

Health and Social Care Committee

Oral evidence: Work of the Secretary of State, HC 523

Tuesday 24 July 2018

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Derek Thomas; Martin Vickers; Dr Paul Williams.

Questions 187 - 334

Witness

[I](#): Rt Hon Matt Hancock, Secretary of State for Health and Social Care.

Examination of witness

Witness: Matt Hancock.

Q187 Chair: Welcome, Secretary of State. Congratulations on your appointment. Welcome to everyone following this. Could I start by setting out personal interests? I declare for the record that three members of my family are involved in and are employees of the NHS.

Dr Williams: I do two mornings a month working in a GP practice and members of my family work for the NHS.

Derek Thomas: I chair two APPGs—brain tumour and vascular and venous disease. I shall be lobbying you about those.

Matt Hancock: Two members of my family work for the NHS. I did not know that that was a declarable interest. They are not my immediate family, but they are family.

Luciana Berger: I am the mental health adviser to the Metro Mayor of the Liverpool city region.

Rosie Cooper: I am chair of the continence APPG, but I do not think there is any financial connection whatsoever.

Q188 Chair: Thank you very much. We have a huge amount to get through today. First, to set some context for those following from outside, the funding uplift is very welcome—3.4% over the next five years. If we then look at that as an age-adjusted and population-adjusted figure, it comes to 2.3% between now and 2023-24.

Secretary of State, in the context of the priorities that you have already set out—workforce, IT and prevention—the difficulty with that uplift is that it does not cover public health, social care, Health Education England and capital, and thus two of your stated priorities: workforce, considering the uplift does not cover Health Education England; and prevention, considering it does not cover public health. How challenging do you feel that the funding settlement will be?

Matt Hancock: The uplift in funding is very significant. The fact that it is long term is a very good step. It is the longest proposed funding settlement in the NHS's history, and it allows us to put in place the long-term plan at the same time, before guaranteeing the funding in the autumn, and to make sure that the funding is spent right, because, of course, ensuring that we get the biggest positive impact on the nation's health from the money that taxpayers put into the health service is a critical part of it.

The 3.4% is in real terms. It has to take into account the increasing pressures on the NHS, not least due to people living longer, as you say, which we have to remember is a good thing, and partly due to the capability of the NHS. There are other parts of the Department for Health



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and Social Care budget that are not yet set, and they will be set in the spending review alongside every other Department, including public health and Health Education England, and the big questions around sustainable funding over the long term for social care, which perhaps we will come to.

I am confident that, combined with the £20.5 billion proposed increase for the NHS, the spending review settlement that we will come to on the non-NHS spend will ensure that we have a budget for the NHS over the medium term that can secure its future. I am determined to see that happen and I am very confident, given the importance that the whole nation attaches to the NHS and its sustainability, that we will get there.

Turning to the three early priorities that I set out, prevention is of course about more than just public health. It is very much about public health, and that is important, but it is also about strengthening primary care, making sure that people can be treated more in their communities rather than in hospital; it is about keeping people out of hospital, not just paying for their care when they are in hospital.

On the skills and training side, Health Education England's budget is very important, but there is also training that goes on in the acute sector, and there is a broader question around that. The three early priorities are consistent with the funding settlement set out so far and proposed, but clearly there is the rest of the budget.

Q189 Chair: To clarify, when will the money from the spending review that is going to go to public health, health education, social care and capital come on stream?

Matt Hancock: I expect that to be settled in the spending review in the normal way.

Q190 Chair: When will it come on stream—for those following from outside?

Matt Hancock: It depends on exactly the period that the spending review is going to settle. It is not this year, but from next year onwards.

Q191 Chair: The money, you think, will come on in the next financial year, starting in April 2019. Is that right?

Matt Hancock: None of that is agreed for the area outside the NHS settlement that is already proposed. The NHS settlement already proposed is from 2019-20 onwards. The rest is to be settled in the spending review.

Q192 Chair: It is very difficult because a lot of things that you have talked about as your priorities, such as prevention, public health and workforce, are dependent on budgets that are not yet set.

Matt Hancock: In improving what it is like to work in the NHS—I was going to say “to be worked” in the NHS, which it sometimes feels like to some people—of course there are issues around CPD, and that budget is



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part of Health Education England and therefore will be settled in the spending review, and around contracts. A lot of it is around ways of working and culture in individual settings, in individual trusts and surgeries and, of course, social care. Inevitably, there are some issues that can be settled alongside the rest of the spending settlement, but there is an awful lot of work that will be done. The vast bulk of this can be put in place strategically as part of the long-term plan, and, for the rest, there is an awful lot that can be done both before and after that.

Q193 Chair: Can I ask about transformation funding? There has been a recurrent problem for the NHS; for example, in the past we had the sustainability and transformation fund, and it all got sucked into sustainability with almost nothing left for transformation. In the money that has been allocated, are you planning to ring-fence funding for transformation?

Matt Hancock: We are considering that. I do not want to prejudge the long-term plan, but I am absolutely determined that money for transformation is made available, not least because the goal of the long-term plan is to ensure that we have a sustainable future to guarantee the long term of the NHS, and we cannot do that without transformation. The money I have announced since I took the post—£487 million for tech transformation—is all transformation funding. I am determined to ensure that the long-term plan requires transformation spending to continue to be available through the period, and that we do not simply spend the extra £20 billion on ticking over as we are, because that is not a sustainable solution for our NHS.

Q194 Chair: That is encouraging. Turning to the long-term plan and your own role in developing it, can you set out how it is going to be developed and how you are going to make sure that you hear voices from the frontline in developing that plan?

Matt Hancock: Hearing the voices from the frontline is very important. In the first instance, as we speak, NHS England is putting together a skeleton outline, which is the big picture, of the items that need to be in it. I propose to come forward in September and October with consultative exercises on the three priorities I have set—workforce, technology and prevention. I am aiming for those to be September, but I said September or October because I have a lot of experience across Whitehall. They will feed into the key decisions that are taken in October, and likely November, for publication of the long-term plan. We are listening to considerations now. There is an engagement exercise, but we want to do a whole lot more of that.

Q195 Chair: To be clear, you are saying that you are going to conduct a consultation exercise around your three stated priorities.

Matt Hancock: Yes.

Q196 Chair: But simultaneously NHS England is going to be coming up with its own framework, and at some point you will try to see where they marry



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together.

Matt Hancock: That is right. One reason I set out those priorities very early is that it is very important that the long-term plan delivers on them.

Q197 **Chair:** Many other areas were set out by your predecessor where they wanted to make progress—for example, waiting times, mental health and priorities around cancer outcomes. Have you heard the nervousness that has been expressed that the funding uplift cannot cover all the priorities that have been set out? What is going to give from those?

Matt Hancock: It depends how the money is spent. We have to spend the money in such a way that it goes as far as possible. At the same time, the plan has to be realistic and deliverable. If you start without the ambition to achieve all the things you want, you will never get there; but, if you start with the ambition to do as much as possible, you have to test that against the realism of delivery. The things that have been set out, both by my predecessor and by the Prime Minister, are very important.

In some areas, it is cut a different way. Take mental health, for instance. Parity of consideration of mental health concerns and physical health concerns is incredibly important, as indeed is the overlap between them, because there is a very high degree of overlap. That is the way I have tried to set out my approach to the job. The priorities, as I said, cut across both mental and physical health. Similarly, to take a specific issue, childhood obesity cuts across different considerations.

Q198 **Chair:** We are going to have a whole section on mental health, on primary care and on prevention in a minute. I want to go back to that point about not achieving everything. For example, one of the priorities was to achieve financial stability in trusts—in other words, deal with trust deficits. Have you looked at the quite long list that was set out of things to achieve from the funding uplift, and decided that you cannot do them all at once and some of them will have to wait?

Matt Hancock: No, because I think you have to seek to do all that you can and then you have to—

Q199 **Chair:** Even if it is unrealistic.

Matt Hancock: As you develop the plan, you test it against what is realistic, to use your word. We are at the early stages of development of that.

Q200 **Chair:** At some point, when we get to the 10-year plan, you will be in a position to set out which of those will have to wait a bit longer.

Matt Hancock: Potentially, but not definitely, because I think there are ways of delivering better outcomes within a tight funding envelope. One of the extraordinary things about the NHS that struck me in my first two weeks in the job is the enormous variance in delivery, from some of the best in the world to areas where there is significant opportunity for improvement, to put it politely, in almost every field I have looked at so



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far. In many cases, the places doing the best are doing it on really tight budgets, and sometimes on relatively tighter budgets than other places that are not getting the right outcomes.

Q201 **Chair:** But we are looking at the role of transformation funding for some of them too.

Matt Hancock: Yes, but it is not as mechanistic as always being about transformation funding. Of course, funding is required sometimes to unlock spend-to-save investments, but not always. A lot of it is down to high-quality leadership, being able to turn around and use resources better and getting rid of rules, and indeed non-rules, or practices—ways of working—that are wasteful.

Q202 **Chair:** At a future session, we will be very interested to hear how you will achieve that. I have been on the Select Committee for eight years and I cannot remember a time when people have not talked about getting rid of the variation as a mechanism of delivering the efficiency. We will be really interested to hear how you are going to make progress on that, but we will not focus too much on it today. Thank you for that.

Going back to formulating the 10-year plan, one person we would have expected to play quite a key role would be the new chair of NHS England. This Committee was asked to set aside a session to conduct a pre-appointment hearing, which we were very happy to do. We hear the name has been with No. 10 for some time, but we ended up cancelling the session the day before because we still had not been given the name. What is going to happen next with that role and appointment?

Matt Hancock: Clearly, being the chair of one of the bodies that spends the most money in the UK is an incredibly important appointment, so we want to get it right, and you will understand that we want to do the right amount of due diligence. We never get into where that is in the internal processes of Government—

Chair: We know that it is with No. 10.

Matt Hancock: It is very important that the correct level of due diligence is done, and I look forward to making a decision as soon as possible; and then there will need to be a hearing of the Select Committee, as is normal.

Q203 **Chair:** Will the person be starting work before Parliament has had a chance to conduct a pre-appointment hearing?

Matt Hancock: No.

Chair: Thank you.

Matt Hancock: I can give you that guarantee, not least because the incumbent changeover date is in October, so there is time to ensure that there is a hearing before.



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Q204 **Mr Bradshaw:** Secretary of State, you clearly believe that prevention is better than cure, because you made prevention one of your three priorities, but when the Chancellor announced the uplift in NHS funding, he made it quite clear that there would be no extra money for any other Department, which in theory would include public health and social care because they go through local government. What makes you think that we will not continue to see very damaging cuts in public health budgets?

