

Health Committee

Oral evidence: One-off session with the Secretary of State, HC 523

Tuesday 31 October 2017

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Dr Caroline Johnson; Diana Johnson; Johnny Mercer; Andrew Selous; Maggie Throup; Dr Paul Williams.

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Witness

[I](#): Rt Hon Jeremy Hunt MP, Secretary of State for Health.



Examination of witness

Witness: Rt Hon Jeremy Hunt MP.

Q1 **Chair:** Good afternoon, Secretary of State. Thank you very much for joining us. We are expecting a couple of Divisions and we have a huge amount to get through this afternoon, so we are very grateful to you for joining us. Can I start by asking whether you have read the House of Lords report on the long-term sustainability of the NHS and social care?

Mr Hunt: I have read a summary of it.

Q2 **Chair:** Yes. You may have noticed that one core criticism is that they see there is a culture of short-termism within the Department of Health and express great concern that there is a lack of long-term planning. They specifically recommend that there should be an office for health and care sustainability. Would you agree with that?

Mr Hunt: In some areas, it is a fair criticism, but in others I think we have raised our game. The area where I have felt the biggest lack of long-term planning has been around workforce needs and the failure to understand—over many years really—the lead times necessary to increase capacity in the system because of the time it takes to train new doctors and nurses. If we want to improve the NHS, it is not just a question of funding, although that is very important, but the need to have the capacity in the system. That is an area over the last couple of years where I have tried to put in place much longer-term planning in the fundamental capacity of the system to deliver the doctors and nurses that we need in the future.

Q3 **Chair:** One point they make very clearly is that there is a lack of good quality data on which to make all these future plans. That is partly why they set out their very specific recommendation on having an office for health and care sustainability, rather as we would have the OBR. The other question is, when are we expecting to see the response to their report, which was published in April?

Mr Hunt: We do owe them a response. I hope we will be able to publish it shortly, but we do not have it ready yet.

Q4 **Chair:** Thank you. One key area for this Committee has been around funding. As you will know, it was very welcome at the time that the spending review settlement was front-loaded, but we are now set to enter some very lean years indeed. In fact, we are looking at a 0.2% increase next year, 0.1% for 2019-20 on a background of 1.1% annual increases since 2010, when in fact in the longer term the NHS has been having around 4% annual average increases. How sustainable and realistic is that funding settlement and what do you estimate to be the financial gap?

Mr Hunt: The reason for the lower rate of increase is precisely what you said that, at the time the NHS was arguing for an £8 billion increase in its



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funding, they argued very strongly that they wanted the bulk of that increase to come early on in the five years. I supported them in that. The result of that was that in the last two years NHS funding has gone up by £5 billion in real terms, which is a significant increase, although it is still not at the 3% to 4% levels that you talk about. The mathematical corollary of that early £5 billion of the £8 billion increase is that there will be a lower proportion of the £8 billion in the coming years. The answer is that that does make it very tough going forward. There is a lot of pressure in the system, as I am sure we are going to discuss later. Waiting times are growing longer and we are working very hard to make efficiency savings so that we can meet the increased demand. The big challenge we face is that the demand growth assumptions at the time of that settlement have proved to be optimistic and demand has grown faster than we were anticipating when that settlement was made. That makes it very tough.

Q5 Chair: Yes. Of course, even with the front-loaded settlement it relied on pay restraint, capital-to-revenue transfers, cuts to public health and Health Education England and many short-term accounting measures just to scrape through by the skin of its teeth. I come back to my point: is it realistic, as we stand, for the NHS to cope with the kind of very drastic reductions we are expecting to see over the next couple of years?

Mr Hunt: They are not drastic reductions but it is tough. In our manifesto at the last election, we committed to an increase in NHS funding of an additional £5 billion per annum on top of the £8 billion, so a total of £8 billion extra during this Parliament. That equates to an additional £5 billion on top of what had already been committed. We recognise those pressures exist and we also committed to real-terms per capita increases in every year of the Parliament. That does mean that next year there will need to be at least some change in the NHS budget in order to meet that commitment.

Q6 Chair: What percentages are you suggesting are absolutely necessary when talking about how that £5 billion is spent?

Mr Hunt: As you know, we have the Budget coming up, so I am in the middle of discussions with the Chancellor as to how we meet those manifesto commitments. That is obviously not a discussion that I can have publicly, but I will say to the Committee that I do recognise that there are very real pressures on the NHS frontline at the moment.

Q7 Chair: No one is expecting you to say what your private discussions with the Chancellor are, but we are asking you to set out what you see as being the absolute requirement in increases for the NHS over the next few years.

Mr Hunt: That is what I am setting out to the Chancellor, but that is not what I am able to set out to the Committee today because we are in the middle of those discussions.

Chair: Thank you. I am going to come to Ben.



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Q8 Mr Bradshaw: Do you think the Chancellor and the Prime Minister understand that the NHS is a demand-led service and in that respect it is not like cutting the police?

Mr Hunt: I think they do, yes.

Q9 Mr Bradshaw: What do you think the Chancellor meant when you said on Marr at the weekend that he might be prepared to give a little more money but only in return for efficiencies? What sort of efficiencies are we talking about, because a lot of people in the NHS would say it is already cut to the bone?

Mr Hunt: The NHS is the most efficient healthcare service in the world. That is recognised internationally and that is partly because of the benefits of what health economists call a single-payer system, which means that we get the cheapest prices for drugs, for example, of anywhere in Europe.

Q10 Mr Bradshaw: If it is already the most efficient service, where are these extra efficiencies going to come from?

Mr Hunt: On a £116 billion budget, there are always efficiencies that you can find and we do have a major efficiency programme, but the Chancellor was talking specifically about discussions with NHS workforce, the kinds of discussions we might have where he would want to see things that could improve the long-term productivity of the people working in the NHS, were he to consider putting extra money in. Let me be clear on what he was not saying and what I certainly would not say: that we would be expecting people to work harder because I do not think that is possible at the moment. People in the NHS do work extremely hard. In fact, I think they are working harder than they have ever worked because hospitals and GP surgeries are very busy places.

Q11 Mr Bradshaw: You would have an extra £100 million now if the NHS had not overpaid pensions to that amount in the last five or six years. Is there any prospect of getting any of that money back?

Mr Hunt: That is something we are looking into, but that is a very good example of how, even with a system that is run, in international terms, as efficiently as the NHS, there are savings that we identify. As to other examples of where I think there are savings, we are hoping this year to—

Q12 Mr Bradshaw: Can you address the specific issue of pension overpayment where you say you are looking to get the money back? Do you have any money back? How much are you hoping to recover and how much have you recovered so far?

Mr Hunt: We do not have any money back now and we are looking to see whether we are able to get money back where we have overpaid.

Q13 Mr Bradshaw: What is your understanding of the current status of the 18-week target?



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Mr Hunt: We are not hitting it. The target is that 92% of people should be starting treatment within 18 weeks and at the moment it is 89.4%. That is not acceptable and we intend to get back to meeting that target.

Q14 **Mr Bradshaw:** How do you intend to do that?

Mr Hunt: We have to do a number of things. It is important to recognise a couple of things in terms of that target. First, getting the NHS into a situation where it is able to treat the majority of people needing elective care within 18 weeks was an enormous achievement of the last Government. It was hard won, it took a long time and we do not want to go back to the bad old days of people waiting a huge period of time for their knees or hips to be replaced. That is a fundamental promise that the NHS makes to NHS patients and it is one that this Government are as committed to as the last Government.

Secondly, we have to recognise the context, which is that the NHS is doing 1.9 million more operations every year than in 2010, so that is about 5,200 more operations every single day. When it comes to out-patient appointments, it is about 10 million more every year, so about 27,000 more out-patient appointments every day. The volume of activity, the amount of care we are giving, is at record levels, but we have not been able to keep up as much as we wanted to with the growth in demand. That is the core issue.

Q15 **Mr Bradshaw:** So has it not been relaxed?

Mr Hunt: No. We have conceded that we are not likely to get back to meeting that target in the current financial year, but we have been absolutely clear to NHS England that we do expect to get back to that target, and they accept that.

Q16 **Mr Bradshaw:** How do you suggest that people who are not being treated within 18 weeks claim their legal right, enshrined in the NHS constitution, because there is no doubt it is a legal right? Lord O'Shaughnessy in the House of Lords recently, after the Government were defeated on this issue, said the 18-week target remains a patient right embedded in the NHS constitution and underpinned by legislation. Should people start suing you for failing to meet the 18-week target?

Mr Hunt: It is a right, but I do not think it is a right that, under the law as it stands, entitles people to sue the NHS if we do not deliver it. But that does not mean to say it is not a very important right and, as I said earlier, a fundamental part of what the NHS offers and what we want it to offer.

Q17 **Mr Bradshaw:** How legally enshrined is a right if it is not claimable in some way by people?

Mr Hunt: The status of the NHS constitution is not, in the law, the same as the status of an obligation whereby if the Government do not deliver they can be sued. That is a matter of fact in how the law stands.



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Q18 **Mr Bradshaw:** Has it been tested?

Mr Hunt: I imagine a lot of people have thought about testing it on a number of occasions. That is not to say that it is not a very serious issue that we are not hitting that target at the moment, and we are looking at a number of things, some of which have been in the public domain about, for example, whether we can improve the efficiency of operating theatres. We think it would be potentially possible to do around 65,000 more operations a year on our current theatre operating capacity if all operating theatres operated at the same efficiency levels as the best. We are looking at all sorts of ways to try to address the issue.

Q19 **Mr Bradshaw:** It is not just the 18-week target, is it, Secretary of State? It is the A&E target, the delayed discharge target, the trolley waits target and waiting times at GPs. The NHS is missing almost all, if not all, of the targets. Would you agree with what Simon Stevens told the Committee two weeks ago that, without extra resources in the budget, NHS performance would continue to deteriorate significantly?

Mr Hunt: I recognise the picture that you paint but I do not agree with the overall inference of that being a fair overall reflection of how the NHS is doing. NHS England, in an independent report published earlier this year, said that outcomes in most major conditions have improved dramatically in the last three, five and 10 years, and the safety and quality of care that we give is improving, according to the CQC. You are right that one important aspect of the quality of people's care is how long they wait. That is the area where we have not been doing as well as we would like to and we need to do everything we can to stop further deterioration, but I fully accept that there is a lot of pressure there.

Q20 **Johnny Mercer:** I am going to come on to workforce in a moment, but talking about demand, which Ben mentioned, there is this thinking that demand is going to continue rising. I did another night shift with the ambulances in Plymouth at the weekend, and, being new to this, I was genuinely taken aback at people's expectations and that demand from what is still an emergency service. Is there any work going on—whether it be education, triaging these calls or some sort of effort—into managing expectations of what you can expect from an emergency service?

Mr Hunt: It is a really fundamental issue because sustainability of the levels of service we are giving at the moment is a function first of making sure we get the funding that we need but also understanding the correct models of care that will bring demand down to sustainable levels. That is not about rationing care but about recognising that there is an enormous amount you can do to reduce the growth in emergency care. For example, to take the ambulance service, we have 4,400 more 999 calls every day than we had in 2010. That creates massive pressure on the emergency services. One reason for that pressure is that we have under-invested in general practice in recent decades and under-invested in the kind of community care that would mean that people would not get to the point of having to dial 999 and needing expensive hospital care. That is



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what the whole sustainability and transformation process is about—properly investing in out-of-hospital care so that we can constrain the growth in emergency care.

- Q21 Johnny Mercer:** It is interesting. That is what I want to come on to around workforce. There is a 5.9% national shortfall in the workforce at the moment. In areas like mine in the south-west that are deprived, we have an 11.6% deficit in employment. I speak to people down there about how we have not managed to figure this out yet, that if we turn the tap off before the water gets to the end of the garden we are not going to be able to water the roses. Why are we only coming to this conclusion now and is it something that you recognise, or the Department recognises, as a national planning issue, that nationally we need to provide a little bit of leadership and deliver on this problem?

Mr Hunt: Absolutely. It is worth understanding what is causing that pressure on workforce. What has happened is that two things have come together. First, we have the ageing population, which means that over the last seven years we have about 500,000 more over-75s, and we will have a million more in 10 years' time, and that creates a lot of pressure.

At the same time, four years ago, we had the Francis report on Mid Staffs, which alerted us to the fact that the quality of care in a number of hospitals was simply not acceptable and that we needed to have many more staff in our hospitals than we had previously been planning. Our expectations on safety and quality increased dramatically, and rightly.

