HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Impact of the Brexit withdrawal agreement on health and social care, HC 1757

Tuesday 27 November 2018

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Watch the meeting

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

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Witnesses

I: Professor Tamara Hervey, Jean Monnet Professor of European Union Law, University of Sheffield; Mark Dayan, Policy and Public Affairs Analyst, Nuffield Trust; and Dr Nick Fahy, Senior Researcher, University of Oxford Medical Sciences Division.

II: Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care; Simon Stevens, Chief Executive, NHS England; Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; and Ian Dalton, Chief Executive, NHS Improvement.

Written evidence from witnesses:

- Professor Tamara Hervey and Nick Fahy

Examination of witnesses

Witnesses: Professor Hervey, Mark Dayan and Dr Fahy.

Q1 **Chair:** Good afternoon and welcome to the Health and Social Care Select Committee. This afternoon we are going to be considering Brexit and health. In particular, we will be discussing the impact of the withdrawal agreement and the political declaration of the future framework alongside the implications of no deal. Martin Vickers is going to open the questioning.

Martin Vickers: Thank you, Chair.

Chair: I beg your pardon; I meant to say, very importantly, thank you to our panel for coming. Could you introduce yourselves to those following from outside and say who you are representing, and a bit about yourselves?

Professor Hervey: I am Tamara Hervey, the Jean Monnet Professor of European Union Law at the University of Sheffield and a specialist adviser to this Committee.

Dr Fahy: I am Dr Nick Fahy from the University of Oxford where I am a senior researcher. I am also a specialist adviser to this Committee.

Mark Dayan: I am Mark Dayan, a policy analyst at the Nuffield Trust.

Chair: Thank you. I am very grateful to both Nick and Tammy for setting out in advance a briefing, published on our website, giving some helpful background. Over to Martin.

Q2 **Martin Vickers:** Thank you, Sarah. Can we open by having a general overview from each of you as to what you see as the pros and cons of Brexit, accepting the fact that the Government are committed to delivering on the referendum result and that is also the preferred view of, I think, the majority of the Opposition? Accepting that it is going to happen, how do you see it developing and what are the pros and cons of Brexit?

Professor Hervey: An important thing to understand and remember is that it is not possible to answer that question for health, the NHS or any other sector unless we separate different forms of Brexit. That is what we have tried to do in our briefing. The form of Brexit where we leave the EU with no agreement in place is much more damaging, problematic, for health and the NHS than other types and forms of Brexit.

The Committee knows, but I will remind you, that the European Union is not a state: it is a rules-bound organisation and it can only act within the law that governs it. Article 50 is part of the law that governs the EU, so, if the date of 29 March 2019 arises, the way article 50 works is that the UK will leave the EU without an agreement and there will be a no-deal Brexit. That is the way the EU works. It might be politically very inconvenient, but that is the legal position. That is the first thing I want to say.

Dr Fahy: Following on from that, what has been put, the 500-odd pages, is a withdrawal agreement, but it is important to clarify that it is not a Brexit deal. It is the transition, the waiting room where we legally sit while we negotiate a future relationship. The withdrawal agreement largely continues current arrangements, so it does not include great harms for the NHS or for health and social care, but it is also only a temporary situation. However, it includes the Northern Ireland protocol, the so-called backstop, and that has implications for the NHS and for health and social care. It has positive implications in some areas, in that it creates a continued free circulation of goods, which enables the continued supply of medicines and medical devices and other products on which the NHS depends, for example, and that applies not just to Northern Ireland but throughout the United Kingdom. In some ways, that backstop is very important for the NHS.

Other provisions that it includes, or rather does not include, also have a consequence for the NHS. It does not include provisions on the health and social care workforce, for example. It does not cover things like reciprocal health arrangements, so, if we were to end up relying purely on the Northern Ireland backstop, all those citizens who rely on reciprocal health arrangements—for example, in Spain—would lose those protections under EU law.