Matt Hancock: There are a couple of reasons. First, prevention is about more than just public health, as I said. It is about public health, and public health is very important and public health budgets are very important, but it is also about primary care, which is within the—

Q205 **Mr Bradshaw:** But good public health keeps people out of primary care as well. It is the ultimate type of prevention.

Matt Hancock: Yes, I agree, and you have to look at this at all levels. The operation of the public health system is important. What matters there is outcomes, and it is broader than purely the public health budget itself. To take the obesity strategy, it has to be cross-Government because it is about schools and about broadcasting—my old bailiwick; it is about a broader approach. The public health element is important, but it is only one element of prevention.

Q206 **Mr Bradshaw:** You sound as if you are resigned to further cuts in public health budgets.

Matt Hancock: No.

Q207 **Mr Bradshaw:** If they happen and if there is no uplift, would you be prepared to reallocate some of the NHS money to public health? I think there is general agreement on how important that is.

Matt Hancock: I am not going to get into “if it happens,” because that is not my approach to the spending review.

Q208 **Mr Bradshaw:** You are still fighting your corner for a big public health uplift with the Treasury.

Matt Hancock: I am looking forward very much to the spending review.

Q209 **Mr Bradshaw:** Can I ask a quick question on performance? According to the latest NHS performance figures, there are now 3,000 patients waiting more than 12 months for vital surgery, which is a 600% increase in just the last five years. What are you going to do to get waiting times down?

Matt Hancock: The first and most important thing is to ensure that we have the long-term funding settlement, with the long-term plan alongside it. When people say funding has been tight in the NHS for the last few years, I readily acknowledge that. Part of the reason for a long-term settlement is to be able to tackle some of those problems. Of course, the number of people waiting more than a year has fallen significantly, to a sixth of what it was in 2010, but that is an awfully long time for anybody to wait, so it is an important part of the long-term plan.



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Q210 **Mr Bradshaw:** When Simon Stevens was asked about this by the *Health Service Journal* last week, he said that he would not want to see us go back to the times when hundreds of thousands of people waited more than a year for vital surgery. That is not a very ambitious target, is it?

Matt Hancock: I did not see that he had said that. Nor would I want to see that, in a literal sense, but the fact is that the number of people waiting over a year has fallen sharply over the last eight years.

Q211 **Mr Bradshaw:** But it has gone up 600% in the last five years. That is the point I am making.

Matt Hancock: Before that it was brought down a lot. It will be an important part of the long-term plan.

Q212 **Mr Bradshaw:** Bringing that number down.

Matt Hancock: I hope to. On targets as a whole, when I arrived at the Department the NHS asked me to make sure that we can think, from a clinically-led point of view, about what targets are best and most effective. It is very important to listen to clinicians on that.

Q213 **Derek Thomas:** Welcome, Secretary of State, to your new job. It is important that we look at how the £20 billion and so on is spent and shared out, but I guess the real big challenge for you this autumn will be the whole issue of social care. There is great anticipation around the country about what the Green Paper will look like, and how social care is to be funded. You are aware, I am sure, that a few weeks ago the MHCLG and this Committee put together and published a report on funding. I do not know if you have had an opportunity yet to look at it.

Matt Hancock: I have.

Q214 **Derek Thomas:** One of our recommendations on social care funding included the possibility of a social care premium. I do not know what consideration you have had of the social care Green Paper, or whether you could share what time you have spent on it since you took office. We would be interested to hear when it is due and whether you are prepared to say anything about how you feel social care should be funded in a long-term funding settlement.

Matt Hancock: It is very early days. We will have the Green Paper in the autumn. This is an incredibly important issue to get right in the short term and in the medium to long term. In the short term, over the last year we have increased spend on social care as a country, not just central Government but including local, by £600 million in cash terms, but there are clearly rising demands as well. I am not able to go too far in this area yet, because I am still reviewing not only the Select Committee report but many other reports, and I understand there are a few forthcoming. I want to make sure that I listen to the broad range of debates and try to find a solution that has a sustainable long-term plan that, crucially, has a high degree of consensus so that it can last for the long term.



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Getting social care right is critically important for the country, and there have been endless attempts and discussions. That is not necessarily a bad thing, actually. The numbers of people who have put a huge amount of effort and thought into this have all added to the collective knowledge of what we might be able to do about it, but finding a course through that is not straightforward. I look forward to a lot of summer reading.

Q215 Derek Thomas: There is a concern that we shared in our report, and that a lot of people share, including a number of charities. It really started with the Prime Minister in the June election last year, when the whole emphasis seemed to be about elder care, and the need to address sustainable funding for elder care, yet we all know that half of social care is spent on working-age people. Lots of local authorities, charities and many MPs are concerned that the Green Paper will only really look at elder care and, as a result of that emphasis, working-age social care will become a poorer cousin.

Matt Hancock: No. The Green Paper will cover adult social care as a whole. My aim is for it to be wide-ranging, because you have to look at the system as a whole, and the opportunity we have, now that social care and health are in the same Department, is to work on the interoperability and integration of the two at the same time. The whole piece needs looking at.

Q216 Derek Thomas: That is good to know. Your Department recently changed its name to the Department of Health and Social Care, and that is welcome, but I am told in my constituency that for 40-odd years we have been talking about integration of health and social care and it has been a challenge to make any progress. Have you given any thought to who should take primary responsibility for social care? If you integrate something, somebody needs to be responsible.

I want to share a brief example of the challenges in Cornwall to shed light on the issue. Over the three years since the extra money, Cornwall Council has received an extra £39 million for social care, but in very recent days both the chief executive of the council and the portfolio holder for social care have referred to that money as a sticking plaster for social care. We are concerned, as we thought it would be transformational rather than just a sticking plaster. Lots of people who are engaged about how we integrate think that maybe social care should and could be transferred to the responsibility of the NHS. Do you have any view on that, or do you think we carry on with the quite bizarre arrangement where different people accept responsibility for someone's care depending on whether it is means-tested or not?

Matt Hancock: The system is complicated, including the different entitlements according to different conditions. One of the issues and challenges facing both the NHS and the social care system is an increase in co-morbidities that also challenges some of the underlying assumptions about who pays for what. That is a problem.



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As far as I am concerned, all options are on the table. When I arrived in the Department, I had been asked to look at the long-term sustainable plan for both health and social care; there is no point putting the two in the same Department if you are not then going to make the most of the interaction between them.

Does that mean I think for definite that there needs to be a structural change? I can tell you this: I am pretty sceptical of—how shall I put it?—large, top-down reorganisations in this area. I use the words interoperability and integration advisedly, because there are opportunities from technology to get better integration and interoperability even if the funding is coming from different places. Sometimes, it ends up being a patch on an existing structure, but we all know that when you choose to completely reform a structure there are downsides to such a big revolution, and evolution is often better.

I know I have not given a direct answer to your question, but that is because I have not fully formed a view, and I am looking forward to spending the next couple of months listening to as many voices as possible in this debate to try to find a way through that commands broad consensus and resolves the problem for the long term.

Q217 Derek Thomas: Would you accept that at the moment we have a situation where we are working hard to integrate health and social care, yet the way it is set up gives opportunities for different people to explain away the lack of progress being made, or even blame other people responsible? Do you accept that, ultimately, we need a system where people see clearly who is accountable for an individual's care?

Matt Hancock: I can see that in theory, but I can also see in practice a huge amount of opportunity from better integration. There are examples already up and running, some of which I have visited in the last couple of weeks, of interoperable systems between GPs, hospitals and social care providers that allow information about needs to flow much better. They do not resolve some of the complications around the direct line through which funding reaches the patient's carer but they provide some very significant improvements on the status quo.

Policymakers, in my experience, are often tempted to try to draw the perfect solution, but you have to start from where you find yourself and ask how we can best improve this for people on the ground. That is what I really care about. I hope to be very pragmatic in the way we take this forward.

Q218 Diana Johnson: First, Secretary of State, congratulations on your new role.

As you know, sleep-ins have been an issue for some time. There was the recent decision of the court in the Mencap case. Have you given any thought to whether it would be a sensible move forward to clarify the position and to amend the regulations around payment of the national



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minimum wage?

Matt Hancock: Yes. I am a very strong supporter of the national minimum wage, and indeed the national living wage. I was campaigning for the national living wage before it was announced that one of the main arguments back was that there are some areas that would find it difficult to cope with paying the national living wage, such as social care. My argument in return was that, if you pay people better, you will get more out of them. There has been evidence of this, so I do not resile at all from my enthusiasm for the sharp rises in the minimum wage paid to people through the national living wage.

Having said all that, I appreciate that sleep-ins have been an acute question over the last few months. On the one hand, I would love to see people paid better; on the other, there has to be the money to do it. The best way to do this is by sensible, organised, forward-looking policy making rather than court judgments that put large, backward-looking burdens on providers who are already under pressure.

I was pleased with the Mencap court decision. I thought it followed natural justice, but it leaves an open policy question as to whether, going forward, we should amend the rules. We certainly need clarification, because it is very important that, whatever the rules are, they are explained properly on this point. Lack of proper explanation was the source of the problem originally. Whether we need to change the rules is formally a question for the Business Department, but one on which I am engaged with them.

Q219 **Diana Johnson:** The decision we heard about in the last couple of weeks might be appealed, and I understand that Unison are considering that. From what you have just said to me, it sounds like you are very sympathetic to the idea of having clarity in the law and clarity in the regulation, but of course the funding would have to follow. If there is going to be a change to regulation, there would have to be sufficient funding to allow, mainly, local authorities to meet that requirement, as they pay for a lot of people, particularly in my own patch, where we do not have many self-funders, and it is down to the local authorities to pay. Do you think that you might set it out in law?

Matt Hancock: If the court case had gone the other way, it would undoubtedly have led to additional pressure. We already have pressures to deal with, notwithstanding the increase in funding that has gone towards social care in the last couple of years, so we would undoubtedly have had to take that into account. It is not at all automatic that it would have led to an increase in taxpayer funding, because funding has to come from somewhere, but it would have led to an additional pressure that we would have had to take into consideration.

It would be very dangerous to say that it would automatically flow from a court decision that changed the standard interpretation of a rule that put added pressure on. That does not automatically lead to increased central



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Government taxpayer funding, whether we like it or not, because we have to make sure that we can find the funding from somewhere.