Part of the reason for much higher vacancy rates is that the NHS recognises it needs many more staff than it did a few years ago, and, in fact, if you look at what the NHS was planning to do with the adult nursing workforce in 2012-13, you'll see that they were planning to reduce it by just under 5,000 across the NHS. We have actually increased it by around 11,000, which is a good thing, and the Health Foundation says that the overall NHS workforce has gone up by 2% in the last year alone. To answer your question very specifically, we need that long-term planning and that is why—

- Q22 Johnny Mercer:** On that specifically, what is the plan to address this, particularly with junior doctors? There is a huge gap in the junior doctor workforce, according to a recent announcement. If that figure were to be only nationally, it would just sort out the south-west, so it is not really meeting demand. Is there a plan to address this and to let trainees flow to areas where they are most needed, such as junior doctors in deprived areas?

Mr Hunt: I am not sure what the recent announcement is to which you are referring, but the most significant point is this. In the junior doctors strike, without getting into the discussion about the contract, there was one aspect on which I thought the junior doctors had a point, which is they said we say we care about patient safety but when they go to work there are gaps in their rotas—there are not enough colleagues alongside



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them to allow them to deliver the kind of care that they want. The truth is that we do need more doctors in the NHS, which is why last year we announced a 25% increase in medical school training places. That takes six or seven years to feed through the system, so it is not a silver bullet, but I do think, when we get to the end of that process, we will be meeting demand with supply when it comes to doctors. This year, we announced an equivalent 25% increase in the number of nurse training places precisely to make sure we are doing the same thing for the nursing workforce.

- Q23 **Johnny Mercer:** When they have finished that, is there a national allocation process of where they can go or do they get a preference in it? In some areas, like mine, they have quite a strong satisfaction rate when they come out of medical school, but they end up going elsewhere, and we still see that deficit in junior doctors or in primary care, for example, in trying to get people to go into a really challenging primary care environment. Is that national allocation process being looked at?

Mr Hunt: It is, because we recognise that one critical issue is persuading medical school graduates to go and work in areas where it is sometimes harder to recruit doctors, so we have introduced an incentive scheme that pays a premium to GP trainees who go into parts of the country where we have not been able to fill a trainee post for three or more years. They get a £20,000 salary supplement. We have just expanded that to 200 every year and it has been very successful.

The other thing we are looking at, with the expansion in medical school places, is to try to increase the recruitment of medical school graduates from areas that are themselves hard to recruit from because it is much easier to send someone back home to the area that they came from. We are looking at a number of measures to deal with those issues.

- Q24 **Johnny Mercer:** Is indemnity one of those measures? In NEW Devon CCG, NHS England has talked about providing that indemnity so people can go and work there. Is that something you would consider looking at nationally?

Mr Hunt: Yes, we already have. In fact, I announced at the Royal College of General Practitioners conference that we wanted to set up a state-backed indemnity scheme. It is a particular issue causing concern in the GP community and may indeed be triggering early retirements, which is one issue that we face with GPs: the spiralling cost of indemnifying themselves, which of course hospital doctors do not have to do because it is covered by their trust. Therefore, yes, we are proposing to go for the state scheme.

- Q25 **Johnny Mercer:** Finally, on public sector pay, on the Marr show at the weekend you talked about an increased link to performance. What did you mean by performance in that case?



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Mr Hunt: It was linked to productivity improvements. That was the conversation I was just having with Mr Bradshaw. That is really a matter for the negotiations with the unions.

Q26 **Johnny Mercer:** Is any pay increase going to come with a tightening of the screw on efficiencies within the NHS or is it going to come from extra money that may come from the Chancellor?

Mr Hunt: The Chancellor has said that he will consider providing extra money if I am able to secure some productivity improvements in the contractual arrangements that we have with staff members.

Q27 **Chair:** Just to clarify, is he saying that it all has to come out of that or that there will be some kind of mixture of the two?

Mr Hunt: He has not given me any more detail than I have given you on this matter. It is that he will consider finding extra funding so any pay rise would not all or in part have to come out of savings in the rest of the NHS, but he would like to see some productivity improvements negotiated as part of those contractual changes.

Chair: Johnny, did you want to ask about regulation?

Q28 **Johnny Mercer:** Yes. The consultation that is going on at the moment around promoting professionalism and forming regulation is running to the end of January, is it not? When will that be looked at with a view to becoming some sort of legislation that will come to the House and be enacted?

Mr Hunt: It is something we have been wanting to do for a very long time, and Ben Gummer, when he was a Minister in my Department, very effectively championed that. The answer is obviously we are keen to get on with it. It is particularly difficult with all the Brexit legislation that is going to be happening, but it is very important for patient safety reasons that we streamline and improve the way that professional regulation—

Q29 **Johnny Mercer:** When do you reckon, roughly? Do you have a timescale in your mind?

Mr Hunt: No, because we do have to wait until this consultation is completed and then we will take a view on precisely what legislation is needed. We will need some legislation.

Q30 **Dr Cameron:** As to workforce, over the last 20 years or so in the NHS it has been pretty obvious that there have been more and more management roles, and perhaps at times at the cost of frontline clinician roles. Are there any reviews in place to monitor that and to try to ensure that funding reaches the frontline and funds the clinicians who need to see the patients?

Mr Hunt: The direction of travel in this Government has been the opposite of that. We do need good managers in the NHS in England, as you do in Scotland, but, from the last time I saw the numbers, I think we



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have 30,000 more clinically trained staff in the NHS compared with 2010 and 18,000 fewer managers. We want to invest our resources in frontline clinicians, but I do not want to get the easy headline of saying, "Managers bad, doctors good," because the thing that doctors complain about more than anything is not having the quality of management that they wish they could have in order to do their job more effectively. Running a hospital is one of the most difficult jobs in Britain today and we need to train and support people to do those jobs.

- Q31 **Dr Cameron:** Is it something that you are keeping a close eye on and making sure that the money does reach the frontline, because there is myriad management within the NHS and when funding is put in at the top it sometimes does not trickle down to where we need it to go?

Mr Hunt: Yes. Of course we monitor it very carefully and the principal change that happened in England was the dismantling of the SHAs and the PCTs, and their replacement with CCGs. Most people would say in the NHS that the CCGs are much meaner and leaner in their efficiency structures than their predecessors were, but it is something you have to constantly keep an eye on.

- Q32 **Andrew Selous:** We are losing a lot of excellent GPs and consultants because of the old pension scheme. A lot of them are being forced out at 60 by pension rules that really bite. Do you think there is a case for a very narrowly restricted public sector carve-out where we are losing key public sector staff because of pensions legislation? Is that a case you would be prepared to make to the Chancellor?

Mr Hunt: It is something about which I have ongoing discussions with the Chancellor because it is a very serious and live issue. One unintended consequence of some of the restrictions in pension relief is that we have ended up with a system that can make people financially better off if they retire early and sell their services back to the NHS as a locum and that ends up costing the NHS more, and indeed we lose the incredibly valuable experience of people at the peak of their careers. That is one of a number of issues. Overall, we do have to do a lot better on retention issues generally with our staff.

Another issue is the availability of flexible working in the NHS. Other sectors of the economy have recognised much more quickly than we have how people in their 50s and 60s might want to work a four-day or three-day week but carry on with the same contract, but that can also be true for people in their 20s and 30s with young families, childcare needs and so on. That is why I announced in October that we would make flexible working arrangements available to all NHS staff during the course of this Parliament.

Chair: Thank you. We move on to patient safety now and Diana.

- Q33 **Diana Johnson:** Thank you. You already talked about patient safety and how important it is to you, and I know personally since Mid Staffs you



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have made a big thing about this and your personal reputation has been staked on it. Do you feel, in the light of recent comments by a variety of organisations and professionals, that the crisis in the workforce is the biggest threat now to patient safety in the NHS?

Mr Hunt: I do recognise that there is a link between patient safety and having a motivated workforce. Putting it very bluntly, happy staff means happy patients, and people who are motivated and happy to come to work are much more able to give a higher standard of care to patients. However, I think there is a more practical reason why that is true, which is that if we are going to be the safest and highest-quality healthcare system in the world, we need to move away from the blame culture that I'm afraid we still have in some parts of the NHS and towards a learning culture. That means people need the time to be reflective. When people are rushed—as we are about to be—they are not always able to reflect on why something went wrong, to learn from their mistakes and to disseminate that information.

Chair: We will go and vote and hopefully be back soon.

Sitting suspended for a Division in the House.

On resuming—

Chair: As we are quorate, we will make a start because we have so much to get through, if that is all right. To recap, we were talking about patient safety.

Q34 **Diana Johnson:** Thank you for your answer when we were so rudely interrupted. I also want to ask you about what Sir Robert Francis said this year when he was talking about the NHS approach to safe staffing, that it may not have changed enough since Mid Staffs. What do you think of that comment?

Mr Hunt: The answer is that there was a massive amount to do after Mid Staffs. We have seen since then 11,000 more nurses in the NHS. Pretty much every hospital in the country has more nurses, but if you are—

Q35 **Diana Johnson:** So why is he saying that?

Mr Hunt: If you are asking whether we have enough nurses yet, the answer is no. There are still places where we need to improve staffing levels and, in a lot of cases, trusts say that it is not actually about money, but that they advertise for a post and cannot find anyone qualified to fill it, which is why we have taken the measures to improve the long-term supply of nurses to the NHS.

Q36 **Diana Johnson:** Can I ask you about that? Reading around your proposals on increasing the number of medical school and nurse training places, you are going to use the HEE—Health Education England—model, if I have that correct, which has not in the past always delivered what needs to be delivered for the workforce in the NHS. What is different



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now? Why can this organisation deliver for you all that you need for workforce training places?

Mr Hunt: Health Education England has only been going since the 2012 Health and Social Care Act, so it is early days for a verdict on them, but you are right, I think, that workforce planning over very many years has not been adequate in the NHS. I think the reason for that is that we have not taken a long enough time horizon. Because of the time it takes to train a doctor and to train a nurse, you have to be thinking outside the current spending review cycle, and if you think within a spending review cycle the structural problem that I think we have often had is that the Health Secretary gets his or her money from the Chancellor and thinks, "Do I want to spend this money on more doctor training, which will not help the NHS for six, seven or eight years, or do I want to spend it on more cancer treatments today?" The result is they take a decision that is understandable but not necessarily the right decision in the long term for the NHS. That is what we are trying to put right.

Q37 **Diana Johnson:** You are addressing the long-term issue, but what about the short-term issue—the fact that you are saying there are not enough nurses and doctors? What is your solution there?

Mr Hunt: There is no silver bullet. We have to do everything we can to try to make sure we deal with the short-term needs, but in the last five years we have 6,500 more doctors in the NHS and 11,000 more nurses, so overall workforce numbers are going up and we continue to recruit internationally. We are trying to recruit 2,000 GPs from abroad at the moment. The need to do that will continue and we have to get through the challenges of Brexit, which obviously have some impact as well.

Q38 **Diana Johnson:** In Wales, I understand that legislation was introduced around safe staffing levels. Is that something you think you would look at for England?

Mr Hunt: I am not aware of the legislation you are talking about with respect to staffing levels in Wales, but I would say that we looked very carefully at whether we should introduce legal requirements for every ward in every hospital and then we had very strong representations from the nursing directors in trusts up and down the country that that would be a bad thing to do for patients, because that would undermine their clinical autonomy to do the right thing on the ground. Instead, we introduced ward-by-ward transparency, so we make it a requirement that, every month, every trust has to tell us what their nursing workforce is in every ward in their hospital. That has directly led to the fact that we have around 18,000 more nurses in the NHS than the NHS was planning in 2012-13.

Q39 **Diana Johnson:** That is also perhaps the reason that Sir Robert Francis is critical of the progress that has been made around safe staffing. It does not go far enough.



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Mr Hunt: Sir Robert Francis has said on many occasions that he thinks the NHS is making a lot of progress in terms of his recommendations and has become safer in the period since he launched his report, but I would agree with him that there is lots more to do and staffing is clearly a key area.

Q40 **Diana Johnson:** Can I turn to Sir Bruce Keogh's interview that he gave in *The Daily Telegraph* at the weekend? That was also about patient safety. He was very critical in that interview of the NHS's ability to roll out critical safety changes. In fact, I want to read to you a quote from him: "The difficulty that we have is that the NHS is a conglomerate of hundreds of organisations, all of whom have their own boards and people in them with their own views." When action was required on safety grounds, "there should be a simpler way," he said. What do you make of that?

Mr Hunt: I very strongly agree with him, but it is important to put those comments in context, which I am sure he would do if he were here. The Commonwealth Fund, an independent American think-tank, said in July the NHS was the safest healthcare system of the 11 countries that they monitor, and that the NHS excels in safety. I think we are starting from a base where we are not safe enough but we are probably a safer healthcare system than many other countries. I personally think it is because we are a national health service.