The future relationship, which is not in that document, but is a much shorter document, has been described as Canada plus—a free trade deal with additional aspects. The point about the plus is that most of that plus does not mean much for health. There is plus around transport, energy, defence and security and foreign affairs, but you are essentially looking at a free trade relationship for health, and, as we set out in our briefing, that does not provide the same kinds of services and mobility as the NHS currently depends upon.

There are two things I want to say at this point. First, it is clear from all these documents that health has not been a priority in the negotiations, sadly. There is lack of recognition for health in the documents. There is no commitment to protecting health in the future relationship. For example, when we look at immigration, there is nothing about adapting immigration around the contribution that people make to the NHS and social care or other public services, or even to maintaining standards of health protection. In fact, public health is specifically identified as an area of potential regulatory divergence in the future relationship. That is not an obvious benefit in terms of health.

Likewise, the reciprocal healthcare arrangements are only envisaged as continuing if they are linked to free movement, which at the moment does not seem terribly likely. Tammy has already referred to no deal as what will happen regardless of what happens, however many people dislike it in this place, unless something else is specifically agreed to. The Government have not so far disclosed the extent of their preparations for no deal, or the preparations of the NHS for no deal, and the argument for

not doing that was that it would undermine the process of negotiations. Those negotiations are now over, so, one way or another, they are concluded and they are here. Therefore, there does not seem any longer to be a reason not to disclose the preparations for no deal, but a great many reasons to disclose preparations for no deal. To return to your question, Mr Vickers, it would be a lot easier to assess the potential impact of the different scenarios if we now had full sight of what the Government's preparations for no deal are.

Mark Dayan: I would absolutely agree with all that. All I would add is that the logical extension of what Nick says about you having the legally binding aspect of it, which deals with issues of how we leave, some issues immediately after that, such as citizens' rights and a time-limited transition period, versus the non-legally binding aspirational document for the future, is that actually signing off the letter of the law here is still compatible legally with a wide range of Brexit outcomes. You could sign this and still go into a Brexit where you stayed in the single market and the customs union, which, from the point of view of the NHS, is largely, if not entirely, a very similar scenario to being in the European Union.

Conversely, you could go more in the direction pointed at by the political declaration—the aspirational document accompanying it—and have a considerably harder Brexit. It still leaves quite a wide space open.

Q3 **Martin Vickers:** I take the point that has been made, that perhaps there has not been sufficient detail coming from Government about the no-deal situation, but they have in their technical assessments provided quite a bit of detail. What specifically is lacking?

Mark Dayan: We have received, as you are probably alluding to, the Government's technical notices for planning on what they would do in terms of the supply of medicines and, to some extent, of devices. That is all the stuff around stockpiling, looking at alternative routes. Two things we have not had yet are full details of how it would work on the medical devices side—exactly how much would be stockpiled, who is going to carry it out for different bits and what happens on the reciprocal healthcare side. I do not think we have had that yet. Those are the examples.

Dr Fahy: What the Government are doing is one thing, but the NHS is such a huge part of the country—the largest employer in many of the towns where there are large hospitals—that it is also about understanding what individual hospitals and organisations in the NHS are doing. That is an area where greater transparency can only help ensure that things do not get missed.

Q4 **Martin Vickers:** Are you saying that local hospital trusts and so on, based on the information that has come to you, are not making sufficient preparations?

Dr Fahy: The point is that none of us knows at this point. The point is about disclosure and transparency, because of the whole argument about not wishing to disclose too much to protect negotiations, but we are now in a different phase. We are also in a phase where you are going to be making decisions in the coming weeks based on your understanding of the different impacts, and the more information we have about them, the better your information, and, surely, the better the decisions the House will be able to make.

Q5 **Martin Vickers:** It follows logically from what you are saying that you do not feel that the public are sufficiently informed.

Dr Fahy: I do not want to speak for my colleagues, but I have worked in this field for a great many years and I am still working my way through all the implications of these very large and complex documents. I would be astounded if the country as a whole was fully seized of all the implications of what these documents mean.