Q220 **Diana Johnson:** As I understand from what you have just said, you are very sympathetic to paying people the right amount when they are engaged in work. That is what you said at the outset of your response to me.

Matt Hancock: I am engaged with the Business Department on what the appropriate future rules should be.

Chair: We come now to the subject of governance and accountability.

Q221 **Rosie Cooper:** Secretary of State, last winter was pretty dire in the NHS and we are now anxiously preparing for this autumn/winter and winter pressures. Could you indicate, from your short time in the role, where you think we are currently on the integrated care agenda? I ask that because the words “integrated care” are used as the magic bullet. We in the Committee have talked about ACOs and ACSs. Perhaps you could talk about where we are with the current state of STPs.

Matt Hancock: Right. Wow. On winter, first and foremost, I have already had my first winter preparedness meeting—it was probably one of the hottest winter preparedness meetings that there has ever been. Clearly, demand increases in winter. We all know that, and we need to be ready for all eventualities. Last winter, the pressures were particularly acute because of a particularly virulent flu, but it is important that we are as prepared as possible for winter.

STPs are, ultimately, a tool to bring people together to try to integrate across a whole series of different organisations. They are a very useful device to ensure that there is as much co-ordination as possible at the institutional level. That is very important. Ultimately, it only works on the ground if there is integration between people working for different organisations in terms of the care they can provide. That can be done both organisationally and using technology so that everybody is working off the same records.

Further work to integrate, co-ordinate and collaborate in various different bits of the social care and health systems is really important. I said in my speech on Friday that we need to go forward in a spirit of collaboration, not competition. That is very important for the future of the NHS and social care systems.

Q222 **Rosie Cooper:** A lot of people will seriously welcome that statement. Using your phrase about starting from where you find yourself, we currently have STPs that openly work around the rules and are openly a fudge to get some of the integration. You have not really described how it will happen, but I want you to talk about governance in that sense. If the NHS itself is finding ways to outwit the rules, how would you deal with individual NHS organisations that behave to circumvent the rules? Who are STPs actually accountable to?



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Going to an area I know very well, it took five years to get to the bottom of problems at Liverpool Community Trust. In that case, staff were bullied and harmed; patients were harmed. As you know, those inquiries are ongoing, and it will be shown that maybe 100-plus deaths have not been fully accounted for. In Gosport, we had 450 deaths—20 years of anguish—and problems with prescribed painkillers and two types of syringe driver. How does that happen? In LCH, eight of the 11 board members refused to give evidence to the Kirkup inquiry. Have we entered a free-for-all in the NHS? Do we have any proper governance? Are we just nodding in that direction?

For example, the fit and proper person test does not apply to anybody other than directors in all the instances I talked to you about; even the regulators have not dealt with it. When we looked at it, regulators cost something like £1.2 billion overall in the NHS, yet all the regulators missed Liverpool Community Trust, so it was down to me—Gosport, whatever. How do you as a Department, knowing that NHS England will go outwith the rules with STPs to do workarounds, hold organisations' feet to the fire when they go outwith the rules and harm people?

Matt Hancock: First, I pay tribute to the work you have done, which I have followed from afar and have been briefed on already as an example of how things that have happened have been uncovered. The fact that it was only thanks to you that the problems were discovered in Liverpool shows just how important it is that the formal accountability processes are made better. That is a big focus of the Department.

I reject the characterisation that, because the various NHS bodies, as set out in statute, are finding ways to work together, it should give anybody any permission to avoid accountability measures for what happens in a trust, whether at director level or in the relationship between the trust and the regulator, and whether it is the CQC or the role that NHSI plays in driving up standards. Working together in a collaborative spirit to ensure that the system as a whole approaches clinical problems in a joined-up way is very important. That does not give anybody permission to cover up a significant clinical problem, or indeed any clinical problem, and a whole range of actions still needs to be taken, despite the enormous levels of effort that my predecessor put into solving these problems, to ensure that we have a culture of openness and transparency around problems when they arise, and accountability of trusts.

Q223 **Rosie Cooper:** I know that you are looking at fit and proper persons in great detail and are hoping to come forward with some improved regulation. For me, so far we all talk a good game and everybody is accountable, but actually nobody is responsible, so the work the Department is doing will, hopefully, nail that down once and for all.

Matt Hancock: Yes.

Q224 **Rosie Cooper:** I take it that you as Secretary of State will send that message out loudly and clearly.



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Matt Hancock: Very strongly. I very strongly support the statement you have just made, yes.

Q225 **Rosie Cooper:** Thank you. My final question, from left field, is about presumed consent. I am having more and more difficulty in ordinary casework dealing with the various organisations, the CSUs that have appeared, that do not accept letters from MPs as consent. You might well look shocked. I have spent the last three months in dispute with quite a number of them. One, the Midlands CSU, will only deal with cases having sent me an A4 pro forma, which I am supposed to send to my constituent, after they have contacted me directly, not third party, in which I am also required to get their NHS number. I feel that this is a way of delaying, circumventing and stopping MPs doing their job. Would you, as Secretary of State, consider at some point in the future—

Matt Hancock: I can do it right now if you like. It is absolutely clear in law that MPs have the right to request on behalf of their constituents whatever information they need to support that constituent in a constituency case. It is in the Data Protection Act that Parliament just passed. Anybody who is getting in the way of MPs supporting their constituents to get the best care they possibly can, and to get to the bottom of problems that might have occurred, needs to stop taking that approach and instead be supportive. If we need to make that more formal, I am very happy to do it.

Q226 **Rosie Cooper:** I would be grateful if you would, because in my latest case I have a letter from an NHS body that says they cannot give me the detail because they do not have consent, so they are going to reply direct to the constituent. The constituent only came to me because they were dissatisfied with the complaint in the first place. It is stupid.

Matt Hancock: That is right, and we specifically made provision for this in the Data Protection Act, which is now a law.

Rosie Cooper: Thank you. I look forward to the fit and proper persons stuff in the autumn.

Q227 **Dr Williams:** Welcome to your new role, Secretary of State. "Collaboration not competition," but CCGs, who are the accountable statutory bodies, are getting lots of legal advice that, even though they believe it is in the interests of their patients to collaborate, they still have to put many services out to the market. Are you open to amending legislation in order to make collaboration easier?

Matt Hancock: I am open-minded on that front. I have had a number of different proposals so far on pieces of legislation that are not quite working in this space. I want to proceed on a consensual basis. I do not want a big legislative shake-up in this area, but if there are improvements that can be made and proposals are put to me that have a high degree of consensus, I am open-minded to that.



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However, all my experience in many other areas of government tells me that often it is the over-interpretation of legislation that is the problem, rather than the legislation itself, particularly when lawyers get involved. They like either to de-risk something to death or to over-interpret, and in some circumstances purposefully over-interpret, laws, so that they can cover their backs. That is not the approach that should be taken.

That does not mean that we should not be looking to deliver services using the best possible technology and whatever is available to do the best for clinicians and for patients. Of course, everybody should be looking broadly at what they can use—whether that is a piece of technology or other people—to deliver for their patients, but it should be done in a collaborative way, switching supplier where needed, and not in an overly legalistic way, which I fear is too often what happens. We should allow doctors, not lawyers, to decide what is best for patients, shouldn't we?

Q228 Chair: Secretary of State, I know that you are very new in the role so you probably have not had a chance to read this Committee's inquiry into integrated systems and partnerships, but we will be pleased to talk to you about it in more detail. Our recommendations were that the legislative proposals should come from the sector itself and that this Committee would be happy to conduct pre-legislative scrutiny rather than its being initiated in the Department of Health.

Matt Hancock: I am very open to that.

Chair: We would be pleased to meet you to discuss it.

Q229 Martin Vickers: Could I focus on an issue that is of particular importance to me, as one of my CCGs and hospital trusts is in special measures? What approach are you going to take to help and support them? Do you have any new initiatives planned, because clearly it is of vital importance to the patients they serve?

Matt Hancock: Do you mean when a trust is in special measures?

Martin Vickers: Yes.

Matt Hancock: Absolutely. I hope that the bringing together of Monitor and the Trust Development Authority in NHSI will mean that there is a better system for turning around trusts in special measures, and giving them the support they need. The question of whether they get more financial support is a very difficult one. You absolutely do not want to incentivise trusts to end up in special measures because they have a financial difficulty.

Trusts need to meet their financial targets. One of the critical ways of ensuring that extra money goes into transformation and improving patient care rather than stabilising the system is that trusts take responsibility for their own finances. We will not sway from that. I hope



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that having NHSI there as an institution will improve the amount of support that can then go to turn around trusts.

One of the observations I have made so far is that often going into special measures leads to new leadership. Sometimes that is absolutely necessary. However, new leadership is no panacea, and it does not automatically solve the problem. Often, you need not only the stick but a big carrot and an arm around a trust to help them out of special measures.

Q230 Martin Vickers: You are saying categorically that you will not be providing additional finance unless you are absolutely satisfied that they have arrangements in hand to ensure that that additional finance goes to the benefit of patients and not, in effect, to prop up the trust.

Matt Hancock: That is right. When trusts are in financial difficulty, especially when they are both in financial difficulty and in special measures in terms of outcomes, it is by no means automatic that they should get extra funding to get out of that situation. They need to manage their way out of it, and often they will need support to do that.

Q231 Martin Vickers: More broadly on finance, the additional £20 billion is extremely welcome and you said earlier that it will secure the future. Obviously, that is the future covered by the £20 billion. Beyond that, do you see that there is a need for fundamental change? I think you said you do not want to get involved in structural change, but what about fundamental change to the funding? Will certain services have to be reduced or are you looking at perhaps some form of insurance?

Matt Hancock: No. I am really looking for a change in the culture of how the NHS works in a number of different ways. First would be a culture of greater respect among the workforce. I have found it extraordinary to see how a highly motivated, highly intelligent workforce has to cope with structures, and sometimes very old-school management, that make it far less pleasant than it should be to work in the NHS.

The NHS ought to be the best place to work in the world. It has amazing values; everybody buys into it and supports the values that it provides, but often the ways of working—old-school practices—get in the way of its being a brilliant employer. It is the culture in ways of working, in the uptake of new technology, whether new clinical technology or new operational technology; and in integration of different systems, making sure that there is seamlessness between the various parts of the NHS—primary, secondary, community pharmacies, public health, the training systems that are often too bureaucratic and outdated and need to be improved, and, of course, social care. I am looking for culture changes rather than a revolution in structures, which I am not interested in.

Q232 Martin Vickers: Even in the medium term, you see the service being provided predominantly through taxation.