Notwithstanding that, if I give you an example of the kind of thing that worries Sir Bruce and me, every week in the NHS we have four claims for a brain-injured baby. There are four times every week where someone thinks that, because of clinical mistakes, we caused a baby to be born brain injured. If a mistake was made in, let us say, Brighton, and the doctors and nurses involved understand the mistake that was made, my question is, why can we not disseminate that knowledge to Newcastle, Cumbria and Cornwall in a matter of days or weeks rather than what happens at the moment, where we might wait 11 years for a court case to be settled? In the system at the moment, it is very difficult to spread best practice. I am absolutely determined that we sort that out and I want to start with maternity, because it is one of the most pressing areas.

Q41 **Diana Johnson:** Why is it so difficult? I do not quite understand. If it is best practice, why can it not be shared more quickly? Why can you not make that happen?

Mr Hunt: We have four doctors on the Select Committee, so they will probably be able to answer that question.

Chair: With respect, Secretary of State, you are in front of us and you are—

Mr Hunt: I have come to answer and I am willing to answer it, but I just wanted to defer to your greater knowledge. Let me answer.



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Q42 Diana Johnson: Can I ask you to answer it as the Secretary of State? That is how I want you to answer it, yes.

Mr Hunt: Of course I will. If you could imagine the most traumatic thing that could happen in any hospital, I would say it is probably when a baby dies because of a clinical error. It is obviously terrible for the family and it is deeply traumatic for the doctors and nurses who were responsible for that child's care, and in a way they are victims as well. What they want to do more than anything else is be open with everyone about what went wrong, to learn from mistakes and to spread the message of those mistakes so that that mistake is not repeated. Sometimes in the NHS we make that practically impossible because they are worried about litigation, the GMC, the NMC, the CQC and the reputation of their trust. We do not support doctors and nurses in those situations nearly as well as we should to be open about what happened. That is what I mean when I say we have to change from a blame culture to a learning culture. That is a big change in culture but one that is absolutely essential.

Q43 Diana Johnson: I can understand in those circumstances all the reasons why it is more difficult, but we are talking about sharing best practice. That is what I do not quite understand. Why is best practice not more easily shared? Why do you think that is?

Mr Hunt: It is for the very reason I have just described, that when things go wrong, you can only share—

Q44 Diana Johnson: I am not talking about where things have gone wrong. I am talking about how things can be done effectively and efficiently. Why is that not more widespread?

Mr Hunt: Because the first step to establishing best practice is to allow people to have the open discussion so that you can understand exactly what it is that went wrong and then you can spread that knowledge, but if you make it difficult for people to talk openly about what has gone wrong, it is much harder to establish best practice. I would say the thing you can do that is quicker than changing culture, because that does take time, is to make sure you have the national systems in place that can spread news around the system as to what best practice is, whether it is maternity, orthopaedics, A&E or whatever. We do have those systems in the NHS and most countries look with quite a lot of envy at the national systems we have, but the issue is not the sending out of instructions. The issue is the compliance. Most people working in a healthcare setting would say that they are not short of instructions from the centre as to what best practice is in doing this or that, but we do not have a system in place that ensures a high degree of compliance, and that is something that we need to address.

Q45 Diana Johnson: Can I ask one other thing, about another report in the media, which is around GPs who are thinking of opting out of the NHS and setting themselves up, I guess, privately? What are you making of that? There is going to be a vote, I think, at the BMA. What are your



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thoughts on why they are doing that?

Mr Hunt: We have to look at the underlying reason why those kinds of motions are being debated. I think it is that GPs feel that their workload is too high and their job has become too stressful. Sometimes, they feel that they are on a hamster wheel of between 30 and 40 10-minute appointments every day, and it is exhausting. The long-term solution to that is to get more capacity into the system, which is why we plan to recruit 5,000 more GPs, which we are in the middle of trying to deliver. Some bits of that plan are going well, other bits less well, but I am absolutely determined to deliver that and I think that is the long-term solution.

Q46 **Chair:** Can I go back briefly to the point Sir Bruce was making? Quite often, you have safety-critical devices that are introduced that we know can make a huge difference, but they are not introduced everywhere. Surely that is something that could change by having a streamlined system to mandate these improvements everywhere. That is what comes through as one of his frustrations in this. What is stopping that happening, Secretary of State?

Mr Hunt: I agree. One example of what you are talking about is the question of “never events.” “Never events” are events that we know should, if everyone followed procedures, never happen—wrong-site surgery, retained foreign objects and so on—but the number of “never events” has remained pretty stable at between 400 and 500 every year over the last five years. It has not been going down. I have asked the CQC to do an independent report on why this is the case but also to look at the systems that we have, because it is not that we do not have those systems for spreading best practice but that we do not seem to be complying with them in the way that you would find routine in the airline, nuclear and oil industries. I have asked the CQC—in fact I had a meeting with Professor Ted Baker’s team about this yesterday—to make recommendations about how we improve the national reporting processes so that we can deal with that very issue.

Q47 **Chair:** That is because there are so many bodies that are already commenting. You are actively going to work on how this is going to be improved so that the “never event” rate comes down.

Mr Hunt: It is broader than “never events.” “Never events” is one of the issues, but the issue, I think, relates to what Ms Johnson was saying earlier, which is, why is it that we have our national systems for spreading best practice—and incidentally I believe that they are better than the systems in most countries, so I do not think we do badly by international standards—but compliance is still not as high as it should be?

Q48 **Chair:** Is that also going to extend to the very reasonable point he makes about the number of devices that we could roll out across the whole NHS that would save lives and reduce costs? Is that something you



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are going to be focused on as well?

Mr Hunt: Yes.

Chair: Thank you.

Q49 **Mr Bradshaw:** How would you respond if the BMA voted to leave the NHS en masse?

Mr Hunt: I would listen to everything that came out of any BMA conference carefully, but the Government make policy on the NHS, not the GPs, and they do have an obligation to follow the contracts that they have, but obviously if there is concern about the levels of workload and the capacity of the system, that is something I am going to listen to very carefully. I hope that GPs had a chance to listen to some of the things I said at the RCGP annual conference, because this is an area of great concern for the Government as well and we are undertaking a number of measures to try to relieve the pressure on general practice.

Q50 **Mr Bradshaw:** But they are private contractors, are they not? They are not NHS employees. You could not stop them. Does this not show how bad things have got that GPs are even considering abandoning the NHS en masse?

Mr Hunt: They are private contractors. In fact, the Conservative Government in 1945 wanted them to be NHS employees but that was overruled by Nye Bevan, who decided they should remain as private contractors.

Q51 **Mr Bradshaw:** That is because they would have threatened to bring down the whole of the NHS and we would never have had it. That is a rewriting of history, Secretary of State, if you do not mind me saying so.

Mr Hunt: No. I am just telling you.

Q52 **Mr Bradshaw:** The BMA would have just brought down the whole of the NHS, and the very high price Nye Bevan had to pay was to stuff their mouths with gold.

Mr Hunt: I am actually telling you history, not rewriting it, but the point I am making is that, yes, they are private contractors but they also do have a contract with the state, which is the source of their income, and we have a responsibility under that contract to look after all NHS patients in the areas they operate.

Q53 **Dr Cameron:** We have heard—particularly in evidence last week—that staff morale is coming down. Staff morale in the NHS we have heard is figuratively at rock bottom. How do you feel about presiding over that and what lessons can be learned to bring the workforce with you?

Mr Hunt: There are a number of issues around morale. The heart of the issue is that staff are finding themselves working harder, with longer hours and more overtime. NHS organisations are busier than they have ever been and I think that creates a particular pressure for frontline staff.



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The staff survey says very clearly that we are seeing an increase in the number of NHS employees who are happy with their training, with the respect with which they are treated by their boss, the quality of care that they are providing and with their ability to raise concerns about patient safety, so there are a number of indicators going in the right direction. One indicator that is a concern is the number of NHS staff who say they have felt unwell because of work-related pressure. That number has been coming down over the last five years, but it is still at 37%, which is far too high. That is why we are looking very carefully at what measures we can do to better improve the mental and indeed physical health of people working in the NHS.

There are lots of things we can do in the short term, but in the long term the only thing we can do is to improve the capacity of the system to deliver the high standards of care that we all want. We do not have that capacity in the system at the moment and that is really about a very significant increase in the number of doctors and nurses that we train.

Q54 Dr Cameron: But 81% say they are experiencing bullying, which is such a high figure; that is endemic almost. How are you going to address that?

Mr Hunt: Those numbers are a very serious concern, and I agree with you and share your concern. That is something into which we are actively looking with NHS England.

Chair: We are now going to move on to mental health with Luciana.

Q55 Luciana Berger: Secretary of State, you were on a number of television programmes on Sunday, both the Peston programme and Andrew Marr, and the focus of your discussion was mental health. I want to better understand some of the points you made and to tease out some of the detail. Because I am sure that you, like me, will have seen the vast amounts of feedback online as a result of some of the points that you made, and people who talked about their own experience of accessing mental health care, which I am sure you would agree, as I would, was far short of what we would all expect.

According to the most recent NHS workforce statistics, there are now 5,168 fewer mental health nurses and only 106 more doctors in mental health. You said on Sunday that there are 4,000 more people working in mental health. Can you explain where those people come from?

Mr Hunt: Yes. That is the 4,300 more people working in mental health trusts than there were in 2010. There are also 2,700 more people working in talking therapies.

Q56 Luciana Berger: But if there are 5,168 fewer mental health nurses and only 106 more doctors, what kind of staff are they? Who are these people working in mental health settings?

Mr Hunt: In mental health provision, there is a need for a whole range of people with different skillsets, but it is important to understand that what



happened to the mental health nursing workforce was a consequence of our desire to make an immediate response to what happened at Mid Staffs, as we were hearing from Ms Johnson earlier. There was an immediate requirement from Sir Robert Francis to improve staffing levels in hospitals. We took action on that, but the unintended consequence was that that sucked nurses into hospitals and out of community settings, which had an impact on mental health nursing, which we are now trying to address. However, the overall mental health workforce has increased significantly and, as to the care we are providing, we can see that in the number of people we are treating, with about 120,000 more people every year than just three years ago—about 1,400 more people every day—and a big expansion in talking therapies, psychological therapies for depression, anxiety and number of other common mental health conditions.

Q57 Luciana Berger: This Committee has heard from a number of witnesses in various sessions we have had about those things you point to in terms of increased talking therapy provision, but you also said on Sunday that there is a move to tread away from hospital care and that it is much better to treat someone in the community. We know there are over 5,000 fewer mental health nurses. Why is it that we are seeing such an increase in children and adults turning up at A&E in a mental health crisis and why are we seeing such an increase in the number of people being detained under the Mental Health Act? According to Sir Simon Wessely, it is a 47% increase in mental health detentions and over 50% more people are showing up at A&E in a mental health crisis. You say on the one hand that it is important, but why, on the other, are we seeing such an increase, with over 100,000 more people showing up in these settings?

Mr Hunt: As to detentions under the Mental Health Act, there are a number of complex issues going on, and that is why we have asked Professor Wessely to do a review of the Mental Health Act, how it works and whether we need to change that, because we also have concerns about some of the things that are happening, in particular the much greater number of people from BAME backgrounds who are being detained under the Mental Health Act, in order to understand exactly what is going on there.

As to A&E provision, the reality is that we legislated in 2012 for parity of esteem between mental and physical health because we wanted to make sure that people who had a mental health crisis were treated as seriously and quickly by the system as people who have a physical health crisis. So, as part of that we are rolling out crisis care for mental health across the nation, including liaison psychiatry and meeting the core 24 standards, as we call them, in A&Es across the country. We are in the process of doing that. Now, I think the latest figures I have seen are that around half of A&Es have mental health liaison services, which means that, if you go to an A&E, you get specialist mental health care, and I think that works effectively.



Q58 Luciana Berger: That is not my question. Why are people turning up at A&E in a crisis, so right at the very end, when they should be helped much earlier on either through prevention services, through early intervention services or in the community? Why are they turning up in a crisis, often having to be detained in order to secure a bed in accident and emergency right across our country every single day?

Mr Hunt: Because our core responsibility in any healthcare service is both to deal with people in a crisis and also to deal with all the prevention issues you are talking about. We need to do both things at once. We cannot ignore the fact we are failing too many people in mental health crisis at the moment. We have to put resource in place to help them but we also have to do the other thing you are talking about, which we absolutely are doing, which is to deal with the things that can stop people getting to a crisis point. That is why you see us as the first country in the world to introduce a waiting-time standard for talking therapies—that is, that 95% of people should not have to wait more than 18 weeks for their talking therapies treatment to start—and we are currently at 99% of people doing that. Those standards are for conditions such as anxiety and depression, which could very easily lead to a crisis if we did not treat them earlier. Do not take it from me. *The New York Times* said this year that this was the world's most ambitious attempt to transform treatment for anxiety, depression and other common mental disorders.

