation with some of those with specialist expertise, for example?



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Mr Hunt: Did you have anyone particular in mind?

Q111 **Dr Davies:** Professional bodies are obviously key. We have a long list of those who presented evidence to us, so any and all of those, plus others. At the moment, you are having meetings and your officials are having meetings. Is there anything that would formalise that process?

Mr Hunt: The answer is yes, for the very simple reason that many of these changes will require changes in the law. Any changes in the law will automatically involve the public consultation that happens before any law is changed. We will do that on a case-by-case basis, as and when we see the need to change the law. I am sure that we will have extensive discussions between us as that process happens. For example, the development of a new immigration policy and of new approaches to workforce planning may well involve changes to the law. Any changes we make to professional regulations could involve a change in the law. There will be extensive consultation and discussion around all those issues going forward.

Q112 **Dr Davies:** The Prime Minister has made it clear that the devolved Administrations will be involved in the Brexit process and negotiations. Of course, health is devolved in Scotland, Wales and Northern Ireland, and to a lesser extent in parts of England, such as Manchester. What is your feeling about their specific involvement as regards health, albeit that those powers are currently not within their jurisdiction?

Mr Hunt: We have to follow what the UK law is in this respect. Reserved matters will remain matters for the Government in Westminster, as the Supreme Court reaffirmed today; but, as the statement by David Davis today made very clear, we will continue to co-operate very closely with the devolved Administrations when it comes to things that might affect their areas of devolved competence, of which of course health is one.

Q113 **Heidi Alexander:** I want to return to a subject area Andrew asked some questions about: the European health insurance card. It is probably one of the most tangible benefits that a lot of people in this country relate to our having been a member of the EU. In five years' time, will I still have a European health insurance card?

Mr Hunt: As you know, I cannot answer that question, because I do not know the outcome of the negotiations.

Q114 **Heidi Alexander:** Will you fight to ensure that British citizens either living in or visiting Europe will have access to a system that is broadly similar to the one we enjoy the benefits of at the moment?

Mr Hunt: That will of course be an important part of the negotiations. The reason why I cannot be specific in the answer is that it is very closely related to the issue of British nationals who live abroad, and indeed European nationals who live in the UK, and their rights to access healthcare. In fact, it is a relatively small part of the costs. The bulk of the costs of reciprocal healthcare payments are for residents who live in



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another European country. My perspective is similar to yours; it is a positive thing for people who travel around the EU. I am afraid that we will have to wait to see what happens in the negotiations.

Q115 Heidi Alexander: I understand that the negotiations about the EHIC card, in particular, are related to the wider question of the rights that sit with individuals living in the UK or British citizens living in EU countries. Will it be a responsibility of the Department of Health to negotiate that? Will you lead on that directly?

Mr Hunt: We will be very closely involved in the negotiations, and rightly so, because it is an area of policy on which we lead.

Q116 Heidi Alexander: Closely involved is not a yes/no answer to the question, "Will you lead on it?" Do you not know?

Mr Hunt: The answer, in terms of who is leading the negotiations, is the same for all Government Departments. Ultimately, the Prime Minister is the person who takes the decisions, but the Department responsible for leading all negotiations on exiting the EU is the Department for Exiting the EU. All other Departments feed into that Department what their priorities and their red lines are. Then you have the normal process of collaboration between Government Departments. The answer that I would give you on that is exactly the same as the answer that the Chancellor of the Exchequer would give you on matters affecting tax policy or that the Home Office would give you on matters affecting immigration policy. We have a lead Government Department that was set up to lead the negotiations, and that is what it will do. All other Government Departments feed into it.

Q117 Heidi Alexander: Will you seek to negotiate 27 separate agreements with different countries of the European Union to provide the sorts of benefits currently attached to the EHIC? Is that where this is going?

Mr Hunt: I hope not. As we have made clear, what we seek is the closest possible relationship and partnership with the countries of the EU, on the basis of co-operation between independent sovereign countries. It is perfectly possible to agree the continuation of reciprocal healthcare rights as they currently exist, but it is not possible to predict the outcome of the negotiations.

Q118 Heidi Alexander: Finally, what estimate have you made of the administrative cost to the Department of Health of dealing with all the Brexit-related tasks you need to do going forward? It seems that we need to go through a hugely cumbersome administrative process. I am interested to know what estimate your Department has made of those costs.

Mr Hunt: I don't think we can answer that question, for the reason I gave earlier, which is that, in the Department of Health, we are not looking at Brexit as the narrow process of changing the basis of our legal relationship with the EU, which of course we have to do and is going to



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happen; we are looking at it as a catalyst for a whole series of policies that needed to be changed. We will now change those faster than we would otherwise have done. Take, for example, the changes we announced in the number of doctors we train—the 25% increase in doctor training places. That is something that should probably have happened anyway. It was catalysed by Brexit. I do not think that it would be right to put a cost on the development of that policy in pounds and pence, because it is something that is beneficial to the NHS anyway, whether or not we leave the EU.