Matt Hancock: Absolutely.



Q233 **Luciana Berger:** Secretary of State, I am going to endeavour in a short time to cover five key themes about mental health. I have some questions that I know members are keen to hear from you about. Your predecessor took on mental health in his brief. We have not heard yet if you are going to do the same and I wonder if you could share with the Committee whether you intend to have ultimate responsibility for mental health as the Secretary of State.

Matt Hancock: Yes. I have ultimate responsibility for everything that happens in the Department.

Q234 **Luciana Berger:** Indeed, but your predecessor had mental health as his responsibility, rather than one of the other Ministers.

Matt Hancock: No. The way I like to run a Department is that every area is the responsibility of a junior Minister and then there are areas where I have a particular focus on which I will work with them, but I prefer not to have an area carved out without junior ministerial responsibility.

Q235 **Luciana Berger:** The Committee will have heard that, but in the wake of this being such a serious issue and its previously being taken on by your predecessor, many people will be looking very closely to see how that works in practice, to ensure that it continues to have the same attention that it rightly had previously.

Matt Hancock: If I can answer that point, it will absolutely have the same focus. It is not only something that is very important to me; it is also very important to the Prime Minister. The importance of seeing mental health in the same regard as we see physical health is absolutely paramount. There has been a big change in society over the last few years—not even a generation, but over the last five years—in which people have more confidence to talk about mental health concerns. I do not yet think that is reflected in the NHS as a whole, and it is incredibly important.

The first answer I was giving was a technical one about how I act as a Secretary of State. There is more focus if both a junior Minister is ensuring that they are completely across the subject and a Secretary of State is putting their focus on it. I think it is a better way to run a Department.

Q236 **Luciana Berger:** Do we know yet who the junior Minister will be, who will have responsibility?

Matt Hancock: It is Jackie Doyle-Price.

Q237 **Luciana Berger:** In the prison health session we had last week, I asked that Minister if she had been to visit a prison health service, which includes many mental health services. She has had that responsibility for over a year and she has not been to visit any prison health services. In the wake of that answer and others that we have heard, I would again



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hope that you will ensure that—

Matt Hancock: But I have only been the Secretary of State taking that approach for two weeks. It was not her responsibility. Because of the way that Jeremy Hunt did it, he took personal responsibility solely, so, to give her credit, she did not even have the responsibility at the time you asked the question.

Q238 **Luciana Berger:** She had responsibility for prison health services, which includes mental health services in prison. That was one example.

You touched on parity and you rightly highlighted the distinction between where the public has moved to and some of the challenges in the NHS. Back in 2012, parity of esteem was enshrined in law. In the wake of that legislation, we have seen a reduction in the number of mental health nurses by around 5,000, over 1,000 fewer beds within mental health and community services decimated. There are a number of documentaries I would urge you to watch to see what the reality is on the ground for those services.

We have seen an increase in people presenting at A&E in a mental health crisis. We know that thresholds right across the country for both young people and adults to access mental health services have increased, and, increasingly, we hear evidence that someone has to attempt to take their life before they even have access to mental health services. On that basis, can you give us an indication of how you will ensure that there will be a fair allocation to mental health in the wake of the funding announcements we have had for the NHS?

Matt Hancock: Yes; this is at the core of the long-term plan. It is incredibly important to get it right. It is our opportunity to set out how this needs to change over a long period of time to fulfil the promise of parity that was set out in legislation six years ago.

Q239 **Luciana Berger:** The Institute for Fiscal Studies told us that in order to provide mental health services to 70% of those who need them—at the moment only around 30% of the population get them—the spend would need to more than double over the next 15 years to £27 billion. Is that something that could be achieved?

Matt Hancock: It all depends on how mental health services are delivered, and the more you can do in the preventive space, and in early intervention, the better. There is a huge amount of work. I have come into the Department to find a huge amount of work under way in this area, and it will be reflected in the long-term plan.

Q240 **Luciana Berger:** We will talk about public health in a minute, but just 1% of local government public health spend goes towards mental health, so anything you can do in that regard will be welcome.

You touched on the five year forward view for mental health, which we are about halfway through. Within that, there are some mental health pathways that were committed to but have not yet been delivered, and



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the Department has failed to appoint an equalities champion for mental health. Will you be committing to report back on the progress that your Department has made on the five year forward view recommendations, so that we can have full scrutiny of those recommendations?

Matt Hancock: I am very happy to do that.

- Q241 **Luciana Berger:** Marvellous. Particularly in the light of the continued delays on the mental health pathways that were promised as part of the five year forward view for mental health, have you considered, or will you be considering, clear access and waiting time standards for all mental health services in the same way that we have them for physical health?

Matt Hancock: As part of the review of how we operate targets and to ensure that they are clinically determined, I want the NHS to look at this. They came to me to ask whether we could look at making sure that targets are better clinically, and I am happy to go back to them and ask that that is taken into account in the work they are doing.

- Q242 **Luciana Berger:** There is a clear distinction between the outcomes that are measured for physical health compared with those for mental health.

Matt Hancock: There is a whole series of areas where the approach taken to physical health is completely different from mental health and that needs to change.

- Q243 **Luciana Berger:** You have a wider challenge of staffing, but one area where the crisis in staffing is most acutely felt is in mental health. At the last election, your party prioritised investing in 10,000 more mental health staff by 2020. Are you able to update the Committee on what progress you have made towards that pledge?

Matt Hancock: I hope you will forgive me if I say I am going to write to you about that.

Luciana Berger: Yes.

Matt Hancock: I will have a look in my pack. I do not have the figure at the top of my head. If I find it in my pack, I will tell you.

- Q244 **Luciana Berger:** On many indicators, while there is recruitment going on, there are many areas where as many people leave the sector as join it. There is a particular challenge with a reliance on bank staff—temporary staff—and the area of mental health is probably where it is least appropriate. Again, there are many programmes you might want to look at to see what the practical effect is for patients up and down the country.

Matt Hancock: Yes, I am very sympathetic to that point of view. However, in some of the other areas where I have been confronted with challenges on the staffing front, the numbers are going in the right direction, not the wrong direction. It is not always the case, but,



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nevertheless, since I do not have the figures in front of me and I have not seen them yet, I am very happy to write.

Q245 Luciana Berger: I can tell you categorically that when it comes to mental health nurses, for example, we have seen a reduction since 2010 of around 5,000.

This Committee did a joint inquiry with the Education Select Committee into your Department's Green Paper on young people's mental health. I imagine you probably have not had a chance to read our report and/or your own Green Paper, but it is worth sharing with you that our headline finding in our joint Select Committee report was that the Green Paper lacks ambition and will provide no help to the majority of the children who desperately need it.

As you know, today I raised at Health questions the fact that, later this week, your Department is expected to release its response to your consultation on the Green Paper. I wonder whether that response is likely to take on board the criticism from this Committee, the Education Select Committee and many organisations and individuals outside this place.

Matt Hancock: Yes; I would say that the response is a good step in the right direction. I will make sure that you know about it as soon as possible.

Q246 Luciana Berger: Thank you. In June, Simon Stevens said that we are going to need a major ramp-up, under any scenario, of young people's mental health services. He said that has to be one of the big things that comes out of the long-term NHS plan. Do you agree with that and, if so, what can we look forward to?

Matt Hancock: Yes. I said it and I strongly—

Luciana Berger: Particularly on young people.

Matt Hancock: I strongly agree with that. This is an area on which in my previous role I worked with the former Secretary of State, because some of the pressures that have led to increased mental health challenges among young people have been from the incidence of social media, which I had responsibility for as Culture Secretary. We worked together on it.

The fact that one in 10 young people now have a diagnosed mental health condition is of great concern to me. On one hand, I am glad that there is diagnosis, and more diagnosis where there are conditions; on the other hand, I would like to see treatment and early intervention to try to tackle the problem and go to the root cause of it. Partly because the technology is moving so quickly, this is an area where the evidence is not as full as we might like it to be, but there is growing clarity of evidence on the role of some of the pressures, including social media. We need to challenge it at all levels.

Q247 Luciana Berger: I urge you to read our report because, with the Education Select Committee, we found that the pressures of our



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education system are having the greatest negative impact on our young people. We were very disappointed with the response we got from both Education officials and Education Ministers to the presentation and discussion at that Select Committee.

My final question again reflects on one of the key findings in our Select Committee report. In particular, it was about young people falling through the gaps and not receiving the services they need as they enter adulthood—the issue about transition from young people’s services to adult mental health services. We heard significant evidence, which has been around for a number of years, that a better transition age would be 25. Can you tell the Committee whether you share that view and whether you have any plans to address that massive challenge right across our country?

Matt Hancock: There are a whole series of areas where over the last few years we have moved the age of transition up to 25. This is well worth looking at. I saw that and I have read that report. I thought the case was well made. We need to consider it more. These moves should not be made lightly; if you make them, you want to make them once and then settle, because there are significant impacts on the system, especially on the treatment of young people between the current age and any future age. We should proceed carefully, but I thought the argument was well put.

Q248 **Chair:** Can we move to the issue of suicide and self-harm? Yesterday, I met the national suicide prevention advisory group, which includes families bereaved by suicide, to follow up on the progress since this Committee’s report on suicide prevention. The situation is that around 4,500 people die by suicide per year, and, although it is encouraging that overall the number is falling, it remains the leading cause of death in men under 50. Are you going to personally take a leadership role in tackling suicide and self-harm?

Matt Hancock: This is an area that I have also looked into. I am very concerned about the numbers. It does not matter if there is an overall fall; 4,500 is still far too high. I am concerned about some potential leading indicators going in the other direction for young girls.

Q249 **Chair:** Yes, for young people.

Matt Hancock: It is interesting that in the data on young boys and young girls, the potential leading indicators, such as self-harm, have sharply risen among young girls but not among young boys, where it is broadly flat. There are clearly some specific changes that have happened where we need to guard very carefully against those data getting worse. They may be data when they are on a line in a chart, but each one of those 4,500 suicides is a life lost.

Q250 **Chair:** Yes. We should regard every one as a preventable death. Would you agree with that?



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Matt Hancock: Absolutely, yes.

Q251 **Chair:** To follow up on a few points they wanted me to raise with you, one of the recommendations of our report was that every local authority area should have a clear suicide prevention plan, and that it should be subject to an independent assessment, but that has been very slow going forward. Could I ask you to look at that and try to break the impasse that has been reached whereby local authorities are not interacting enough with health services to make sure that there is independent assessment of those plans? Would you look at that area, Secretary of State?