Q59 Luciana Berger: For the record, Secretary of State—and this came up in the last session—*The New York Times* article to which you referred was corrected because it had some untruths in it, things that were not accurate. I do not believe this House should rely on the views of one journalist in *The New York Times* as a basis for deciding the state of our healthcare in this country. We saw the CQC report, one of many only last week, which highlighted many issues within all stages of accessing mental health care and in-patient services as well.

If I can bring you to resource, because the crux of this issue is making sure that money gets to where it is intended, again on Sunday you said we are seeing a real increase in resources. You said we are spending over £0.5 billion more on mental health this year. Why is it, then, that in areas like mine, Liverpool clinical commissioning group are cutting mental health services? My main young people's mental health service is being cut by 43%, nearly £750,000. I have a schedule here of other services, such as our children's bereavement services. Why is this happening, not just in my area but right across the country?

Mr Hunt: I do not think you are painting an accurate picture about what is happening across the country. If you look at the figures in terms of what is actually being spent on mental health, it has gone up by £1.4 billion in the last three years, as I mentioned earlier, treating 120,000 more people every year. If you look at what happened in the last year, you'll see that, of 209 CCGs, 177 spent their target mental health funding and 32 did not. It sounds like your CCG is one of those, and we are in discussions with all the CCGs that did not meet their target mental health



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funding, but the overall impact was that around £0.5 billion more was spent last year and that has made a very big difference to many thousands of people across the country.

- Q60 **Luciana Berger:** One chief executive of a CCG told me that the money comes in but there is nothing to hold them to account to ensure it does reach the frontline when it comes to mental health. Some two years ago, you said in a debate we had specifically on mental health that all CCGs are committed to increasing the proportion of their funding that goes into mental health, and yet now we see the goalposts move. According to the evidence we heard from Simon Stevens the other week, there is not now a requirement for every single CCG to meet the mental health investment standard. Why are we seeing the goalposts moved and do you not think now is the time to ring-fence mental health funding to ensure that money that you tell us time and again is being put forward for mental health actually arrives where it is intended?

Mr Hunt: I am afraid, again, the picture you are painting is just not correct. If you look at the funding for CCGs last year, you'll see that it went up by 3.7%, and the amount they spent on mental health went up by 6.3%, so we are seeing money getting through to the frontline in very significant numbers. Where there are places that that is not happening, we are in discussions to try to sort out those issues. That is exactly what is happening. What we are seeing overall is a big expansion, but that does not mean to say there are not places where people are waiting too long. If we did not think that, we would not be having the big expansion that we are seeing at the moment.

- Q61 **Chair:** Just before we break for the Division, Secretary of State, would you be able to send a note to the Committee setting out exactly where the 4,300 extra mental health workers are, and additionally the 2,700 in talking therapies? That would be very helpful. Thank you.

Mr Hunt: I would be delighted to.

Sitting suspended for a Division in the House.

On resuming—

Chair: We still have a lot to get through, so we will make a start. I know Luciana has a further question.

- Q62 **Luciana Berger:** Secretary of State, have you ever been to a locked mental rehabilitation ward?

Mr Hunt: Yes.

- Q63 **Luciana Berger:** Do you know how many patients there are in these wards across the country?

Mr Hunt: I do not have the figure to hand.

- Q64 **Luciana Berger:** It is over 3,500 patients who are in a locked mental health rehabilitation ward across the country. There are 248 wards, the



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majority of which are provided by the independent sector. You might have seen the CQC report recently that has questioned the role of this model of care in a modern mental health care system. How do you intend to address what I think is this quite invisible but rapidly growing part of our mental health system and how will you ensure and provide assurances to patients, families and taxpayers that people are not being locked away in what are very high-dependency, expensive settings, being deprived of their liberty for longer than is necessary?

Mr Hunt: You are right to raise that issue as a concern. We are concerned that in some cases people are put in a locked rehabilitation ward and effectively parked there, and sometimes, if it is an area a long way from where they live, they may even be forgotten about. That is totally unacceptable, if it is happening.

Therefore, following that CQC report I have had an extensive meeting with the CQC and with officials to discuss it. They are coming up with a recommendation to me as to what we do to address that, but I think the heart of what you are saying is right, which is that there may be a role for people to undergo rehabilitation in a secure unit, but it should be absolutely kept to the minimum and it needs to be constantly monitored and checked. There is evidence from parts of the country, such as Sheffield, that they have managed to eliminate completely their dependency on locked rehabilitation, with better community services, which also happen to be cheaper as well, but they are infinitely better for the patients.

Q65 Dr Cameron: I am particularly concerned about pathways of care from childhood to adult services. Patients speak about it being fragmented and difficult in streamlining the services when you move from one to the other. Is this something on which you are making progress? Are there areas of best practice that could potentially be rolled out?

Mr Hunt: I recognise the concern, and it is something on which we have to do better. We have a children and young people's mental health Green Paper coming out, and that is one of the issues we are looking at to see how we can do transition a lot better. Families say that it feels like a cliff edge when they get to the point where they are no longer the responsibility of CAMHS and then move to adult services if it is mental health; indeed, for anyone with long-term conditions, not just mental health, that is an issue, but for mental health it is something we are looking at, yes.

Q66 Dr Cameron: I also want to ask about access to psychological therapies, the point of contact and the targets. That is improving over time, and I know that from having worked in the NHS myself over quite a lengthy period, right across the UK, but how are you monitoring that the time that is logged in terms of access to treatment is a proper time as to consultation and treatment starting rather than, per se, assessment by telephone and then being put back on to the waiting list?



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Mr Hunt: The target is for treatment to start within a minimum of 18 weeks. We have just started measuring this and are hitting 99%. The target is 95%, but demand is increasing the whole time and it is our intention to be treating another 600,000 people with psychological therapies as part of the mental health forward view that we are implementing at the moment. It is a big area of expansion for us.

Q67 **Dr Cameron:** Will someone be monitoring the definition of treatment between the different trusts in terms of how that is then logged to make sure that there is parity for everybody?

Mr Hunt: I will write to you with a detailed response to that question. However, my understanding is that we do have a standard definition that we are expecting everyone to follow, but I will give you some more information about the extent to which we think that is being followed nationally.

Q68 **Dr Cameron:** On mental health in older adults, in terms of transition from health to social care, it is going to be really important that psychological issues are also addressed in that population. What steps will you be taking to ensure we meet the mental wellbeing as well as physical health needs of older adults, including those quite difficult issues of depression and loneliness, when they are moving to care homes or into social care, and address adjustment times?

Mr Hunt: That is a really important issue that does not get as much attention as it should. The figures I saw were that 40% of older people in care homes suffer from some kind of depression. I think it is 20% of that age group as a whole, but with people in care homes it is particularly high. People with dementia in particular often do have issues around anxiety and depression for totally understandable reasons, but sometimes the mental health needs are clouded in people's minds by the physical health needs, so that is essentially the reason that, even though we are hitting the 99% standard, we are planning a big expansion in the capacity of psychological therapies so that we can reach those groups. Of course, it is very important in helping to prevent deterioration in their physical health if we can look after their mental health needs.

Q69 **Dr Williams:** Secretary of State, I would like to ask you about autism diagnosis waiting times for children. The NICE guidance says that when a child is identified as having suspected autism, their assessment by a multi-agency autism team should begin within three months. In some parts of the country, including my constituency, a child referred today will wait nearly four years before their assessment begins. For how long do you think they should wait?

Mr Hunt: They should wait for no longer than the NICE guidance says. That is absolutely clear.

Q70 **Dr Williams:** The NHS has set some waiting time targets for areas like access to psychological therapies. We are very good at setting waiting time targets for physical illness. Would you consider setting a waiting



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time target for autism diagnosis assessment?

Mr Hunt: I would. I need to look into it in more detail, but I am very aware of the agony of parents who have to wait a very long time. Indeed, for the child concerned a delay in diagnosis could mean that their physical and mental health needs are not met as quickly as possible and—I do not know enough about autism—there may be a deterioration, as in other mental health conditions where a delay in diagnosis often leads to a deterioration in the condition that could have been avoided with an earlier diagnosis. Obviously, that is something you want to avoid.

- Q71 **Dr Williams:** Yes. A diagnosis of autism actually requires health services to work in partnership with local authorities because the diagnostic assessment is made by a team that includes people who either work for or are commissioned by local authorities. Part of the problem, in my view, is that we have fragmentation. We know that the health service of the future has to get local authorities working in partnership with health services, with CCGs, in a much better way. What would you say that you are going to do? There will be parents listening today who have children with suspected autism and they know that a diagnosis is often a doorway to management or to access to other services. What would you say to a parent who gets a letter that tells them they are going to have to wait years for that process to even begin?

Mr Hunt: I would say it is not good enough. As we were talking about earlier in this Committee, the NHS is under a lot of pressure and that is one of a number of areas where we need to do better. I will happily take away the issue as to whether we can do better in terms of getting the NHS more consistently to meet NICE guidelines with respect to autism diagnosis, because I recognise the concerns you are talking about.

- Q72 **Dr Williams:** Thank you. More than 140 MPs joined me in writing a letter to you a couple of weeks ago. I hope you take the time to look at that in detail, and I will happily meet you and help to shape any response that you are interested in making.

Mr Hunt: Of course I will respond, but the first thing I need to do is talk to people in the NHS about what the particular issues are and what the solution is.

Chair: It is certainly an issue that has been raised many times in the House. Lisa, do you have a follow-up point to make on that?

- Q73 **Dr Cameron:** I have a quick follow-up. In terms of planning and diagnosis, there are training courses that staff need to undertake in order to be able to diagnose autism. Do you have a sort of map of how many clinicians you have in each area who are trained? Are there gaps? How are you going to take that forward? We do not want it to be a postcode lottery.

Mr Hunt: I do try to be on top of all the facts and figures around the NHS, but I must admit that I do not know the answer to that question, so



I will have to find out for you. However, you do make an important point, which is that the answer to Dr Williams's question may be a question of financial resources, but it may also be a question of clinical capacity and the time it takes to get the necessary skills properly disseminated around the NHS. The thing that I have learned over recent years is that you need to think about those two things at the same time.

Chair: Thank you. We are going to move on to dental services now.

Q74 Dr Caroline Johnson: Secretary of State, this morning there was a debate in Westminster Hall about children's dental care in particular. We heard about children as young as two having all their teeth removed and the cost not just to the NHS, which is £836 for removing the average child's teeth, but to the child themselves in terms of the distress and the long-term psychological effects that having missing or rotten teeth can cause. Whose responsibility do you think ensuring children have good oral health is? Is it the parents, the nursery schools—we heard about children having their teeth brushed at nursery school—or the NHS?

Mr Hunt: It has to be a combination of all of those. It cannot be any one person's responsibility. Parents have the primary responsibility to make sure that their children brush their teeth properly, and, having children myself aged three, five and seven, that is easier said than done and can be quite a challenging process. I am probably one of many parents who underestimated just how difficult it is to get them to brush their teeth properly. Parents have a really important role to play, but the NHS has a role in setting the whole prevention agenda. I think oral health is improving for children, but we do have particular concerns and the chief dental officer is looking at what we need to do to improve our approach to children under three. We are also particularly concerned about what happens in areas of high deprivation and that is why we have the Starting Well campaign targeting 13 areas.

Q75 Dr Caroline Johnson: I was going to come on to that. There is the Childsmile programme in Scotland, which has improved the oral health of Scottish children—from a much lower base than it was in England, it must be said—by around 50%, in terms of the number of children with good oral health. There is good evidence from that since 2001, so that programme has been going a long time and there is a lot of evidence that it works. You have now suggested starting something similar in England called Starting Well, but only in 13 areas. Why only in 13 areas?

Mr Hunt: Initially, we are looking to start this programme in the areas with highest need, so that is what we are doing. The context is that we are starting from a higher base than Scotland and that overall oral health is improving across the country, but we want to see the impact of the Starting Well programme. As you rightly say, we have learned from what happened in Scotland but the situation is not identical to what happened in Scotland, so we want to see whether this programme works, and then we will make a decision about rolling it out.



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Q76 Dr Caroline Johnson: Given that there is evidence from Scotland but also from Wales and other countries on how these programmes work and what they do, why is it necessary to do it as a pilot in the rest of England? If I look at my constituency, for example, which does not fall in any way into any of these pilot areas, there are still 630 children who have been admitted to hospital to have dental extractions. That is quite a lot of children who will not be getting this programme and be missing out.