We are looking at Brexit in that positive way. We are saying, “Across the whole range of our policies—our support for the life sciences industry or our ability to get new medicines to market more quickly or to encourage the development of new medicines in the UK—let’s use this as a moment of change and opportunity.” That is why we think that probably about two thirds of the civil servants in the Department will deal with Brexit-related policy at one stage or another.

Q119 Dr Whitford: At the beginning, Secretary of State, when you were talking about your interaction with the Cabinet group and the plan going forward, you identified various areas that are not health but have an impact on it, such as immigration. How do you envisage consulting the devolved Governments—from my point of view, particularly Scotland—regarding the fact that they have exactly the same concerns and will, therefore, need to be consulted in those areas?

Mr Hunt: Very closely. The Prime Minister and David Davis made that commitment again this week. We absolutely recognise that we have the same shared interest, and no conflicting or different interest, in getting immigration policy right, in medicines regulation and in reciprocal health. In those areas, I do not think there is any divergence of interests between Scotland and the rest of the UK.

Q120 Dr Whitford: Do you recognise the divergence regarding immigration, in that both the view of society is different and our needs are very different? Part of Brexit was to get immigration down, but before the expansion of the EU eastwards, the Scottish population was diving below 5 million. We need immigrants. Therefore, our Government require the ability to have a different solution for Scotland, or we will not be able to maintain health and social care—or even our population.

Mr Hunt: Of course I recognise that there are differences of history and geography and differences socially, but when it comes to reserved matters, the UK Government take decisions on the basis of the whole of the UK, not just the needs of England or England and Wales. When we are assessing immigration policy, we look at the needs of Scotland, as well as the needs of the rest of the UK.

Q121 Dr Whitford: Do you not think that immigration is very different not just for Scotland, but across England? There are parts of north-west England where they really need younger people to come in, and parts where



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people clearly felt overwhelmed by immigration. Therefore, we need some local mechanism to feed in.

Mr Hunt: We need a national policy that recognises local differentials. In London and the south-east, there is a particular need for lower-skilled labour from the rest of the EU. The proportion of people from the EU working in care homes in London, for example, is higher than anywhere else in the UK. It is absolutely the case that there are different regional issues. That is the purpose of a national immigration policy.

Q122 **Dr Whitford:** Is that something you will support and speak up for, for people who are trying to do the same job as you in different parts of England and the other three nations?

Mr Hunt: I hope I do. I have to speak up for all the different parts of England. That is my responsibility as Health Secretary for England. As you rightly say, there are big regional differences there as well.

Q123 **Chair:** Secretary of State, are you able to stay on for a short while, to allow us to raise other health-related questions with you?

Mr Hunt: Sure.

Q124 **Chair:** Can I return to the earlier point about GP seven-day services? I know that many GPs felt very demoralised and concerned about what they saw as their being scapegoated for problems in A&E. To take you back to the conclusion of one of our previous inquiries into primary care, we expressed some concerns about possible unintended consequences if an overstretched workforce was expected to man co-located GP services in A&E at the same time as out-of-hours services and the new seven-day access and Sunday services. There was some concern that that could undermine the ability to man some of the out-of-hours services. Alongside that, there is the separate issue of whether Sunday afternoon services that are relatively underused are best value for money, given that resources are so stretched in the health service. That is a bit of the context.

We then heard from Alistair Burt, who defended the use of the pilots. I agree that it is a good idea to have pilots. He said, "If it turns out that it is a complete waste of resource in particular areas, that is a material fact that I would take into consideration." It is therefore of some concern to read in *Pulse* magazine that GPs in Greater Peterborough, which is one of the second-wave areas to pilot this, are apparently being instructed that they have to put measures in place to increase the use of weekend slots. Surely the whole point of a pilot is genuinely to assess the level of demand, and the crucial point is whether it is good value for money and whether there are unintended consequences.

There are several points. First, there is the impact of the statement that was made last weekend, which has been very serious. I think it is very undermining. Secondly, what is your response to the concern that we will not see genuine results from the pilot if people are being instructed to create supply-led demand? I am sorry that it is a long question, but I



wanted to set out some of the context.

Mr Hunt: The first thing I want to do is to recognise the very tough job that GPs do, and the fact that it is very hard work and they are extremely stretched. I have done that on many occasions. The first speech I gave when I became Health Secretary after the 2015 election was to general practice. Since I became Health Secretary, I have championed putting more resources into general practice and getting more doctors working in general practice, because I recognise that that is the key to unlocking what we all want—to reduce pressure on hospitals, to move to prevention rather than cure, and to do all the things that we know are logical and right in terms of health system reform. I think GPs do a fantastic job and they work extremely hard.