Matt Hancock: I will happily look at that, yes.

Q252 **Chair:** Another issue they raised with me is bereavement support for families who are bereaved by suicide, particularly because we know that those who have been bereaved are at much higher risk themselves of taking their own life. Is that something, again, you would look specifically?

Matt Hancock: Yes, I am very happy to look at that.

Q253 **Chair:** Would you look specifically at trying to provide those services and making it a priority across all Government Departments, because there are many areas that come into this?

Matt Hancock: That is right. There are potential impacts from a whole series of different changes in different policy areas. We talk in a sort of policy language about integration of different services, but, ultimately, a suicide is the fundamental failure of integrated support for an individual by society as a whole. We all have a role to play in trying to prevent it.

Q254 **Chair:** One thing that came across very powerfully from families during our inquiry was that very many of them had not been informed that their loved one was at risk of suicide. They felt that, had they known that, they could have taken steps to avoid it. The NHS has developed a consensus statement that allows professionals to ask people for permission to inform someone in a way that makes it much more likely that they will agree. The difficulty is that this kind of culture change is happening far too slowly and too often people have not even heard that there is a consensus statement, even those working in the relevant departments.

Matt Hancock: Yes.

Q255 **Chair:** Clinicians across the full range could be stepping in and asking. It touches on the point Rosie referred to: sometimes it seems to be being used as a barrier, and professionals think they will be blamed if they share information. Could I ask you to look again at how we can put this in place, because it will play a very important role in reducing suicide?

Matt Hancock: Yes. I am very happy to do that; in fact, I am enthusiastic about doing that. In a way, it is the most acute example that we have discussed today of a point that several people have raised. When I say I am not interested in big structural reforms, it is partly because the



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improvements where I can see potential in the NHS and social care systems as a whole are about better ways of working, which is not about some law that we pass in this building; it is about people working together better, having the confidence and technical capability to do so, and doing so in a culture that provides the permission to do that, the incentive to do that, and to reduce the number of barriers to doing that. This is true across what Dr Williams—Paul—and I were discussing, and your work, Rosie.

This is just the most acute example of that. It is that sort of culture change, where good practice is taken up faster and spread more rapidly across the NHS to reduce the variances we were talking about, where there are the biggest opportunities for improvement. I think, and everybody who works in the NHS tells me this is true, that a lot of that is about breaking down individual barriers and rules, and then empowering people to make improvements themselves.

Chair: It will be very helpful to see that included in your work in tackling variation. We come now to primary care.

Q256 **Dr Williams:** First, I want to talk about data sharing. You will probably be aware from your previous role that there was a memorandum of understanding whereby data was shared between NHS Digital and the Home Office for immigration purposes.

Matt Hancock: I certainly am.

Q257 **Dr Williams:** You will be aware that the MOU was suspended. Could you update us on any progress being made with the revision of that MOU?

Matt Hancock: I thought that the resolution we came to, which reduces by around 90% the amount of data transfer, and means that data transfer only occurs in the most serious of cases, was a good resolution. I will chase up the timetable for implementation of that and make sure that it happens.

Q258 **Dr Williams:** We wrote to your predecessor. We are particularly concerned that stakeholders are consulted in the revision plan, so please can you take that into account as well?

Matt Hancock: Yes.

Q259 **Dr Williams:** On the broader issue of NHS Digital's role in protecting patient data, we as a Committee were quite disappointed when we had NHS Digital in front of us that they did not seem to take that responsibility as seriously as we as a Committee would have liked them to. We know that within the NHS it is really important that data is shared.

Matt Hancock: Yes—appropriately.

Q260 **Dr Williams:** Appropriately. There are far too many barriers to appropriate data sharing in the NHS and social care.

Matt Hancock: Yes.



Q261 **Dr Williams:** Would you agree, though, that we need to protect data from being inappropriately externally shared as part of that deal as well?

Matt Hancock: Yes, absolutely. The opportunities for better use of data in the NHS and social care system are enormous for making patient care better, for making the lives of those in social care easier and for improving clinicians' lives so that they can concentrate on what they really care about, which is caring for patients. There is absolutely no doubt that there are huge opportunities for improvement. I have seen some for myself, both in my previous role and in this role. Data has to be protected and people's health data is some of their most sensitive personal data. It is no more sensitive than other categories of sensitive data, such as financial data, for instance; it is just very sensitive personal data and, therefore, must be protected to the highest standards.

The new Data Protection Act puts that into place. I pay tribute to Fiona Caldicott and her work to try to make sure that standards are promulgated throughout the NHS. There is a strong requirement and expectation from society that people's health data will be protected, both in terms of cyber-security, where there are aggressive external attempts at accessing data inappropriately and often unlawfully, and in terms of privacy, with the often unintentional internal oversharing of data.

Having said all of that, there is absolutely no inconsistency between high-security data sharing that improves clinical capability to use that data, improves patient care and is highly innovative, on the one hand, and highly secure data usage on the other. In fact, the two go hand in hand, because if you have a high-quality data architecture you often get more secure use of data and, at the same time, better, more innovative and more flexible use of that data.

To take the example of the fax machines that infamously still exist in the NHS, if you type one wrong digit into a fax machine when you are dialling the number, you have spewed off the data to somewhere and you have no idea where it has gone. That is poor use of data and poor security of data. It is only by having a modern, highly capable data architecture, with high levels of interoperability and the right security structures, that you can get this right. There is absolutely no trade-off between high-quality security and high-quality innovation.

Q262 **Dr Williams:** In the first speech you gave as Secretary of State for Health and Social Care, you quoted Mahatma Gandhi, saying that a nation's greatness is measured by how it treats its weakest members. I asked a question in Health and Social Care questions today because Neal Russell, a doctor who worked with Ebola victims, and many of his colleagues have given back their Ebola medals.

They are concerned that some of the weakest members of our society are unfairly denied access to healthcare because of the hostile immigration policies the health service has to manage. If a patient, such as a refused asylum seeker, needs non-urgent care, say maternity care, and they are



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chargeable under the current rules, but they have no means of paying, how are they supposed to access that healthcare?

Matt Hancock: The first point to make is that nobody who needs urgent care should be rejected on the basis of the need to pay. You say that maternity is non-urgent, but it is by the end. On the other hand, we have to ensure that the health system appropriately supports the people it is right that it supports. There are many burdens on the NHS, and making sure that the people who have the right to access to it are the ones who do access it is important. There is a balance to be struck.

Q263 **Dr Williams:** Acceptable collateral damage.

Matt Hancock: No. I reject that characterisation absolutely. There is a balance to be struck between making sure that everybody who needs the NHS and anybody who needs urgent care for a very serious condition gets it, but that at the same time the NHS provides for those who pay for it and have the right to use it.

Q264 **Dr Williams:** There are several difficulties with what you have described. One is that, to work out whether or not somebody has an urgent problem, they need access to care. I am particularly talking about people who are vulnerable migrants, not about people who have come to this country for the purpose of seeking healthcare; I am talking about people who may have been trafficked here or people who may have been through the asylum system whose asylum has been refused and who may not be able to be sent back to their country of origin for many practical reasons. Also, with the current hostile environment regime, many people who should be getting care are not getting care. The press are reporting cases of cancer patients for whom chemotherapy was withheld until they paid a £54,000 bill. An Ethiopian asylum seeker with advanced breast cancer had chemotherapy delayed by six weeks while people were trying to check her immigration status.

As the team who are giving back their medals today are trying to demonstrate, is it not true that the environment is causing so much hostility that it puts people off accessing care, and the cost to their individual health, the cost to public health and the cost to the whole system is going to increase as a result?

Matt Hancock: I do not think that is the case. This is an incredibly important area to get right. A lot of the solution lies in ensuring that the ways checks can be made are as reasonable and straightforward as possible. I understand that is not always the case, but, ultimately, there has to be a balance, because we have to ensure that NHS funding is sustainable. Making sure that we get the balance right in a highly sensitive way is very important.

Q265 **Dr Williams:** Your Department is currently consulting—I think it may have closed in June—and a formal review taking place, on the NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017. Have you any idea when the results of that review will be published?



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Matt Hancock: No, because I want to take a very close look at it and ensure that we get the right balance.

Q266 **Dr Williams:** Thank you for that. Moving on to primary care, you have shared that you are a great fan of GP at hand, provided by Babylon. Do you get why that challenges the current model of GP funding?

Matt Hancock: I understand some of the concerns. Some of the concerns are misplaced but some are understandable. First, we start from the point of view that this is a new technology that has the potential significantly to improve the way that many patients can access the NHS. This sort of technology is coming. The question is how we can bring it about in a way that best supports the NHS as a whole and ensures that we get better care as a result, which is, as I described it, the holy trinity of better care for patients, being easier for clinicians and staff and saving money. If you can achieve all those three, that is terrific and it means that more money is available for the frontline elsewhere.

When there are challenges, you have to make sure that the rules are changed to take that into account. For instance, some people have said that GP at hand services mean that per capita funding moves with them, and only the most fit and healthy people, on average, tend to go to—

Q267 **Dr Williams:** Economists would call that adverse selection, wouldn't they?

Matt Hancock: They would, but it is not how the rules are operating, because the funding follows the basket of the geo-demographics of those who choose to go. We have to make sure that that is working right. I also understand the pressure that if you are running a GP surgery and some of your patients decide to register elsewhere, whether or not the appropriate amount of money flows with them, there is still a reduction in demand on your service when you—

Q268 **Dr Williams:** Without them being able to collapse costs.

Matt Hancock: It brings its challenges. It does not necessarily follow that you cannot make—

Q269 **Dr Williams:** If it is generally young, fit and healthy people who are using GP at hand, they are people who are likely to have had low demand on services in the past.

Matt Hancock: But they have also had low payment attached to them and only the low payment moves over.

Q270 **Dr Williams:** No. There is a per capita payment that is done at scale, so the GP will lose that proportion. If 500 patients leave, the GP will lose the payment for 500 patients.

Matt Hancock: But the amount of the payment depends on the geo-demographics of the person, of the individual.

Q271 **Dr Williams:** Only on aggregate.



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Matt Hancock: It determines the amount of money that moves over.

Dr Williams: It does not.

Matt Hancock: In a way, the detail of this—

Q272 **Dr Williams:** The detail is important.

Matt Hancock: Yes, but the point about it is that making sure that the rules are adapted to get these sorts of details right is critical.

Dr Williams: Yes, okay.

Matt Hancock: The wrong solution would be to say, "These new technologies have no place; they are disrupting things." The right thing to say is, "These new technologies are disrupting things; how do we make sure the rules work for everybody in the future?"