Mr Hunt: Not necessarily, because in an environment where resources are very constrained it makes sense to try an approach in a smaller area first, to evaluate the impact and then make a decision as to whether it would be appropriate to follow it in constituencies like yours and mine, but it is good practice to start it off and to learn lessons that need to be learned. The NHS has different structures in this country from those in Scotland, but we have learned from what happened in Scotland and that is why we are doing the Starting Well programme in England.

Q77 Dr Caroline Johnson: We are talking not just about children here but adults, and we heard this morning that in Cornwall there are 14,000 people waiting for a dentist. The question is why. I spoke to some dentists who told me the NHS contract is paid in bands—this is the description given to me by a dentist—so if a patient arrives and needs one filling they get the same as if a patient walks in and needs four, seven or even 10. If they need a root canal, which is very time-intensive, it is the same fee as a patient who has one filling. That is quite difficult, is it not, because if you are a dentist and you take on a patient with poor dental health, you are not going to get paid as well for your work as if you take on a patient with good dental health? There is also no money for prevention. If you are a dentist and you see a child, do a check-up and their teeth are generally okay and you send them out of the door again, you get paid the same as if you put fluoride varnishes on and you give them a hygienist clean. In other words, you are not getting any extra money for that as an incentive to do this work. What are your plans to address that and to improve the dental contract to encourage dentists to want to continue to work in the national health service as opposed to going privately?

Mr Hunt: My understanding is that access to NHS dentistry is improving, that more people have access to it than previously—I will write to you with the exact numbers on that—but the reason that the contract is structured in the way that you describe is precisely because we want to incentivise dentists to think about prevention and not cure and to keep the population for whom they are responsible, and for whom they are being paid to keep well, healthy and well. We therefore want to avoid the false incentives of simply paying for activity, which sometimes can have unintended consequences of treatment that may not be necessary. That is why the contract is structured in that way, but I will happily write to you with our latest evaluation as to whether that is the optimal structure for a dental contract.



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Q78 Dr Caroline Johnson: Yes. We heard about how, in areas of high deprivation, you see more poor oral dental health, and that may be areas where it is more difficult to recruit a dentist because if you are a dentist and go and work in an area like your constituency, which has one of the best oral health profiles in the country, then, as a dentist, you will have a reasonable income for the work that you do; whereas if you were to work in, say, Middlesbrough, one of the 13 target areas and where I was born, the remuneration for the work you do will be much lower.

Mr Hunt: That is precisely why it is extremely important to have an NHS dental offer because, if we are going to deal with health inequalities, we need to make sure services are available in areas of high deprivation and low income where oral hygiene might not be as good as it might be in other areas.

Q79 Dr Caroline Johnson: But if you are a dentist choosing whether to work in Surrey or Middlesbrough, apart from any other reasons that you might make the choice, it may relate to the work and the money you get paid for what you do.

The other question I want to ask you—I am not sure if it is for your Department—is in relation to sugar and the sugar tax. If it reduces the sugar consumption in children, it will help not just their teeth but their health in general, obesity and suchlike. At the moment, if you are a company producing a sugary fizzy drink, you are taxed on that formulation, which is great and I really welcome that as a step forward, but there is nothing to say that you have to pass the cost on to the consumer for that given product. You can actually spread that cost across brands that you produce, which may include low sugar alternatives. Should it be better directed?

Mr Hunt: It is very early days. It has not come into effect yet, but we are seeing that it has had a very immediate effect, with some large supermarkets reformulating their own-brand products so that they fall below the sugar thresholds at which the sugary drinks tax would apply. That is exactly what we wanted to happen because, in the end, the evidence, if we are going to tackle obesity and childhood obesity in particular, is that the best way to do this quickly is through reformulation by manufacturers. The sugary drinks tax is part of that and that is designed to create that incentive, but we are also working very closely with the food and drinks industry to encourage them to reformulate the levels of sugar in many other products that they sell because we think that is so important.

Q80 Dr Caroline Johnson: Moving on to ambulance services, which you know we have spoken about a number of times, I want to know about the progress being made. East Midlands ambulance service, which is our local trust, did not meet the targets for its red 1, red 2 or A19 calls in terms of attendances in speedy fashion for those people who are the most unwell. I know you said that you were going to change the way that the targets are formulated so that people in rural areas are not disadvantaged by



them in the way that they were before. How is that working? Can we have a little more detail on how that is working and whether you think, since it was introduced I think in July, it has made a difference to people in the rural areas of Lincolnshire and others?

Mr Hunt: Yes. The roll-out will be complete across the country by the end of the year, so everywhere will do this. We have piloted it in a number of areas. The essential problem we are trying to address is the fact that, if you have a target that for a certain category of a certain severity of illness an eight-minute response is required and the target says for 75% of calls, then it may be more advantageous for an ambulance service to deal with the calls in cities that are closer to them than in more remote rural areas. The other problem we are trying to address is the fact that very often, because they have to make an instant decision, the call handler may err on the side of caution and dispatch an ambulance when it is not actually required within the eight-minute target. This change has been carefully thought through to, first, give an extra minute to call handlers to make a judgment. It does not mean they will always use up that minute but it gives them a little longer to make the decision. We are trying to avoid what happens at the moment, where you get a lot of ambulances sent out that do not need to be sent out, which end up being called back halfway through their journey and because of that unnecessary journey they are not available for other people who may need them. We are very confident that this will reduce the unnecessary dispatching of ambulances that we currently have.

Q81 **Dr Caroline Johnson:** Will it improve the responses for people living in areas that are not big cities?

Mr Hunt: It will help. I do not think it is going to completely solve that problem, but as part of those changes we are also improving the way that we measure responses for heart attacks and strokes to make sure that we are measuring the thing that actually matters, which is the time it takes from the moment that you make the call to the time treatment starts. At the moment, the system does not always incentivise that because hospitals and ambulance services are working to different performance measures.

Q82 **Dr Caroline Johnson:** That was another thing I was going to bring out. When you call for a 999 ambulance and they come to your door, they may contain very highly trained paramedic staff who have additional skills or they may contain more technical staff who are very skilled but do not have those additional skills. In areas of the country where, simply by geography, there will be long travelling distances between a person's home and the hospital, do you think it will be beneficial to ensure that there is a much higher proportion of ambulances—or even all of them—that have fully trained higher-level paramedic crews so that effectively you have brought the hospital treatments to the patients such that they are already being treated en route?



Mr Hunt: Yes. That is exactly what this change is designed to facilitate. For example, under the current system, one anomaly is that if an ambulance is sent to someone who has a heart attack or a stroke, providing a car reaches the patient within the specified time, the target is met, but actually what that patient needs is to be conveyed to hospital in an ambulance and that might take longer than the target time set, but as far as the ambulance service's target is concerned the target has been met. That is clearly nonsense. It is those kinds of things that we are trying to iron out in the changes.

- Q83 **Dr Caroline Johnson:** There is also the fact that if you have a paramedic who can provide, let us say, some of these clot-busting drugs for a stroke, that patient has already been treated before they get to hospital rather than being picked up, put in the back of an ambulance and travelling—they could live a long way from hospital—and the quality of care that they got has been improved.

Mr Hunt: Absolutely.

Dr Caroline Johnson: I have one last very short question.

Chair: We are very short for time and have a lot to get through.

- Q84 **Dr Caroline Johnson:** It is very short. Where trusts are in special measures, such as East Midlands ambulance service and United Lincolnshire hospitals, and they come out of special measures, as ULHT did, and then go back into special measures after a reasonably short period, is that a sign that the support that you give to trusts in special measures after they leave is not quite enough?

Mr Hunt: We need to think about that question. It is a very fair question to ask. The special measures regime is new. Since we introduced it, 37 trusts have gone into special measures and 20 have come out. On the whole, our view is that it has worked extremely well. Eight of the trusts that came out of special measures went straight from special measures to a good rating. We have seen some dramatic improvements, but there are occasions, as you rightly say, when people have gone back into special measures. Is it that we made the wrong decision to let them come out of special measures when the leadership was not quite ready or that we did not give them the support they needed when they came out of special measures, or is it other factors? That is something we are constantly evaluating.

Chair: We have several major themes to get through and another vote, so, Diana, do you have a very short question? Then we are going to move on to Brexit.

- Q85 **Diana Johnson:** Yes, and it is about dental health. What is your view about fluoridation, because I heard a previous Secretary of State say that fluoridation could give poor kids rich kids' teeth? Do you have a view on that?



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Mr Hunt: At the moment, it is not our view that we should change the law on this, but it is something that we are constantly keeping under review. Before we move on, for the record, because we talked about the pensions issues earlier, I have just been told that we have collected £62 million of pension overpayment to date. I wanted to put that on the record.

Chair: Thank you. That is useful. I know Maggie has very quick question before we move on to Brexit.

Q86 **Maggie Throup:** While we are still on ambulances, in Derbyshire the fire brigade were part of a pilot to be trained to respond to ambulance calls. It was very confusing for some residents when a fire engine rather than an ambulance turned up on the doorstep. That pilot has been stopped. Do you have any feedback on how successful it was and whether it was a useful tool?

Mr Hunt: The answer is that the results are mixed. You have obviously talked about some of the confusion, but there are other examples where collaboration between the emergency services has been extremely successful. I do not want to make a rushed judgment as to whether these things are working or not. I would say that, while I am very happy to look at any innovations in terms of collaboration between the different emergency services, the biggest collaboration that I want to see more of is collaboration between the ambulance service and other parts of the NHS, because we still do not have as integrated an approach between acute services, mental health services and the ambulance services as I would like to see, particularly in the joining up of IT systems. There is a lot more we can do.

Chair: Thank you. Now we must move on to Brexit, and Paul is leading on that.

Q87 **Dr Williams:** How will leaving the European Union help the NHS?

Mr Hunt: I was not expecting the question to be put quite that way.

Dr Williams: You are now a leaver.

Mr Hunt: We can talk about my own views on it, if that is what the Committee would like, but I will talk about the NHS. The answer is that Brexit will pose a number of challenges for the NHS. There are no two ways about that. The most immediate challenge it poses is with respect to the NHS staff who are from the EU and who do a fantastic job.

Dr Williams: That is 62,000 people.

Mr Hunt: It is 62,000 people, including, I think, 21,000 nurses and 10,000 doctors.

Dr Williams: It is 10% of our doctors.



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Mr Hunt: Yes. They do an absolutely fantastic job, we want them to stay and we are confident they will be able to stay.

Q88 **Dr Williams:** The rate of people joining is reducing and the rate of people leaving is increasing, though, is it not? We are moving in the wrong direction.

Mr Hunt: This is a period of great uncertainty, inevitably, as we renegotiate our relationship with the EU, but it is important to stress how important they are as part of the NHS family and how we want to do everything we can to get them to stay. The current workforce is one issue. There is always turnover, whether it is a home-grown workforce or an international workforce, every year, and of course in this period of uncertainty it is harder to recruit replacements from the EU.

Q89 **Dr Williams:** We saw a 92% reduction in EU nurses registering last year.

Mr Hunt: That is true and, to a certain extent, one would expect that. That is why we need to get through this period of uncertainty as quickly as we can in terms of the negotiating process. It is also true to say that when we were going to be staying in the EU we sometimes drew false comfort from the ability of fishing in the European labour pool during doctor and nurse shortages when, in reality, we are not the only country with an ageing population, and countries like Spain and Portugal, as their economies have started to grow, are starting to recruit much larger numbers of their own nurses for their own needs. That is why we have to think about long-term training requirements as a central policy objective now.

Q90 **Dr Williams:** So we are not going to be helped in terms of workforce. There are some other challenges. How else are we going to be helped or hindered by leaving the EU?

Mr Hunt: The other challenge I would talk about is the fact that the most important thing for the NHS is the strength of the economy because it is funded through taxpayer pounds. That is why it is very important to secure a good deal with the EU as part of these negotiations and it is what we are hopeful and optimistic that we will achieve, but obviously any economic shock that had an impact on the taxpayer—

Q91 **Dr Williams:** As the economy shrinks—if the economy shrinks—there may be less money for the NHS as a result of leaving the European Union.

Mr Hunt: That is what we want to avoid.

Q92 **Dr Williams:** Can you update us on our plans to leave the European Medicines Agency?

Mr Hunt: I will happily tell you what I can. The reality is, as I think I said to this Committee when we had a previous discussion on this, that I have always thought that it was inevitable that the EU would want to move the headquarters of the EMA away from the UK.



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Dr Williams: It is disappointing as there are 900 very skilled people working there and we have pooled our resources and worked together with medicines.

Mr Hunt: As I said before, I always thought it was inevitable they would want to move the HQ. I did not think it was inevitable that we could not continue to have very close co-operation with the EMA, including, I think, between a quarter and a third of their work, which is actually sub-contracted to the MHRA and to British scientists.