Q6 **Martin Vickers:** But the public, of course, expect Government, the NHS, and so on, to be making preparations, and you are saying you cannot advise the public at all, in effect, because, as you say, you yourselves, who spend most of your lives looking at this, do not know.

Dr Fahy: That is why transparency is so important because, as we have seen in other areas and in other areas of operation of the NHS, the more transparent we are, the more possibility there is that oversights and mistakes can be caught.

Professor Hervey: One of the things our report highlights is that for every type of Brexit there is a negative effect for stakeholder and parliamentary scrutiny. The more that can be in the public domain, the less the negative effect would be.

Mark Dayan: I completely agree with Nick's call for transparency at this stage, but we must not fall into the trap of thinking that somehow, if preparations are perfect enough, we can rule out some of the negative repercussions of a no-deal Brexit. That is for two reasons. First, there is an intrinsic risk of chaos involved, basically, of border systems in particular not being able to cope. That was pointed out very clearly by the National Audit Office recently.

Secondly, it is hard to overstate the extent to which there is no test case: no country has ever left a big trading bloc like this before. Our sources of real, experimental data on what happens when that happens are non-existent. It is a leap into the unknown.

Q7 **Martin Vickers:** We are continually being told by industrialists and people in the NHS and so on about chaos, but no one ever defines what this chaos is. It is just getting out to the public, "Oh, it's going to be chaotic." We hear about potential hold-ups at borders and so on, but what else is there? What else is chaotic, or potentially chaotic?

Mark Dayan: I can answer on borders and Tammy is better placed on the legal side of things. At the border, which for me is a huge issue in and of itself, a no-deal Brexit means a huge leap in the amount of red tape that companies have to go through to bring things into the UK. Some of it is being waived, but not all of it, and not all of it is within the power of the UK Government to waive. That raises two problems.

First, there is the direct delaying effect of additional requirements, declarations, and so on; there is the effect they have on the way companies run things when they are used to being able to get goods through on a lorry that rolls on and off a ferry. Secondly, there is a risk that the people who sign things off and implement the additional checks and regulations—in the UK's case, HMRC and the Border Force—will simply buckle under the strain of the huge leap upward in the amount of work they have to do. That is where I come from on the border side.

Professor Hervey: I want to add something about some of the evidence that we heard about the way the NHS currently copes with shortages—temporary shortages. There are always shortages of some kinds of consumables across the NHS in the UK. I know that there are provisions made to share between NHS England and the NHS in Scotland, Wales or Northern Ireland if there are specific shortages, but those kinds of shortages are minuscule in scale compared with what we are talking about, because of the nature of supply in the NHS.

The NHS has been asked to become more efficient over time, and that, along with modern manufacturing systems, has meant a just-in-time system. A just-in-time system only works if things can get to where they need to be just in time. For all those reasons, that system may well not work if any element of the way a particular consumable is created gets held up somewhere. We heard evidence to this Committee about how products in the making cross borders several times, and in distribution, once they are made.

Q8 **Chair:** Can I follow up a point that you made earlier, Professor Hervey, about the legal position? The default is that we go to no deal in, I think, 122 days, if I have that right. There is a kind of assumption that Parliament can stop no deal happening. Could you set out for us why it is not possible for Parliament just to pass a motion saying that we are not going to have no deal?

Professor Hervey: The making of treaties is an Executive power in the UK; it is not a parliamentary power. The way that article 50 works, according to our Supreme Court, is that, with parliamentary support, the article 50 process can be triggered by a letter. All of that has happened. The European Court of Justice is yet to rule in the Wightman case—it heard evidence today—but, as far as we know, the article 50 notification cannot be unilaterally revoked. There will be some legal clarity on that when the European Court of Justice rules, but simply a parliamentary motion in itself would not be enough to stop the process that article 50 mandates.

Q9 **Chair:** In other words, 122 days from now, we fall out and, if there is nothing in its place, the de facto position is that we have no deal. Is that your view?

Professor Hervey: That is the legal position.

Mr Bradshaw: But not necessarily the political one.

Q10 **Chair:** Yes, so wishful thinking will not change it.