Q273 **Dr Williams:** You would like to look at the rules.

Matt Hancock: Absolutely. We already have a review under way on that. It is incredibly important. Likewise, on the clinical safety of the algorithmic element of these devices, as we discussed at Health questions, it is incredibly important that that is got right. There again, the solutions are constantly improving the algorithms that are available and making sure that the safety follows clinical guidelines. That is good. You have to take into account that humans are not perfect either, and replacing imperfect with imperfect but better is worth doing even if everybody would rather replace imperfect with perfect. That often is not available.

Q274 **Dr Williams:** I get that. Thank you.

The Government pledged to increase the number of GPs from baseline by 5,000: 5,000 extra GPs by 2020. How is it going?

Matt Hancock: I am glad to say that we have record levels of GP recruitment.

Q275 **Dr Williams:** And record numbers of GPs leaving as well.

Matt Hancock: And part of my focus on the workforce is to try to increase retention by making sure that some of the barriers that lead to people leaving are reduced.

Q276 **Dr Williams:** If the answer to "How is it going?" is that we actually have 1,000 fewer GPs than we had when that pledge was made, we now need to recruit an extra 6,000 GPs in order to catch up.

Matt Hancock: There are lots of different ways that we can improve primary care, both through more GPs, which is important, and through different ways of working in GP surgeries. It struck me when I was looking at the initial analysis of the NHS workforce that in an acute setting, on average, there are twice as many nurses as doctors. In primary care, there are typically twice as many doctors as nurses.



Dr Williams: Absolutely.

Matt Hancock: A difference might be appropriate because they are different settings, but I know that lots of GP surgeries, or groups of surgeries, are moving to a more structured basis where GPs see the cases that only the GP can see, and there are lots more nurse practitioners and others.

Dr Williams: I could not agree more.

Matt Hancock: That direction of travel is really important. It does not mitigate the fact that of course we need more people in primary care, and I am delighted that there are record numbers of GPs going in, but we also need a culture change in the way our GP practices work.

Q277 **Dr Williams:** Many of the people who are leaving are mid-career GPs who are struggling with workload. The 2% payment that has been announced today—the 2% increase—is less than the DDRB recommended, and less than inflation. Will it be enough to retain GPs?

Matt Hancock: I hope so. It is a first step. I want now to have a wider conversation about a multi-year settlement and improvements to the contract, not least on the sorts of issues we have discussed, but also on indemnity, QOF and other areas of significant concern for GPs.

Q278 **Dr Williams:** I agree entirely that we need to invert the pyramid of workforce in general practice and have many more non-medical workers in general practice. The 2% uplift, though, only allows GPs to fund their other non-medical staff at 2%, which is a much less attractive offer than the Agenda for Change offer that secondary care has. Isn't that likely to lead to a drift away from practice nurses, to hospitals, because they are going to get a worse pay increase than hospitals?

Matt Hancock: That is the in-year settlement. We have already started discussions on a longer-term settlement that can also include changes to the contract. I regard this as a first step. This year, in-year, we had an agreed 1% increase, which has been doubled, so it is a step forward, but there is a much wider conversation to be had. In the same way as the Agenda for Change settlement, which I thought was a very good one, there was a strong increase in pay focused on the bottom end of the pay scale; a 20% rise in starting salaries is very significant. There were also changes in the way that the contract operated in lots of different areas. I look forward to having discussions to try to tackle some of the big issues that we have been talking about.

Q279 **Dr Williams:** My final question is on community services, which are all the district nursing, community, physiotherapy, palliative care and other services, often run by NHS trusts, but not always. During the last financial year, income for NHS trusts increased by more than £2 billion, but despite the Five Year Forward View having a direction of travel where we were going to try to do more in the community, during that period of time investment in community services fell by £300 million. Why do you



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think that was, and what do you think you can do to boost investment in out-of-hospital services?

Matt Hancock: This comes full circle to the earlier discussions with the Chair. I am absolutely determined that more funding will move towards prevention rather than cure. That means having tough conversations, especially with acute trusts that have been overspending. They are not going to be able to overspend in that sort of way; it is not acceptable. The increase in funding needs to get to places that can solve some of these problems closer to home and before they get more serious.

Q280 **Chair:** When you visit primary care to look at the future models, will you also include isolated rural primary care? In the past, there have been times when a one-size-fits-all approach has been plonked down and it really does not turn out to be particularly effective.

Matt Hancock: Tell me about it. I represent a pretty rural area of the world. In my constituency, I probably have every different type of model of primary care, from federated models delivering on the inverted structure that you were talking about all the way through to very small classic GP practices.

Chair: Thank you. We come to public health.

Q281 **Diana Johnson:** Secretary of State, you have already made lots of comments about how positive you feel about the prevention agenda. When the additional £20 billion was announced, the Association of Directors of Public Health put out a statement that prevention is better than cure, with which I am sure we would all agree. They also said: "We now need to put serious effort—and money—into helping people to not get ill in the first place, and if they become ill and go into hospital, to help them get back home as quickly as possible. If we don't do this then we will need to find another £20 billion or more in a few years' time." In the light of your positive comments, and in the light of those comments, what do you think the future is for public health funding?

Matt Hancock: I strongly agree with their sentiment, and I have set that out already. Clearly, we need to ensure that we deliver on the prevention agenda. I cannot prejudge the spending review. All I can say is that the inexorable logic of prevention is that it reduces higher costs later, but you have to put the money into getting prevention before you can take it out of solving the acute problems; you cannot do it the other way around.

Q282 **Diana Johnson:** We know there are 6% more cuts to public health budgets coming along between 2017 and 2020. We know in particular, if we turn our attention to sexual health budgets, that half of councils have had to cut funding to sexual health services. In the Chamber, in Health questions, I raised a point about the levels of some sexually transmitted diseases; gonorrhoea is up 10 times since 2008, syphilis is at the highest level since the second world war, and for the first time, I think, we are seeing babies being born with syphilis. If we are serious about public health, what is going wrong if we are seeing those kinds of statistics?



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Matt Hancock: In the answer Jackie gave at the Dispatch Box, she pointed out that in one of those cases it depends on where the starting point is, but I do not want to have a statistical dispute. What I really care about is solving the problem.

Whatever direction the statistics have gone in recently, what matters is reducing them as much as possible. The statistics you mentioned about what is going to happen over the next three years are not quite right because we have not yet settled the spending review, and solving a lot of these public health problems is going to be incredibly important. It also matters how well the money is spent. Again, there is great variation and there is a lot to learn.

Q283 **Diana Johnson:** The reason I used the figure of 6% is the public health grants to local authorities in 2018-19. The King's Fund analysed the allocations and found that public health funding per head is due to fall by a further 6% between 2017-18 and 2019-20.

Matt Hancock: I am sorry, I thought you said 2020 to 2021, which has not yet been settled.

Q284 **Diana Johnson:** No; 2017 to 2020 is the period of the 6% fall.

Matt Hancock: As I say, we are going into the spending review.

Q285 **Diana Johnson:** You will be looking for an increase in public health spending to local authorities.

Matt Hancock: Prevention is not just about public health, but it is partly about public health. It is all about the outcomes from the public health spending that takes place.

Q286 **Diana Johnson:** The Government are launching a consultation about the way public health will be funded for local authorities, and the idea of its coming from the retained business rates from a local area. Is that something you think is a sensible way forward?

Matt Hancock: That is a discussion we are having with MHCLG. The idea of councils raising locally more of the money that they spend locally is important, but it speaks to the tension that there has been throughout the existence of the NHS between elements of it that are provided through local authority budgets and elements of it that are provided through national taxpayer funding. Both organisationally, referring to our earlier discussion on making sure that accountability is right, given those two different democratic accountabilities, and in ensuring that you get the funding at both levels, I do not think it was ever intended that the Department for Health and Social Care should be the single biggest funder of local authorities, but that is the situation we find ourselves in. Making sure that we get the right local funding and the right national funding, and that they are tied together as well as possible, is a complicated but important piece of work.

Q287 **Diana Johnson:** There is clear concern that some of the poorest areas



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that have the worst public health outcomes will not be able to generate sufficient funds from business rates to meet the needs of their communities. I am sure you will be taking that into account.

Matt Hancock: Of course. Equalisation in local authority funding is very important, but some local authorities in very deprived areas do this very well, so you cannot just look at the level of deprivation and automatically say that there is necessarily a worse outcome.

Q288 **Diana Johnson:** Can you provide details of that? I think we would all be interested to know which very disadvantaged local authorities are able to deal with this.

Matt Hancock: I will be very happy to write.

Q289 **Diana Johnson:** Thank you. Can I move on to screening? We know that early diagnosis is really important, and I want to ask about the concerns that people have at the moment about the rates of take-up for smear tests, which are at a 20-year low. Are your views on this that it might be to do with the fragmentation of services in the NHS? You cannot just go along for an appointment, say for contraception, and get a smear test as part of that, because the contracts do not allow it. Do you think that might be one of the problems? On the news last night, there was a woman in Lincolnshire who had gone for a smear test and had to wait three months for the results. Could you say something about your approach to screening and how important it is?

Matt Hancock: I think it is incredibly important. As we have seen, through some of the problems we have had recently, making sure that we get the right information to the right people at the right time is a mission-critical part of it, and there is much to do to improve the systems. It is a core part of early intervention.

Q290 **Diana Johnson:** With the recent breast cancer screening problem, have all the women who were missed off the invitation for screening now been contacted?

Matt Hancock: I am very happy to give you a complete and full account of where that is up to. When problems like that are uncovered, it is absolutely vital that we are fully transparent about the consequences and about the action that is taken, and the Select Committee played an important role in that.

Q291 **Diana Johnson:** I do not know if you have had sight of a letter I sent you on 13 July, signed by 50 Members of the House of Commons and House of Lords. It was about early medical abortions and home use of the second tablet. Do you want to comment on that today?

Matt Hancock: I entirely understand the reason that so many colleagues have the view that you expressed, and I understand why it is such a sensitive issue. It is very important that we get it right. I received the letter last week, and I saw it the moment you sent it. I am going to look at it very closely.



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Q292 **Diana Johnson:** Because Scotland and Wales have already decided that they want to proceed with home use, it seems odd that English women would not be able to take advantage of the dignity provided by allowing them to take the tablet at home.

Matt Hancock: The case you made was very powerful and I want to look into it very carefully.