Q93 **Dr Williams:** It is a large part of the MHRA's income as well.

Mr Hunt: Yes, and we have made an offer to the EU to continue to have that relationship and to continue to work closely with the EMA. As far as we are concerned, we are very happy if we continue with the same close relationship, or a different close relationship, but none the less a close relationship.

Q94 **Dr Williams:** So we are not going to be a member.

Mr Hunt: We will not be a member but there is no reason that we could not have a high degree of convergence between UK regulations and EU regulations when it comes to medicines.

Q95 **Dr Williams:** We will lose our influence.

Mr Hunt: We will potentially lose our influence, that is true, but it is also the case that most people in the EMA would recognise that British scientific expertise has helped the EMA to do a better job than it would otherwise have done. So, our offer is on the table, that British expertise is still there and is available for the EMA to tap into, wherever they are headquartered, if that is what they would like to do.

Q96 **Dr Williams:** There are some people who estimate—*The Economist* magazine's intelligence unit—that the increased cost of recruitment and the higher prices that we might have to pay for medicines if we do not get the right deal with the EMA might cost the NHS an extra £7.5 billion a year or £144 million a week. Do you agree with that?

Mr Hunt: There are potential additional costs. It is mathematically true that, if the pound is worth less on the international money markets, then we have to pay more for our imports, and we obviously import a lot of medicines from overseas. There are also potential benefits to the UK economy if we get the right deal, and that is what we are trying to do.

Q97 **Dr Williams:** Are you cognisant of the fact that if we do not get the right deal with the EMA then we may, like Switzerland, delay NHS patient access to new medicines by maybe six or 12 months?

Mr Hunt: I do not think that is going to happen, because when we leave the EU we will have control of our own regulatory structures. Therefore, the time it takes for new medicines to come to market will be within our own control, and it is absolutely our priority to increase the speed at



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which new medicines are available throughout the NHS compared with what happens at the moment.

Q98 **Dr Williams:** What is the cost of setting up our own regulatory structures going to be?

Mr Hunt: We have our own regulatory structures at the moment so there is no additional cost.

Q99 **Dr Williams:** It is largely funded, or lots of it is funded, through the European Medicines Agency as well, though. We pool our resources at the moment, do we not?

Mr Hunt: Actually, I think the question is the extent, and what we have said is that we would be very willing to look at systems of mutual recognition so that we recognised EMA accreditation and they recognised ours and so on. Our offer to the EU is to continue the very close relationship that we have in medicines regulation for the benefit of both sides, and we have a certain degree of confidence that we should be able to end up with a sensible deal because it is so patently in both sides' interests to do so.

Q100 **Dr Williams:** We now know there is a secret paper that we are not allowed to see on the impact of leaving the EU on the pharmaceutical industry. Have you seen that paper?

Mr Hunt: I am afraid I do not know which paper you are talking about.

Dr Williams: There are—

Q101 **Mr Bradshaw:** It is the DExEU impact assessment. Have you read it?

Mr Hunt: Right. I think I have seen summaries of it, but my responsibility as a Cabinet Minister is to minimise the impact of Brexit on the pharmaceutical industry and indeed to make sure that—

Q102 **Mr Bradshaw:** I am sorry, but would it not help you minimise the impact if you had read the impact statement that your fellow Government Department has drafted?

Mr Hunt: I think I probably have read a summary of that paper for the precise reason I have just given you.

Q103 **Dr Williams:** What does it say?

Mr Hunt: I have read all the papers that I think I need to have read, because I am the Cabinet Minister responsible. I think our assessment is that, if we get this right, Brexit could be a big opportunity for the life sciences industry, but we want to negotiate a deal that allows it to go from strength to strength.

Q104 **Chair:** Secretary of State, can I just point out there are four impact statements that are relevant to health? We know that, of the 58, as I understand it, there are ones on life sciences, pharmaceuticals, medical



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devices, medical services and social care. Could I ask on behalf of this Committee whether, in advance of our inquiry into Brexit and health, we could have sight of those documents? We do not believe that it would prejudice our negotiations but we do believe it would be of great assistance in our examination. Could we formally request that?

Mr Hunt: Your request is noted.

Q105 **Mr Bradshaw:** Have you read the others?

Mr Hunt: As I say, I think I have read all the papers that I need to read with respect to making sure that we get the best deal for our life sciences industry and—

Q106 **Mr Bradshaw:** Do you think they also say that Brexit is going to be jolly good for those sectors?

Mr Hunt: Like all the assessments of economic impact, there are risks and opportunities, and what you would expect Government Departments to do is to make a proper assessment of what they are.

Chair: We shall be returning to this in great detail because we have a whole inquiry on it and we can probably look forward to examining it then, unless Ben or Paul have further points.

Mr Bradshaw: No.

Dr Williams: That is fine. We will move on.

Chair: We do have a lot to get through still. We are going to come on to the whole area of prevention, on which Andrew is going to lead.

Q107 **Andrew Selous:** Secretary of State, we live in an era where money is very tight, but there are things that the Government as a whole could do that would not cost your budget money and would significantly reduce demand on the NHS. In terms of the obesity strategy, why would we not have a traffic-light food labelling system across all products? The supermarkets have done it with their own brands very well but many of the branded proprietary products are frankly misleading.

Chair: I do apologise to everyone who has come to follow this session, but we are going to have to have another break to vote. Secretary of State, can I just check before we leave what time you will be able to stay until this evening?

Mr Hunt: I think I have time until 5.30 pm, if that is of help.

Chair: Thank you.

Sitting suspended for a Division in the House.

On resuming—

Mr Hunt: Chair, there was one thing I meant to say when we were having the discussion about workforce earlier on, which is that HEE will



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be publishing an NHS workforce plan for the whole of the NHS before the end of the year. I wanted to put that on the record because that will be helpful for you.

Q108 Chair: It will be helpful to know that, thank you. I guess my earlier point from the House of Lords report is that they felt that there was a very significant lack of good quality long-term data on which they are making all their projections.

Mr Hunt: Yes. That may be true. I think the data is there on the whole; it is just that we are not very good at acting on it. Anyway, we will publish an NHS workforce plan.

Chair: Thank you. Shall we return to Andrew's questioning on prevention?

Q109 Andrew Selous: Thank you, Chair. My question is, why would we not adopt a universal traffic-light system on food that is clear and easy to understand so that at least we are giving consumers the information they need to make good choices?

Mr Hunt: We looked into this very carefully when we were devising our obesity strategy. I was advised that it would be against EU law and would contravene single-market requirements, so your day may come on this important issue.

Q110 Andrew Selous: Okay. Moving on, there are nine different types of food that the Department is tracking. I gathered that was up to the end of August and we do not get the results until March next year. Given that we have established the principle of a tax on sugary drinks—and, okay, that is the worst offender—why not extend those taxes to the other eight types of food product in order to accelerate reformulation?

Mr Hunt: The answer is that we need to see what happens with the sugary drinks tax and the impact that it has before you can take a view on that. There is an understandable concern that the public have that we are going to move into a system of taxing absolutely everything that is vaguely unhealthy. The public would say that part of this is about personal responsibility, and I think the complexity that you have with diet is that in moderate quantities it can be perfectly healthy to consume sugar. It is not like smoking, which is always bad for your health, so you just have to get the balance right, because there will be people who consume alcohol and chocolate in sensible quantities who would be resentful if they felt they were being penalised. That is one reason why it is worth seeing the impact of the sugary drinks tax, and then taking stock.

Q111 Andrew Selous: We understand that five-year-olds are consuming their own weight in sugar at the moment, so it is quite an urgent issue. What about making it illegal to market high-sugar products before 9 pm at night? Would that not help you in your role?



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Mr Hunt: All those kinds of measures are under active consideration, but the strategy we have at the moment is, we think, the most ambitious strategy anywhere in the world, which is to reduce the amount of sugar in products consumed by children by 20% over a four-year period, including 5% in the first year. That is the ask that we made of the food industry. They have signed up to and said they are going to do that. If it is done voluntarily, that is much quicker than using regulation or legislation, so we want to see if that works.

Q112 **Andrew Selous:** I am glad to hear you wanting to be the most ambitious in the world. I wonder in that case whether the Department is aware of the Amsterdam healthy weight programme, on which the Centre for Social Justice has done a big study. That has had an evaluation now and it has been most successful in reducing the weight of the most deprived children. Given that you want to be globally ambitious in this area, is this something you could ask the Department to look into if it has not done so already, please?

Mr Hunt: I would be very happy to do so. It sounds like something we should look at.

Q113 **Andrew Selous:** Moving on, because time is tight, to variation, you said in response to Diana Johnson's \$64,000 question about why we cannot replicate best practice, "We do not have a system...that ensures a high degree of compliance." The Getting It Right First Time programme and the work of Sir Muir Gray as well as that of Professor Tim Briggs seem to me to be an attempt to try to standardise this across the NHS. There are three areas. If we look at the 25-fold variation in infections to start with, what timescale can we expect to see that variation coming down in as a result of the Getting It Right First Time programme?

Mr Hunt: It is one of those things where I am not sure the process will ever really end, because of the advances we are making in medical science. We are constantly redefining what best practice is and, in orthopaedic infections, we know that our best hospitals infect around 1 in 500 patients, but in our least well-performing hospitals it is 1 in 25 patients and it can cost £100,000 to put right an orthopaedic infection. This year we are hoping to save around £300 million by bringing down the infection rates of some of the places where they are the highest. It has been a very successful programme. At the same time as we look at the places with the highest infection rates, the best places are delivering even better performance and I would expect that process to continue.

Q114 **Andrew Selous:** Moving on to another area, we know from the evidence of the National Joint Registry that cement joint implants for over-65s are much the most successful, yet they are used only in 40% of cases. Ironically, they are much cheaper, just over £700 roughly, whereas we are using less successful implants costing up to £3,700. By when could we expect to see improvements in this area, given we have evidence about what to do?



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Mr Hunt: I think that relates to the earlier discussion we had about Sir Bruce Keogh's comments in *The Sunday Telegraph* because, at the moment, the only mechanism we have for spreading best practice is a voluntary mechanism, which is essentially the sharing of this information, which is what Professor Briggs is doing through the GIRFT programme, but the question Sir Bruce was asking was whether we could have a system of mandation. We are looking into that because I agree with you it seems crazy if we know the best way of doing something that we do not just have a better way of guaranteeing that best practice is being adopted across the NHS.

Q115 **Andrew Selous:** A final example from me is this. Again, the evidence says that surgeons who do more than 35 operations a year have better outcomes, unsurprisingly, because they get more practice at doing it, yet a quarter of surgeons do 10 or less of one particular operation and 16% do five or less. Could you give us an update on what plans there are to try to improve those figures?

Mr Hunt: Yes, I am happy to do so. Professor Sir Norman Williams is leading a programme, which is a sister programme to the Getting It Right First Time programme called the national clinical information programme, and that is designed to see whether we could be the first healthcare system in the world over the next three years where every doctor is given relevant information about their clinical performance relative to their peers, not as a tool to beat people—this is not information that will be published—but in order to promote best practice. As we do that, we hope that the surgeons who are doing fewer than 35 operations, exactly as you say, can be shown the information that indicates that their outcome rates are significantly less good and therefore we can prompt change either in increasing the amount of work they do or them deciding they do not want to practise that kind of operation.

Q116 **Dr Cameron:** Rather than deciding they should not be doing that work and should move on to something else, is there some mechanism in that case to improve their continued professional development, training and skills? We spoke about morale earlier on, and surely investing in the workforce and their CPD is key to that.

Mr Hunt: Yes. This is supposed to be a supportive process, because, if you have surgery outcome data that indicates that you are an outlier, then there could be a number of things that can be addressed. The first step, if we want to be the safest healthcare system in the world, is to have good quality data that we share openly with people so that people know. In most cases, people are not actually aware in those situations. It is only a small minority of people involved, but they are not aware that they are an outlier. We have found, for example, in heart surgery, which is the first area to pioneer this approach, that we had a dramatic impact in reducing the number of outliers. It was a very consensual process. It was simply a question of sharing data and then people very quickly work out whether it is more CPD they need, whether they need to be doing a greater volume of work or what it is that needs to change.



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Q117 Dr Caroline Johnson: I have a point about the business of surgeons doing fewer than 35 of these or fewer than 24 of those, or whatever. It is important to recognise—and I wonder if you would agree with me on this—that, while some people who do lots of the same thing do it very well, some people who do lots of the same thing do not. Equally there are—like riding a bike, which one never forgets—procedures in medicine that are performed very infrequently, sometimes because they are a rare occurrence.