I am not suggesting for a moment that you were doing this, but it is very important not to foster—as some have—misunderstandings about the Government's seven-day GP offer. It is very clear that, where there is lower demand for weekend services, GPs can offer a networked solution. The promise to the public, which was a manifesto promise, is that people can access a routine GP appointment in the evenings and at weekends. It may not necessarily be at their nearest surgery; it may be at another surgery in the same town, and that is precisely to respond to the point that you just made—the fact that the demand pattern is different.

We think that there is some demand on Sundays, but much less than on Saturdays. There is some demand on Saturday mornings, but much less than during the week. We think it is right that the NHS should offer evening and weekend appointments to all NHS patients, because some people find it difficult to take time off work in the week. The NHS needs to be there for everyone. We need to make sure that people can book routine appointments at a time that is convenient for them, but we recognise that in order to do that we need to increase the capacity of general practice. That is why, alongside those plans, we announced a significant increase in funding of 14% in real terms, or £2.4 billion a year, which is a reversal of the historical trend of a lower proportion of NHS funding going to general practice—the proportion going into general practice will go up for the first time—and around an additional 5,000 doctors working in general practice by the end of the Parliament. That is a better deal for GPs than for any other part of the NHS—except possibly mental health—in terms of the increase in investment. As part of that, we think it is fair to deliver on our manifesto commitment. That is why we were disappointed by suggestions from some GP leaders that GPs should not do that commitment.

Q125 **Chair:** Isn't the point that it is better to allow CCGs and those who are designing local health systems to be able to prioritise the funding based on clinical need? If they are demonstrating that there is poor uptake—genuinely poor demand—isn't there an absolute duty on the Government to allow them the flexibility to put in place what is necessary in their area? Yes, people can access it in a number of places, but rather than



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having top-down, rigid instructions as to how that should look, shouldn't we much more genuinely allow CCGs to prioritise?

Mr Hunt: We have to meet our manifesto commitment. You would not make my life comfortable if in two years' time I said to you, "We made this promise in the 2015 manifesto, but locally people decided they didn't want to do it." We made a promise that people will be able to access routine GP appointments in the evenings and at weekends, and we have to deliver that.

The assessment that needs to be made is to match the supply of weekend appointments to the level of demand in different areas. In order to be true to the spirit of the manifesto commitment, we need to make sure that, where Sunday appointments are made available, they are publicised so that people know about them. I have been to GP practices that say that, when people know about those appointments, plenty of people want to take up the opportunity to have them, although obviously not in the same volume as they would on a weekday.

Q126 **Chair:** But the cost of each of those appointments is far higher. I agree that, finally, we are starting to see a reversal of the decline in funding to primary care, but it is still not a great deal. It is still a relatively small amount. When money is very tight, is the best use of a very small uplift in funding to have supply-led demand for appointments? Would it be better, in terms of patient care, to prioritise other areas?

Mr Hunt: I do not agree that this is supply-led demand. Around 20% of GP practices offer weekend appointments to their patients, and there is a statistically significant reduction in demand for A&E services in those areas. Part of this has to be about reducing the pressure on A&E departments, and I believe that GP practices have a role to play in that.

Q127 **Dr Whitford:** Is it not the case that some of the pilots did not show a reduction at A&E? While many GPs accept that Saturday mornings, for people who work during the week, are arguable—there tended to be bigger uptake in the pilots and so on—Sunday afternoons, with a 12% uptake, are somewhat harder to justify.

Mr Hunt: That is why we are not saying that we should have the same capacity available on Sunday afternoons as we have on Saturday mornings. We need to honour the commitment that we made to the British people and they voted for, which is to have some appointments available.

Q128 **Dr Whitford:** What is the timescale? You say that the extra doctors trained will be in the mid to late 2020s. The extra 5,000 will be in 2020 or 2021. When do you expect to have the seven days, given that lots of practices can barely cover five days?

Mr Hunt: The commitment to having around 5,000 extra doctors in general practice and to the seven-day NHS is for this Parliament, so it needs to happen by the end of this Parliament.



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Chair: I will take one very quick supplementary before we have to dash off. We will finish the session there.

Q129 **Luciana Berger:** It relates to the point you made about mental health funding, Secretary of State. You will know that there have been a number of reports, particularly in recent weeks, which have shown that 50% of clinical commissioning groups across the country are siphoning off the funds you have committed for child and adolescent mental health services to other parts of the NHS. What are you going to do about that?

Mr Hunt: I do not think it is acceptable when that happens. Overall, I hope you will be pleased to see that this year we are on track to spend about £1 billion more on mental health than we were spending two years ago. The proportion of CCG budgets going to mental health is increasing from 12.5% to 13.1% this year. You are right; there have been areas where take-up of our drive to improve commitment to mental health has been patchy, but the overall picture is that the tanker is turning.

Chair: Thank you very much, Secretary of State and Paul MacNaught. We appreciate your time.