Q293 **Diana Johnson:** My very final question is about workforce, which I know is a priority for you. Recently, additional places have been made available at medical schools, including the Hull York Medical School, about which we are really pleased. Because of the need to increase the number of doctors in this country, particularly with Brexit just around the corner, and becoming self-sufficient in doctors, do you envisage more places being made available in medical schools in the next few years?

Matt Hancock: I am very glad that we have managed to increase the places at medical schools. This is an area in which I have had a long-standing interest. In my first ministerial job, I introduced the nursing apprenticeship route and I am delighted that it has seen some uptake, although I think more could be done. This whole area of getting training right is important. It is not just the numbers; it is also about how it is done—the flexibility of the training, which at the moment seems to me extremely inflexible. There is an awful lot that could be improved.

Q294 **Luciana Berger:** I have a few more questions on public health, Secretary of State. The Committee has heard a lot about the value of the investment in early years and what the positive ramifications can be for all our long-term health. There are many areas we could pick up on, but in particular there are now 2,000 fewer health visitors in our country since 2015, and we are seeing a lack of start-of-life investment, particularly in antenatal support and breastfeeding peer support. We know that hundreds of children's centres no longer exist. What are your reflections on what could and should be done to ensure that we give every baby born in this country the best start in life?

Matt Hancock: Children's centres in particular are very important. What you said is not quite right, because more people are going through children's centres than ever before. There has been consolidation in how they are structured, and sometimes that is interpreted as a reduction in the numbers, but that is not quite right. It is a very important area to get right, and, if we think about early intervention as part of prevention, early intervention at a young age is especially important.

Q295 **Luciana Berger:** According to the Shaw Trust, there are up to 1,000 children's centres across our country whose doors are no longer open. In Liverpool, although we have maintained all our children's centres, the level of service provided in communities, in terms of what you can access, has massively diminished. That is replicated right across the country, and it includes services such as antenatal support, and particularly breastfeeding peer support, which is so important to



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encourage new mums and give them the support they need to be able to breastfeed; it is not one of the easiest things, but we have heard lots of evidence about how important it is. I can point to many services across the north-west that no longer have funding. That is just one area. I ask you to reflect on the reality on the ground.

Matt Hancock: You said two different things. I know the figure that you have just mentioned about 1,000—

Luciana Berger: It is from the Shaw Trust.

Matt Hancock: When two Sure Start centres become one organisation so that they can run more efficiently, that is counted as a reduction in the number, whether or not the service continues to be provided, so I just caution on the statistics.

Q296 **Luciana Berger:** So there are no children's centres across our country whose doors have closed since 2010.

Matt Hancock: That is not what I said. I said we need to be cautious about those numbers.

Q297 **Luciana Berger:** Again, I reflect on what I know has happened not just in my own constituency in Liverpool but right across the country; the level of services and activities that were previously provided is no longer available because of the cuts to public health, which we have just discussed. The figure of 6% between now and 2020 is obviously going to have an impact on the availability of those services, which in turn results in less support for new mums, for new babies and from conception right through to age two, which we know has a very significant impact on the life chances, the life outcomes and the health outcomes of those children in adulthood.

Matt Hancock: This whole area is incredibly important to get right. For instance, there has been an overall increase in the number of nurses, but it has been focused on an increase on nurses in acute settings. That is part of the reason for driving the increase in funding that we have towards community and primary care and the whole prevention agenda.

Q298 **Luciana Berger:** Would you come back to us in particular on the reduction in the number of health visitors? That can really make a difference.

We have also seen a very significant cut, 18%, in drug and alcohol treatment budgets since 2013. What role do you think that 18% cut has played in the 26% increase in drug-related deaths during the same period?

Matt Hancock: I am very happy to look at that in detail, but it is not something I have had prior sight of.

Q299 **Luciana Berger:** Thank you, Secretary of State; it is an area that does not get the attention it deserves and we are seeing a massive increase in



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the numbers of people up and down our country who are losing their lives because they are not able to access appropriate drug treatment.

I have one more question for you on public health. You will know that there are a number of external organisations that seek to stymie any sort of public health action taken to protect our nation's health, and in some cases that is children's health. One of those organisations is the IEA—the Institute of Economic Affairs—which, in my view most egregiously, challenged the campaign that resulted, finally, in stopping smoking in cars when children are in the back. I have been in the press with them, and in debates many a time when they very publicly challenged many actions taken by the coalition Government, the Conservative Government and the previous Labour Government.

Can you confirm that you have received over £32,000 from the chair of the Institute of Economic Affairs, an organisation bankrolled by Philip Morris, British American Tobacco and Imperial Tobacco?

Matt Hancock: All my declarations to my local campaign are accounted for.

Q300 **Luciana Berger:** I am not suggesting that they are not, but can you confirm that you have received seven payments, most recently one in November?

Matt Hancock: Yes, but I do not see the relevance.

Q301 **Luciana Berger:** But you do see the relevance of an organisation that—

Matt Hancock: No, because I do not agree with this organisation and I have never discussed any of these things with them. My position on these matters is incredibly clear. My support for intervention on public health grounds—for instance, the smoking ban and other areas—and my lifelong commitment and support for the NHS are unequivocal and very strong. I have never discussed any of these things with the IEA.

Q302 **Luciana Berger:** To confirm, the IEA said that it believes the NHS is the “sick system of Europe” and should be replaced by a social health insurance system. Would you subscribe to that view?

Matt Hancock: I certainly do not. I completely disagree with it.

Q303 **Chair:** I wrote to your predecessor at the beginning of May to ask what action he was going to take to investigate the slowdown in life expectancy, in particular for older women, and, alongside that, the unexpected increase in deaths in the early weeks of this year, which did not seem to be fully accounted for by flu and cold weather. I have not received a reply. I realise that you cannot be over every aspect of your brief in the first two weeks, but I just want to draw that to your attention, because it is part of a wider concern around widening health inequalities. What are you going to do personally on the health inequality agenda?

Matt Hancock: First, of course, I will look for that correspondence and make sure that you get a full reply. The health inequality agenda is



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central to improving the health and wellbeing of the nation. It is item No. 1 in our mandate to NHS England and will be a core part of the long-term plan. The variance we have talked about is one of the reasons that it exists, but by no means the only one. There is a huge amount to do in this space, all the way from public health and prevention to ensuring that the right access to health services is available to everybody.

Q304 **Chair:** Will you be working with other Government Departments to make sure that we tackle it as a sort of health in all areas agenda?

Matt Hancock: Yes, absolutely. It is part of a cross-Government effort.

Chair: We look forward to hearing more from you about that in future.

Q305 **Luciana Berger:** As a Committee, we have had a relentless focus on all the areas we have covered on tackling health inequalities, because the gaps have widened not only for health but for healthy life expectancy. On mental health prevalence, a child from the most deprived background is three times more likely to experience mental ill health than a child from the least deprived background.

In our joint inquiry on young people's mental health, we quizzed your colleagues about what in the Green Paper was going to contend with the inequality issue for children. We were told that that was not the place to deal with it. Can you share with us where you intend to tackle health inequality in children's mental ill health?

Matt Hancock: In the long-term plan. A skeleton of it will be drawn up soon, but one thing I know about it, and that both the NHS and I are very clear about, is the importance of putting health inequalities and the resolution of health inequalities as much as possible throughout the long-term plan.

Chair: We look forward to talking to you about that in more detail. We now come to Brexit.

Q306 **Mr Bradshaw:** Secretary of State, how well briefed do you feel on the implications of a hard or a no-deal Brexit on the NHS?

Matt Hancock: I have absolutely been briefed on the potential implications, and I think there is work to do to ensure that we are ready.

Q307 **Mr Bradshaw:** Have you read our two recent reports on the subject?

Matt Hancock: I have looked at them, and I have been briefed on what we need to do.

Q308 **Mr Bradshaw:** Could I recommend that you add them to your heavy summer reading list in full and study them, because they are very serious? One area that we highlight is the potential interruption of the supply of vital medicines and medical equipment on which millions of patients in this country depend; tens of millions of batches go in and out of the UK to the rest of Europe every month. What contingency plans are in place in the event of a no-deal Brexit to ensure that medicines and



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medical equipment are available to the patients in this country who need them?

Matt Hancock: The first and most important thing is that we are seeking to avoid a no-deal Brexit. I am confident that it can be avoided, and I do not want it to happen. But any responsible Government need to prepare for a range of outcomes, including the unlikely scenario of no deal. Since I arrived in the Department, I have asked for this work to accelerate and I have met industry leaders to discuss it.

We are working right across Government to ensure that the health sector and the industry are prepared, and that people's health will be safeguarded in the event of a no-deal Brexit. This includes the chain of medical supplies, as you mention, vaccines, medical devices, clinical consumables and blood products. I have asked the Department to work up options for stockpiling by industry, and we are working with industry to prepare for the potential need for stockpiling in the event of a no-deal Brexit. This is exactly the type of contingency planning that you would expect us to be doing.

Q309 **Mr Bradshaw:** How have industry responded to that request?

Matt Hancock: They are highly engaged. Like us, they do not want a no-deal Brexit, but they have responsibilities to their patients and customers.

Q310 **Mr Bradshaw:** How many months' worth of supply have you asked them to stockpile?

Matt Hancock: We have not gone into the details yet. We are assessing the answer to exactly that question. We need to get the balance right between being prepared for all eventualities and making sure that people are going to be able to access the drugs that they need; there is also a cost implication.

We are focusing on the importance of a continuous supply of medicines that have a short shelf life; some of the medicines that would be most difficult to provide in a no-deal scenario where there was difficult access through ports would need to be flown in, for instance. I hope that, even under a no-deal scenario, there will still be smooth movement in through ports, because it is not our intention to provide barriers to that, and the work will take that into account. But you can imagine that it is incredibly important for me, as Secretary of State, to ensure that people will have access to the medicines they need.

Q311 **Mr Bradshaw:** It is industry rather than the NHS that is responsible for the stockpiling.

Matt Hancock: It is obviously work that we are doing together. The stockpiling will be done by industry, but we are prepared to step in jointly to ensure that those arrangements can be put in place.

Q312 **Mr Bradshaw:** You appreciate how important this is for the public,



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because, unlike food, for example—we can all stockpile food and I suspect many people will if they think a no-Brexit is likely—they cannot stockpile the medicines they need.

Matt Hancock: You mean a no-deal Brexit.

Mr Bradshaw: Yes.

Matt Hancock: I entirely understand how important it is, and it is vital that we get the preparations right, but I am also confident that with the right amount of work we can mitigate the worst of the circumstances.