I personally would not like to see a situation where people are targeted on, “You cannot do something, even if you do it well, because you did 33 this year and not 35.” I say this from personal experience because recently I had to choose an orthopaedic surgeon for my daughter. The chap I chose does a number of operations that he does relatively infrequently but for which he has a 0% revision rate, so I think it is not just about quantity but quality and the two are not always intrinsically linked.

Mr Hunt: I totally agree. With respect, given that you are a doctor, in a way you answered your own question because the key is the collection and the availability of good quality data and there can be lots of different facts. We know one reason we do not implement WHO checklists as consistently as we could is that on some occasions people are overfamiliar with the checklist and so they just tick, tick, tick when actually they are not properly making sure that everything has been done. There are a number of factors, but what does not change is the clinical outcome data. That is what I think we have to make sure is widely available.

Q118 Chair: Before we move on to STPs, now that we are seeing a minimum unit price for alcohol being introduced in Wales as well as Scotland, are you saying that we should join so that we do not undermine the benefits of that in Scotland and Wales?

Mr Hunt: We want to see how it works in Scotland and Wales. That is our priority at the moment. I am very aware of the potential impact on alcoholism rates and the potential health benefits of minimum unit pricing, but we want to see what happens.

Q119 Chair: Indeed. Is there not a danger, if it is introduced, that we will undermine the effectiveness of those pilots because of the border issue? Would it not be better to say we are going to introduce it everywhere, but have a sunset clause if we are not convinced it would be effective?

Mr Hunt: I understand the risks you are talking about, but we do have devolved health systems. That is the decision we took as a country. There are going to be things that are done differently in Scotland, Wales and Northern Ireland, and on something as important and profound as that we have to do the thing that is right for England, but I do not rule out doing it. I just want to see how it works.

Q120 Chair: To press you on that, would you accept there is a risk that we



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undermine what is happening in Scotland and Wales by England having a separate system?

Mr Hunt: When we devolved the healthcare systems, we were accepting cross-border risks on a whole range of issues. For example, when we reduced the agency pay rates in England, you could argue that we were less effective in doing that because, in the areas that shared borders with Wales and Scotland that were not doing that, it was a less effective policy.

Q121 **Chair:** Indeed, but that was not my question. My question was, do you accept there is a risk that we will be less likely to identify whether there are genuine benefits from minimum unit pricing in Scotland and Wales if we do not join them?

Mr Hunt: No. I think we will be able to identify whether there are genuine benefits from minimum unit pricing. We need to see whether there are and then take our decision.

Q122 **Dr Williams:** When will that be?

Mr Hunt: As soon as we can get clear evidence.

Q123 **Dr Williams:** There is clear evidence from Australia.

Mr Hunt: Indeed, but we want to look at it in a British context and I think that is when we—

Q124 **Chair:** That is the trouble. We are not going to see it in a whole British context. We are going to see it undermined in Scotland and Wales.

Mr Hunt: In the context of the British Isles, I think we will be able to see it.

Chair: We are going to move on to Maggie and sustainability and transformation partnerships.

Q125 **Maggie Throup:** Secretary of State, a couple of weeks ago in front of this Committee, Simon Stevens seemed quite flippant in stating that STPs are not the silver bullet. Do you agree with him?

Mr Hunt: I do not recall the entire context of those comments. Clearly, they are not going to be something that solves every problem that we face in the NHS, but they are a very important part of our long-term strategy for the NHS, which is to move the centre of gravity in our healthcare system to one where prevention is taken as seriously as curing disease. That means tackling issues upstream in an out-of-hospital context, investment in mental health, general practice and other out-of-hospital services where it is much cheaper to address issues than if you wait until people need expensive hospital treatment. It is a core part of our strategy.

Q126 **Maggie Throup:** Does it mean that STPs will simply be sidelined when something else comes along and they will be just a stopgap?



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Mr Hunt: I very much hope, because they are very important and there is a big consensus in the system—and, I think, a pretty big consensus in Parliament as well—that they are the right approach in the long run, and moving to a system of population health management will lead to the right decisions being taken and reduced pressure on our hospitals.

Q127 **Maggie Throup:** Obviously, there is variation across the country as to how they are being implemented. Has your Department identified the barriers to the successful progress of all STPs and, if so, what has been done to overcome these barriers?

Mr Hunt: Yes. We are still in the very early days of STPs, but the first step that we took this July was to set up an Ofsted rating system of STPs and therefore to publicly define which STPs we thought were doing a good job and why. So, we have assessed all STPs across nine key areas of activity that relate to the hospital performance, out-of-hospital transformation and leadership and finance. From that, you can see there are some STPs that are doing extremely well, such as Frimley, Dorset, South Yorkshire and Luton and Bedfordshire. They are some of the best in the country. Then there are other STP areas that have been less successful. We are not trying to single anyone out, but we just want people to know where best practice is so that they can learn from it.

Q128 **Maggie Throup:** Do you think simply there are too many vested interests in STPs for them all to be successful?

Mr Hunt: The key issue for a successful STP is to have good leadership in place: is there someone who you can say is the chief executive of this STP; is there a proper board in place; is there someone who is able to make governance decisions? Somewhere that has done this extremely well is Greater Manchester, where they have appointed Jon Rouse into that role, and we saw—early days—the superb response of the NHS to the Manchester Arena bombings, which I think was in part because of much better co-ordination between the Manchester hospitals than had previously been the case. I think the moving towards an STP structure helped.

Q129 **Maggie Throup:** The success of the five year forward view is almost dependent on the success of STPs and we are getting near the end of that five-year time period. If you look at the education system, where there are failing schools, you'll see that they put in a good school or a good headteacher to help it out. Is there something that can be learned from that, so that where we have some really good STPs somebody from there can come in or there is some learning process to redress the problems, such as partnership working?

Mr Hunt: Absolutely. That is exactly the kind of cross-fertilisation that we are looking for. The other thing I should say that gives us confidence in the principles behind STPs is that the predecessor of the STPs was the vanguard programme. We do now have the data on growth in emergency admissions in the vanguard areas, which is about 1.5%, which is about



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half the growth in emergency admissions in the rest of the NHS, so we think that is clear evidence that this approach is right.

Q130 Maggie Throup: That has pre-empted another question I was going to ask later on. If changing the way the NHS works in social care can reduce the admissions and obviously then the need for beds, does that bust the myth that it is all about money and that it is about the way we do things?

Mr Hunt: It is all connected because, like healthcare systems all over the world, we have massive pressure on sustainability and the call that we made in the NHS is that the way to make our healthcare system sustainable is to find an alternative to the 3% to 4% annual growth in emergency care that has become a feature of the NHS over the last few decades. That is why we want to move to population-based health and the STP model.

Q131 Maggie Throup: At the hearing a couple of weeks ago, both Jim Mackey and Simon Stevens stated that we can get to 80% to 90% delivery of STPs without the need for any further legislation. Mr Mackey seemed to imply that we had to get to that 80% to 90% before anything else was looked at. Given the time it takes to pass new legislation, surely we should be planning for that extra 10% to 20% now. What are your thoughts on any legislation that might be needed?

Mr Hunt: Legislation involving reorganisations of the NHS does not have a glorious track record, so I think, given what we all learned from the process of the 2012 Act, there is a lot to be said for allowing STPs to bed down so that we understand exactly what legislative changes they need to make them more effective on the ground before rushing into legislation. I think there is some benefit in holding back for a bit, but we do recognise that in the end we will need legislation, and indeed in our manifesto we were explicit at the last election in saying that we would be prepared to bring forward legislation to help STPs function more effectively.

Chair: Thank you. Are you able to re-join us after the vote?

Mr Hunt: I am happy to re-join you for a few minutes.

Chair: Yes. There is one more set of questions.

Sitting suspended for a Division in the House.

On resuming—

Chair: Thank you very much for coming back, Secretary of State.

Mr Hunt: Not at all—no problem. We just have the hard core behind us.

Chair: Yes, indeed. When the audience has left, you know you are running late. It is a very wide audience outside this room, though.

Andrew Selous: If it is any consolation, Foreign and Home Affairs are



also going till 6 pm.

Chair: We are going to start again—thank you very much, Secretary of State—and I know that Maggie has another question.

Q132 **Maggie Throup:** Following on from the last question, this is still on STPs and obviously the variation across the country with regard to the success or not of them. In order for STPs to be successful in their entirety, local authorities really need to be on board, and I think probably in some areas this is where they are not quite gelling. From some things I have heard, the local authorities are blaming lack of funding. Do you think it is time that we explore legislative changes to the Local Government Act to address this and bring them on board with regard to STPs?

Mr Hunt: We are a bit early for the issue of legislation for the reason I said, not because I do not think it will be necessary ultimately but because we need to work out what changes we want and what the system is telling us. There are things that we can do before then that will help resolve your issue. For example, it is possible under the current structures to give the entire NHS commissioning responsibilities, through CCGs, to local government leaders in areas, and I think we are starting to see joint commissioning happening in particular parts of the country. It is definitely true that cuts to social care funding, which are now thankfully starting to be reversed, have made the context of collaboration between the NHS and local authorities much harder, but I am hoping that will start to ease.

Chair: I know one member wanted to ask about visitor charging.

Q133 **Dr Williams:** I will quickly get my notes. You will be aware, I expect, that there were some changes made to charging for overseas visitors. Regulations are being piloted over the next couple of weeks, and I think they are being rolled out next week. Clearly, there is trepidation among some NHS staff about having to check people's immigration status. I guess the greatest fear around this is that there are people who need care who might be denied it. How assured can we be that the regulations do not risk refusing free care to people who are entitled to it?

Mr Hunt: We can be very confident about that. I understand people's nervousness about this, but we also have to look at what happens all over the world. In practical terms, there are no other countries that we have been able to identify in the rest of Europe, for example, that do not verify people's identity pretty quickly when they arrive at a hospital, and you need to do it for clinical reasons apart from anything else. We also have to recognise—I know this is not always an easy message to give, and I think it is a good thing that London is probably the most international, cosmopolitan city in the world, and long may it remain that way—that we cannot afford to give free care to anyone who just turns up in London.



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We need to have systems in place that mean that people who should be paying for their NHS care as an international visitor actually do pay for their international care, and we need that because we need money to fund NHS services. What I hope I can reassure doctor colleagues on is that, with the advent of electronic health records, it should be a completely seamless process. In other words, when someone arrives at A&E—when we have proper electronic health records available seamlessly throughout the system, which we are gradually getting towards—the first thing people will do is get someone's medical record up, and hopefully that will make it very clear whether they are entitled to free NHS care or have a chargeable status. Then I think the normal ethical rules apply, that if someone is in need of emergency care—a life-saving situation—they would get that anyway, as would happen in France or Germany, but then they might be asked to pay for it afterwards if they are not paying for the NHS through their taxes.

Q134 Dr Williams: There are a couple of issues around that. One is that you often need to make the clinical assessment of somebody in order to work out whether they have immediately necessary treatment and whether or not a healthcare professional then has a duty of continuing care to somebody having started that relationship with them. The other concern of course is that these regulations apply to hospital care, but they also apply to community services, so there is some understandable nervousness with regard to vulnerable families—let us say people whose asylum claims have been refused. There are also other vulnerable groups who are not going to get a health visitor. We also know there are groups of people who are still refused access to general practice. There are a small number of people who cannot register with a GP. This morning I met representatives of the Gypsy and Traveller community, who told me there are people who try to register with a GP but are turned away. It is just about having that assurance that the Government are looking out for these vulnerable groups.

Mr Hunt: We are very alive to all the issues you have talked about. First, there are some very clear public health exemptions. We are not going to charge for GP consultations because we know that a consultation might be necessary to establish, for example, whether someone has TB or an infectious disease, so we recognise the public health concerns in that. We do understand the concerns about vulnerable groups. All I would say is that countries that are recognised as having good healthcare systems with universal access, such as France or Germany, have found ways to avoid exactly the problem you are talking about, and I think we need to do the same. We also need to have a system where we are able to say to the British people confidently that the NHS that they are paying for with their taxes is being made available free of charge to people who are entitled to free care but in other cases we have systems in place to make sure people are asked to make a fair contribution.

Q135 Dr Williams: The evidence is that the amount of healthcare tourism is not as great as people perceive it to be. I hope what we will do is learn



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from the early roll-out in a small number of areas and, if necessary, make changes to the system to ensure that vulnerable groups are protected.

Mr Hunt: Yes. In fairness, the evidence is quite hotly disputed around what the actual level of health tourism is and we did commission an independent study that said there was potentially around £400 million to £500 million of revenue that could be recouped if we were better at collecting money from people who should not be getting free NHS care. The point you make is an important one. We need to make sure that this does not interfere with clinical processes either for Brits who are entitled to free healthcare or for anyone who might need it in an emergency situation.