Professor Hervey: That is where my point about the EU being a rules-based organisation starts. We need to think about the way that domestic law and EU law interact. We have the European Union (Withdrawal) Act, which rolls forward into UK law a huge amount of EU law. What it cannot do is roll forward obligations on the part of the EU or its member states, because the UK itself has no power to do that.

Q11 **Chair:** The point is that there is a lot of wishful thinking in this place that Parliament can somehow stop or legislate against no deal. What you are saying to us very clearly is that we run out of road and that is what happens, however much people would find it distasteful, unless we have something in its place. Is that a fair assessment?

Professor Hervey: Parliament can legislate for the withdrawal agreement, so, in that sense, Parliament can do something; it is not completely powerless.

Q12 **Chair:** What I mean is that there is a sense, or you hear among some parliamentary colleagues, that they can pass a motion that blocks no deal without having anything else in its place. What I am hearing from you today is that that is just political wishful thinking. This is what happens if you run out of road.

Professor Hervey: With the greatest respect, it is legal.

Q13 **Chair:** That is the legal position.

Professor Hervey: Yes.

Chair: We talk about what the public understanding is, but there is also a lack of understanding sometimes in this place about the fact that we are about to run out of road and how urgent all this is.

Q14 **Mr Bradshaw:** I hate to intrude and make this a rather complex legal argument, but the reality is that, if Parliament passes a motion against no deal, it is inconceivable that the Government would just sit back and let us crash out over a cliff. That is my first point.

There would have to be reams of legislation to implement whatever is agreed, if there is a deal or no deal, and again each piece of that legislation is amendable. I am not sure that this is a particularly fruitful conversation. The idea that any Government would simply ignore the will of Parliament overwhelmingly expressed against no deal or, for argument's sake, for another referendum is for the birds.

Mark Dayan: But there is nothing that the Government unilaterally can do to prevent no deal. Only with the EU as a counterparty in some form or another can they do that.

Q15 **Mr Bradshaw:** Yes, but the EU 27 have made it absolutely clear that, were we to wish to extend article 50 for a general election or a referendum, they would be happy for us to do that. It is important to get on the record in this Committee that we are not looking down a barrel. The choice between this deal and no deal is a false choice, and Parliament will make sure that does not happen. Our EU partners do not want it to happen either. There is a difference between some of the legalistic approach to this and the political reality. The political reality is that this Parliament will not allow no deal. Amber Rudd herself has said it, and the EU 27 have said they would keep the door open for us if we wanted to have another referendum or a general election.

Dr Fahy: Yes. I am certainly not going to try to gainsay a Member of Parliament about the dynamics of the politics of the House of Commons, but the principal risk of no deal occurring is that we continue the political discussions and we do not reach an adequate conclusion in time. I completely share your view that none of the actors in this wants no deal—not the United Kingdom Government, the European Parliament, the British Parliament or the European Council. No one, apart from a very small minority of people, has set out no deal as an objective. The risk is not that anyone wants it. The risk, as Professor Hervey has set out, is that there needs to be an agreement on something else.

Q16 **Mr Bradshaw:** I think you will find that parliamentarians are very aware of that need and are planning for that contingency now.

I have a couple of questions about the process. One of the criticisms of the future declaration is that it is not legally binding. It is full of aspirational language but nothing very concrete, and once we leave, if we leave, we will be out of the room, so we will be even less influential and even more powerless in fighting for our own interests. Give us your view or analysis. Is that a fair criticism or do you think it is unjustifiable?

Mark Dayan: There are elements that are fair and elements that are unfair. The element that is unfair is the suggestion that it somehow ever could have been legally binding, because the EU has made it clear from the start of this process that for them there is quite a strict demarcation, as per the letter of article 50, between sewing up the departure issues and a future trade agreement, which can only be done with a country that is already out of the EU.

Q17 **Mr Bradshaw:** But the British Government have promised consistently that we would have a much clearer idea about what the future trading relationship would be like at this stage.