Q313 **Mr Bradshaw:** What advice would you give to UK citizens, who currently enjoy the benefits of the European medical card, who are planning to travel to the rest of the EU after March next year? In the event of a no-deal Brexit, should they take out extra insurance?

Matt Hancock: I am hopeful and confident that we will be able to get a deal and will have some sort of mutual recognition in that area.

Q314 **Mr Bradshaw:** What contingency plans are you making for the NHS to look after the British citizens who live on the continent in the event of no deal?

Matt Hancock: That is also a consideration. Three countries have the vast majority of British citizens who live in the rest of the EU—France, Spain and Ireland. We are engaging directly to ensure that there is adequate provision.

Q315 **Mr Bradshaw:** Last week, the Government lost a vote on the amendment sponsored by your colleague Phillip Lee and co-sponsored by Paul, essentially creating a single market in medicines, which is something this Committee had called for, and I think most on the Committee would very warmly welcome. Your junior Minister, after initially getting it wrong in the House earlier today, confirmed that the Government would take this on board.

Matt Hancock: Yes.

Q316 **Mr Bradshaw:** What is that going to mean in practice?

Matt Hancock: The amendment was, essentially, equivalent to the Government policy as set out in the White Paper. It means that we want as close as possible participation with the European Medicines Agency, with observer rights, and we appreciate that would involve making a financial contribution.

Q317 **Mr Bradshaw:** What implications does that have for our legal and political relationship with the rest of the EU, in particular the ongoing role of either the EFTA court or the ECJ?

Matt Hancock: That is a question for the negotiations.

Q318 **Mr Bradshaw:** You may have seen that Faisal Islam, the highly respected political editor of Sky News, said that in his view the only way



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of fulfilling the amendment legally is for us to join the EEA. Is that something you have reflected on?

Matt Hancock: That is his view, and he is indeed the highly respected political editor of Sky News.

Q319 **Mr Bradshaw:** Do you think he is wrong?

Matt Hancock: There are a number of ways that this can be done, and it is a matter for negotiation.

Q320 **Mr Bradshaw:** How else could it be done apart from us joining the EEA?

Matt Hancock: We could have a bespoke arrangement, and we are seeking that in lots of different areas.

Q321 **Luciana Berger:** Could I ask a supplementary question to Ben's questions on what we might be able to get in or get out? You said you hoped that that would be possible, but there is a particular issue around medical radio isotopes, which have an extremely short shelf life, and which we have no capacity currently in this country to create. Over 800,000 people in our country rely on them every year for both diagnostics and treatments. In the event of a no-deal Brexit, how are you going to ensure that those 800,000 people in our country will be able to get the diagnostics and treatment they need?

Matt Hancock: First, I very much hope that the ability to transport things in through the border will be free flowing, but there are different ways to bring things in quickly, whether that means moving things from land to air transport and, therefore, being able to buy them from different places, or whether it means ensuring that there is free passage at the ports. There is a series of different ways we can do that, and that work is very important.

Q322 **Luciana Berger:** It is important, but what is actually being done to ensure that it happens?

Matt Hancock: We are working with industry to ensure that exactly that sort of medicine, or rather diagnostic need, is taken care of. I said there were things with a very short shelf life, and this is one of the examples.

Q323 **Luciana Berger:** If you reflect on the experience of what happened when there was a fire in the channel tunnel at the same time as industrial action around Calais and Dover, it resulted in long queues, and impacted on our ability in this country to provide diagnostics and treatment for people who needed it from medical radio isotopes. That was while we were a member of the EU.

Matt Hancock: Yes, but that happened with no prior contingency planning, in an instant. It is currently July, so we have nine months to ensure that we have a contingency plan. We are actively working on that. As I said, I have asked for those preparations to be accelerated.

Q324 **Chair:** Secretary of State, if there are profound consequences of no deal,



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and no deal has looked like more of a possibility over recent weeks, and, as you say, we only have nine months to plan for that, are you going to set out in very plain English what the full extent of those consequences is, because I do not think that has really filtered through properly?

We are talking about the entire lifecycle of drugs, right through from early research to the product appearing on the shelves. In the course of that, it is not just friction across borders but things such as the professionals who are responsible for batch testing and quality. It is about licensing arrangements and how quickly products appear. It is really very serious indeed. If we end up with no deal, all of that will collapse. Isn't it time that the Government actually spelt this out as clearly as possible so that, if nothing else, we actually step back from the edge of the cliff we seem to be moving rapidly towards?

Matt Hancock: We will be setting out more details of what we are doing to mitigate the problems that would otherwise be caused by no deal, not least in the area of transportation of medicines, but there is a whole series of other areas. For instance, we would need a domestic licensing regime for drugs; we would have to put that in place and it would need to operate from day one.

Q325 **Chair:** But it is right through the lifecycle—for example, the ability of people with rare diseases to participate in clinical trials. It is right through the entire lifecycle of a drug. Are you going to actually set that out in plain English, not just the contingency planning but what the consequences would be?

I am very worried that we are racing towards the edge of the cliff without people being informed fully about all the ramifications for products, for medicines, devices and substances of human origin. There are also the consequences, as Ben set out, for people being able to travel abroad. People may assume that they can just travel, for example, to Spain and France on holiday next year, and are booking holidays and are not aware that they might find themselves completely uninsurable, or, even if they are insurable, it would be at a much higher cost. These are the kinds of things we need to set out in plain English for people.

Matt Hancock: We will be setting out the contingency plans that we are putting in place. There is a whole series of areas where this can be eminently dealt with. For instance, when you travel to the United States, there is no reciprocal medical arrangement; you need to get insurance. Some things need concerted Government action to ensure that there is a very serious, solid solution on day one; for instance, the passage of drugs needs to be resolved. But if we did not manage to get a reciprocal agreement on healthcare, the question of people needing to take out health insurance for travelling to another country is something that happens at vast scale already for other countries.

Q326 **Chair:** Let us say, for example, that one of us has a constituent who requires dialysis and they are thinking of booking a holiday next year to France. Should we be saying, "Don't book that holiday yet without it



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being refundable, because you won't be able to access dialysis if you go on holiday in Europe in the way you can at the moment"? Those are the kinds of contingencies. We need to be warning people not to book holidays in advance without considering the implications for them of access to healthcare in Europe.

Matt Hancock: It is important to be clear with people about the work that needs to be done to mitigate the short-term effects of a no-deal outcome, but at the same time we are working very hard to ensure that there is not a no-deal outcome.

Q327 **Chair:** We all appreciate that you are working very hard not to.

Matt Hancock: That is the best way to resolve most of these problems.

Q328 **Chair:** Could I suggest, though, Secretary of State, that one of the ways that might help us to step back from the edge of the cliff of a no-deal Brexit is to spell out very clearly to people in plain English what the consequences would be? I do not think there has been a proper appreciation of the full ramifications of no deal for health, not only for the workforce but for medicines and devices and, as I say, for people's ability to travel, or even for pensioners in Spain who currently rely on us to have a deal in order for them to continue to receive care.

Matt Hancock: As I say, I am confident that we can get a deal. I think the next step is to ensure that the mitigations are in place, and that is the work we are doing, but I certainly agree with you that the best solution to these problems across the board is to make sure that we get a high-quality deal because then we will avoid them.

Q329 **Chair:** Going back to my question, Secretary of State, will you also commit to publishing a plain English guide to what the consequences of no deal would be?

Matt Hancock: When we publish the further documentation on the plans needed to mitigate the consequences of a no-deal Brexit, we will ensure that we set out at the appropriate level the consequences as we see them.

Q330 **Dr Williams:** I would like to ask you about our EU workforce. We have 150,000 EU nationals working in our health and care systems. I particularly want to talk about nurses and midwives. We did a report recently on the nursing workforce. In 2016-17, more than 6,000 nurses and midwives joined the register from EU countries, but by 2017-18 that had reduced to only 805 EU midwives—an 87% drop in midwives coming here from other EU countries. What effect do you think that is having on an existing workforce crisis and what can you do to mitigate it?

Matt Hancock: The first thing we can do to mitigate it is to ensure that we get a good deal for Brexit, as well, of course, as ensuring that we keep expanding the domestic training. Setting those important steps to one side, the question is then how we ensure that in the meantime we keep attracting people to do the jobs that need to be done. Overall, we



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have seen an increase of over 4,000 in the EU workforce in the NHS. If you listened to some of the debate, you would not think that was the case.

Q331 Dr Williams: That is because even though we saw an initial rise in the year after the referendum, when people had probably already made their plans to come here, the trend is massively downwards. Last year, we only had 805 nurses and midwives join, but we had 3,962 leave. You are correct that in the period since the referendum we have had an increase, but we are now having a massive exodus of EU staff. The tide has turned and people are leaving rather than coming here.

Matt Hancock: That is not how I see it. I think you are taking a partial view, looking at one important subcategory of the NHS workforce. Nevertheless, having said that, clearly, I want the jobs that we are opening up in the NHS fully filled.

Q332 Dr Williams: We have relied on workforce coming from overseas for many years. We have had a small increase in non-EU nurses—about 1,000—but it does not make up for the massive exodus of EU nurses.

Matt Hancock: Although on non-EU we have only just changed the visa rules to remove the cap for doctors and nurses, which I think is a big step forward.

Q333 Dr Williams: It is very welcome—belatedly welcome. What is your message to the EU staff who are working in our health and care services about their future?

Matt Hancock: EU staff who are here are very welcome to be here. When I say that I value the work that the NHS workforce does and the care they give to everybody, the care they give to people in sometimes their hours of most need, I mean everybody who works in the NHS wherever they come from, and that of course includes staff who work for the NHS who come from another EU country. They have over many years provided an enormously high quality of care and done a fantastic job.

We are now offering residency, and we are getting the service to allow for application for residency up and running. That is very important. We have been clear that we want to allow for ongoing residency. I would prefer it if the EU side had signed off on that fully, but we are absolutely determined to ensure that people who have come to the UK to serve in the NHS and work in our social care system are not only welcome but deeply valued.

Q334 Chair: I have one final question for you, Secretary of State. Are you intending to move to a situation where people have their own medical records, which they can hold digitally and share with whoever they wish at whatever level?

Matt Hancock: It would be an incredibly positive step to get there. There is an awful lot of work to do to ensure that there are interoperable



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patient records. In the first instance, linking up between primary care, secondary care, social care and other parts of the NHS is vital. That is ongoing. When we can get to the point of all of us as patients being able to see what is written on our record, I think that would be a very good place to get to.

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