Q136 **Chair:** It would be helpful if you could write to the Committee to set out how we can ensure that all the people such as those who are sleeping on the streets, who have no documentation, will receive the care that they need.

Mr Hunt: I am happy to do so.

Chair: Thank you very much. I am conscious that we are going to come on to Rosie's questions on accountability, but Andrew has a very quick question first on electronic records.

Q137 **Andrew Selous:** When will these electronic records be up and running so that you go into A&E and they can access your GP records, for example?

Mr Hunt: It has started to happen. In more than two thirds of A&Es now you can access a summary of your electronic health record, so it is beginning to take off. I may be wrong on this, but I think five years ago there might have been one A&E in the country—I think Airedale was the only one at one stage—that was actually doing this. It is starting to happen. At the moment, it is a summary, not your entire GP record, but next year is a very big moment because NHS England has promised me that the NHS's present to NHS patients in our 70th anniversary year will be that everyone will be able to access their full GP record through an app on their phones and that will be a very big milestone in the spreading of electronic health records. It will mean that even in places where they have not set up the IT links you could potentially show your records to your NHS care provider, so that is a big step forward.

Andrew Selous: Gosh. Thank you.

Chair: Now, on to Rosie and accountability.

Q138 **Rosie Cooper:** Thank you. The questions I am going to ask are mundane, as you will be expecting, but of course I ask them in the light of the awaited Kirkup review and the National Audit Office current inquiry into the matters I have raised in Liverpool. The Health and Social Care Act 2012 restructured the NHS, creating CCGs, which were given much independence and commissioning power. It was also broadly known that



they were to be overseen by NHSE, but when I talk to NHSE regional officials they tell me that any failure in governance and regulation is down to the wording of the 2012 Act. How well do you think it is working—that is, working in terms of accountability and responsibility—and, where it is failing, what can be done to rectify it? You obviously know I am referring to Liverpool CCG, but, in talking to other colleagues across the House, there are many other areas, such as Staffordshire, where these kinds of problems exist but there is no real grip on what is going on.

Mr Hunt: First, as to how well it is working, it was obviously a very big change to the structure of the NHS and some of those changes are working better than others. The bit that in some ways has worked best has been the establishment of NHS England as an independent arm's length body. That has been positive because it has depoliticised quite a lot of decisions that the NHS has taken. From a politician's point of view, you do not get the Health Secretary endlessly announcing new schemes for this and that because these things now tend to be done by NHS England, but on the whole there is more coherence to our approach, and decisions that are rightly clinical and not political are more likely to remain that way. I think that bit of the Act has worked well.

As to the CCGs, we introduced Ofsted ratings for CCGs. You can see from that that there is a lot of variation and you obviously have direct experience of an area where it has not been working as well.

Q139 **Rosie Cooper:** They are CCG of the year. It is about to be debunked very hard, as you might well expect.

Mr Hunt: Okay. The truth is that NHS England does have powers in the Act to intervene where CCG governance is failing, and it is doing that. The broader point I would make is that where I think there has been a consensus after the Act, which perhaps the Act did not facilitate as much as we might have wanted, is on the need for collaboration between health bodies, collaboration between health commissioning and local authority commissioning, and that is what we are now trying to make sure happens.

Q140 **Rosie Cooper:** I talked about responsibility and accountability and you will be well aware—I have written to you regularly, and Simon Stevens and I are great pen pals—that the reality is that the system, and it has taken me four years, has not reacted well to this. I do not know what Kirkup is going to say, but I know what evidence is out there, so I think that case will be made strongly. Because NHSE and NHSI did not deal with the procurement process over Bridgewater well, I have given my evidence to the NAO—because you would not do it yourselves—and they are now holding an investigation. I believe the truth will out.

The bigger question is this. Two weeks ago Simon Stevens was here, and in response to my CCG questions he indicated that he had acted soon after he received the Deloitte report commissioned after my Prime



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Minister's question. He failed to acknowledge that NHSE did have oversight and, as you have just said, powers to intervene; therefore, they were the ultimate responsible body and he should have known what was going on, as indeed should the auditors, for example, who signed off accounts paying a non-executive £105,000.

In response to Diana's question earlier, you said that we should have a learning culture and learn from our mistakes. Should we begin with NHSE, NHSI and, dare I say it, the Department of Health? We have to stop these workarounds, fudging and mudging, as I call it, which appears to be institutional dishonesty. The question I am really asking is: what has been done and what will be done to ensure these accountability problems are addressed? It is a direct question: should there be amendments to the Act, not another fudge, because this will likely come out in Kirkup and in the NAO report?

Mr Hunt: I am not clear that the failings that you are talking about there are as a result of failings in the Act. I think they may be failings in implementation of the Act and the execution of statutory responsibilities, and that is something we need to look at, and Kirkup will help us understand that particular issue. I do not want to minimise the problems you are talking about in Liverpool, but all I will say is that if you talk to CCGs, most of them will say that they think there is too much oversight from NHS England and they wish they could be left to their own devices more often. It is a difficult balance.

Q141 **Rosie Cooper:** Forgive me, Secretary of State, but if that were true they would not have got away with this. I have had a searchlight on this for four years. If what you are saying is true, were you paying these people for not doing their job and should we be looking at disciplinary hearings? What is going on?

Mr Hunt: I do not want to pre-judge the outcome of an investigation that is happening, but in practice what is needed is a lighter touch with CCGs that are doing a good job but earlier intervention in those that are doing a less good job. That is why last year we introduced the Ofsted rating system for CCGs so that we can understand which CCGs are doing a good job and need to be backed and supported and to a certain extent left alone, and which require earlier intervention.

Q142 **Rosie Cooper:** That would depend on officials doing their job, people telling the truth. For example, the CCG in Liverpool was known to be good, being *Health Service Journal* CCG of the year, talking a good game, but now we are about to find out what has really been going on.

Let us leave that and move slightly on to another thing, which will be part of all this that will come out. You have often said that the merry-go-round of failing staff simply being moved to another NHS post needs to be stopped. How successful do you think you have been?

Mr Hunt: I think that has been pretty successful because now we have an independent CQC assessment system. If you are running, for



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example, a trust that fails a CQC inspection and gets put into special measures, it is much harder than it was 10 years ago for that person to be moved to another part of the country and given another trust to run. That transparency of the system is much more effective. I do not say it always works and I do not say that we have it right, but I would say that we have moved in the right direction.

Q143 Rosie Cooper: Thank you for that. Three years ago I was told the CEO of Liverpool community trust had been sacked, but actually she turned up at another trust for mentoring. That was three years ago, so you might say things have got better since. Recently, after my Prime Minister's questions, the Deloitte report and people getting my further questions, which will become public fairly soon, I would imagine, the chief executive and the finance director of Liverpool CCG were allowed to resign. No investigation took place about any of the decisions or the lack of governance, which is patently obviously now going to appear. What are you doing to encourage the system to deal with their problems and not move them? I know that is what you intend, but really this whole session today has been about what should be. I am trying to tell you what is. I spent four years looking at what is, and it is very clear that, if we get to a system where there are almost fudges and muddges and we all lose sight of what the real situation is, then people can resign and walk away.

My question comes down to: what are you doing to encourage the system to tackle their problems and deal with the problems they unearth? If these problems would have been subject to disciplinary action, why were they allowed to walk and what is to be done now?

A further question is whether it is appropriate that the "fit and proper person" test be applied should they want to work in the NHS in future.

Mr Hunt: We do have a "fit and proper person" test, which this Government introduced with respect to people working in trusts.

Rosie Cooper: It has not been very good.

Mr Hunt: It is early days. It was introduced as a recommendation from the Francis report, but the broader answer to your question is that the only way you can get to what should be is by being totally open and transparent about what is. We can confidently say, despite all the challenges the NHS faces, about which we have been talking this afternoon, that it is the most open and transparent healthcare system in the world and that we are very open about the challenges that we have. We have a legally independent inspectorate, and I am not aware of any other country that has a chief inspector of hospitals, full stop, but that also gives its inspectorates the legal powers that the CQC has to tell truth to power about what the situation actually is.

I do not say we have got there. What I need to do, if I may, is write to you about the details of the case that you have raised, but I am fully prepared to accept that that transparency has taken longer to be applied



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to the commissioning side of what we do in the NHS than it has to the provision side, and there is a bit of catching up that is going on.

- Q144 **Rosie Cooper:** Thank you. Secretary of State, just to go to the core point of this, it was NHS England that allowed these two to resign and not deal with the problem. They could have been left in post and the inquiry started or they could have been suspended while the inquiry started, but the fact is they were allowed to resign. Is that something you approve of?

Mr Hunt: I do not want to comment on the specific case, if you do not mind, without looking into the details, but I will write to you about it.

- Q145 **Rosie Cooper:** Okay. My final question is, would you like to comment on the state of healthcare in prisons and whether prison healthcare contracts are adequately funded, and indeed whether you know of any top slicing, so that when the contract is offered the NHSE regionally takes a portion off the top to hold for whatever it needs?

Mr Hunt: I am not aware of what you are specifically talking about. I think healthcare in prisons has improved since the NHS took it over, but I do have some particular concerns about areas that we could do better, particularly when it comes to addiction services and mental health.

- Q146 **Rosie Cooper:** Secretary of State, you must be aware—I have not written to you about this because I have been a bit preoccupied, but I will do so—that I have been dealing with NHS England regionally about Liverpool Prison and the fact that it is vastly understaffed. I actually have Datix that prove what I have been saying and that people have suffered serious injury because they have not had adequate care or medicine management and that there have been mistakes and, obviously, deaths in prison and people not receiving the appropriate medical checks within 72 hours of when they come into prison. All of that is coming down the line to you. Are you able to say you are happy with the level of funding for NHSE contracts for prison services?

Mr Hunt: Rather than giving you an answer on the hoof, I need to look into this, but, as you are going to write to me with particular detail, your letter may help me give you an accurate response.

- Q147 **Chair:** Secretary of State, it was something that was raised with Simon Stevens by several of us, so it would be helpful for you to address your reply to the whole Committee on your assessment of prison services.

Mr Hunt: I am happy to do so.

Chair: We have two very quick final questions from Paul and Lisa, if that is all right.

- Q148 **Dr Williams:** If I understood your answer to Rosie earlier, you said the Health and Social Care Act perhaps did not do enough to promote collaboration. Is that right? That is because, in many circumstances, it mandates competition—competitive tender. I am wondering if you might consider whether there might be an opportunity to repeal or amend



section 75 of the Act in the future.

Mr Hunt: We have had such a constructive discussion, and I share with you that some aspects of the Act have not worked as well as they were intended to. I do not think that the competition element of the Act was new; that was enshrining in legislation what was already required by the EU. There have been many debates in this place about section 75. I think the issue is that NHS structures that we have had for a long time mandate competition and make collaboration difficult—for example, the payment-by-results system, which encourages hospitals to increase activity as a way of generating income, even if it is not necessarily in the best interests of the patients or the NHS. There are much broader issues than the 2012 Act in how we promote collaboration. We said in our manifesto that we would look at the functioning of the internal market and we would be prepared to consider legislation where we felt that it was not acting in the interests of the NHS and the collaboration that we all recognise is needed.

Dr Williams: I think you probably would get a lot of support from across the House if the intent and the purpose of the legislation was to reduce mandatory competition and promote collaboration.

Chair: Certainly the predecessor of this Committee was assured by Andrew Lansley that integration would trump competition but unfortunately it does not always appear that that is the case, so it is useful to hear that is something you are actively looking at. Finally, Lisa.

Q149 **Dr Cameron:** Very quickly, in terms of changing culture, as you have mentioned, it is really important when staff come forward to point out issues with things, such as performance that needs improving or safety issues, that those staff are not then victimised. Do you have some way of monitoring, when these types of issues come up across the trusts, that staff are not being punished for raising these extremely important patient safety issues?

Mr Hunt: I will always remember that the previous chief inspector of hospitals, our first chief inspector, Professor Sir Mike Richards, used to say that, if you put him on a lifeboat and told him he could have only one data source that would tell him how safe a hospital's care was, he would ask for the staff engagement because there is such a direct link between strong staff engagement and safe care, and actually more cost-effective care because unsafe care is always the most expensive care that you can give. I completely agree with you. We do monitor all those things. They are reflected in the CQC assessments, and when we are trying to turn around a hospital in special measures the first thing that the new leadership team will always do is try to improve the levels of staff engagement. I completely agree with you that it is something we have to look at. I have to say that even in our best hospitals there is a long way to go, though.

Chair: Thank you very much, Secretary of State, for staying on for an



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extended period.

Mr Hunt: Not at all. Thank you all very much.