Mark Dayan: That is where I think you can make a legitimate criticism, which is that, even though it will never be legally binding, could it be more specific? Probably, yes. There are some fairly concrete questions to

do with medicines and medical devices that certainly could have been outlined, aspirationally speaking, in the political declaration, and they are not. It is not fair to say that you want it to be legally binding. But could they give more detail? In theory at least, yes.

Professor Hervey: Another dimension is that, with respect to products, the Northern Ireland protocol could be read as indicating what a future agreement might look like. We have a lot of detail there; it is almost as long as the withdrawal agreement itself, but that is only with respect to products, and of course the NHS also cares about people and services.

Q18 **Mr Bradshaw:** Can I ask you about the loss of the term "frictionless"? In Chequers and elsewhere the Prime Minister has consistently said that she wanted frictionless trade, and, as we know, and have heard in this Committee many times, that is absolutely essential for the NHS and the health service in general, for public health and for our pharmaceutical industry. What is your assessment of the loss of that aim or aspiration from the political declaration?

Mark Dayan: The bottom line about both the political declaration on the future relationship and the Northern Ireland protocol is that they both envisage a scenario in which the UK leaves the single market. That is a consequence of quite fundamental positions on both sides. The UK wants to end the free movement of people, which is alluded to several times in the political declaration, and the EU has adopted a principle that it will not consider ending the free movement of people and maintaining other freedoms of the single market, which again is something that the UK Government signed up to several times in the political declaration.

The end of the single market in that sense will inevitably introduce frictions. In my opinion, for medical devices, a sort of Canada-plus style trade deal might be able to reduce that friction quite a lot. For medicines, the other goods that are of most concern to the NHS, it is much less so, and we are not likely to have a considerable amount of friction. Yes, the word "frictionless" is not there, and that reflects quite a deep truth about the kind of relationship this is pointing towards.

Q19 **Mr Bradshaw:** The current consensus is that this withdrawal agreement and political declaration are doomed, to quote the former Defence Secretary, and the Government are looking at a defeat of at least 150 in less than two weeks' time. Have you factored in more likely scenarios than the ones we are asked to discuss, which are either no deal or the deal? A more likely scenario could be a pivot to Norway or no Brexit, in which case could we have, please, your hierarchy of relative harm? The Government have themselves published a hierarchy of economic harm for no deal, this kind of deal and no Brexit. Could you do the same, please, in front of the Committee? That would be very helpful, not least as we are going to be voting on this in less than two weeks' time.

Dr Fahy: We did that in the original analysis piece that we did, based on some of our original advice to the Committee, which was published in *The*

Lancet. There is a link to that in the briefing, which is published on the Committee's website. It set out the three scenarios of what we call a soft Brexit, otherwise known as the Norway option; a hard Brexit, which was our best assessment of the Canada-plus option; and a no-deal Brexit.

Our basic message was that any form of Brexit has negative consequences for the NHS, and the harder the Brexit, the more negative the consequences. As Mark has already set out, if you take a soft Brexit, the UK becomes a rule taker, so the UK's ability to sit in representative institutions and to shape laws goes, but at least in the short term the everyday operation of the NHS—the mobility of staff, the ability to access products and medical devices; all those different aspects—continues largely unchanged. If your criteria are what is the best option for the NHS and social care in the immediate term, it is very clear that that Norway option is the best of the available options for Brexit.

Q20 **Mr Bradshaw:** But not as good as remain.

Dr Fahy: Not as good as remain.

Q21 **Mr Bradshaw:** Mark, you have put a financial figure on no deal, haven't you?

Mark Dayan: Yes.

Q22 **Mr Bradshaw:** Have you had time to do the same on the withdrawal agreement and the political integration, and can you give us the comparisons?

Mark Dayan: Yes. I should be clear that it was, essentially, specifically about the costs of supplies—medicines, medical devices and other stuff the NHS buys, such as food and vehicles. For a no-deal Brexit, I put that at £2.3 billion. Modelling has not yet been done in the same way for this deal specifically, and given how, in some senses, non-pinned down it is—

Q23 **Mr Bradshaw:** Is that an annual figure you gave?

Mark Dayan: It is an annual figure, yes.

It would be difficult to know exactly, but in so far as this deal is laying down the path towards a free trade agreement modelling has been done by the Government and by the University of Sussex that would let you get a similar figure for that. My best guess would be that it was somewhere in the region of, in annual terms, £100 million extra for devices and £300 million extra for medicines. It could be higher, but I assume it would be much less than under a no-deal scenario, partly because of two things.

First, you would not expect the same drop in the value of the pound driving up costs, and, secondly, when you are dealing with small increases in price, for many medicines the Government should be able to hold prices down through the new pharmaceutical scheme announced last week. If there was a bigger rise in price, there would be less confidence

that they would be able to hold the line on that. That would be my answer; £400 million is my best guess. Somewhere in the hundreds of millions would possibly be more accurate, but certainly much less than no deal.

Q24 **Mr Bradshaw:** To be clear, as the likely scenarios in two weeks' time are going to be a pivot towards Norway, which I do not think will be deliverable in this place any more—it could have been a few months ago—or another referendum and staying in, how much worse would a pivot to Norway be than the status quo?

Mark Dayan: That depends if by Norway you mean what Norway actually has, which is that it is in the single market but not the customs union, or you mean staying in the single market and the customs union. If we did what Norway actually does—not in the customs union but in the single market—you would still expect small price rises. The University of Sussex reckons 2% on the group that includes pharmaceuticals. However, if we did what some people call Norway-plus, which is staying in the single market and the customs union, it is not entirely clear to me why costs should be any higher than remaining.

Mr Bradshaw: Thank you.

Q25 **Andrew Selous:** Can I probe or challenge a little bit on two areas—immigration and medicines? It is going to be within the gift of the United Kingdom Government to have a very liberal and open policy in respect of the health and social care workforce, in that, if we have needs, we can extend the door very wide and give a huge welcome to EU 27 nationals to come in. On the workforce point, given that the UK Government will have control of that, why do you think workforce issues are going to be problematic?

Dr Fahy: What we have to work on are the texts on the table. We have the very large texts of the withdrawal agreement and the Northern Ireland protocol and the other protocols and, as Mark said, the very thin text of the political declaration. There are very short statements in the withdrawal agreement about particular kinds of purposes for which there is a shared ambition to facilitate free movement, in particular around things such as education—people coming to study or do research. There is nothing about NHS social care or public services more generally. You are completely right that it would of course be open to a future Government to do something different, but you asked why we take the approach that we do. The reason we take that approach is that that is what is in the declaration at the moment.

Professor Hervey: There are two other things. Compared with the current situation of EU membership, one is sort of psychological and the other is legal. In the current position, EU citizens, citizens of other EU countries who are here, are citizens and feel like they are citizens and part of something. That has some tangible elements too; they can vote for Members of the European Parliament and vote in local elections. That

disappears no matter how open the UK's immigration policies and laws are.

The second thing is legal. The entitlements to free movement under EU law are enforceable using the full power of EU law, whereas outside the EU immigration entitlements, entitlements to bring your family in, or for your children to have the same treatment as nationals, or whatever, are only enforceable using domestic rules, and there is quite a lot of information in the public domain about the administrative capacities in the UK to make fair decisions, to make quick decisions for incoming migrants.

Q26 **Andrew Selous:** On the medicines issue, the United Kingdom will have control of our own customs and tariff arrangements from the EU, so we could say that we are not going to have customs checks on medicines that we have already accepted and we are certainly not going to put tariffs on them. Yes, there may be a slight delay at the Calais side, but that can be planned for if it is short term; you can order a bit in advance.

Secondly, is it not possible for us to buy those drugs from, say, India, the United States or China? There are other markets around the world. Sometimes there seems to be a perspective that it is only the European Union that makes drugs. India has a huge pharmaceutical industry, China a burgeoning one and the United States a very established one. Given again that we will have control of our customs and that there are other markets, isn't this a little bit of a doomsday scenario for a great trading nation?

Mark Dayan: Those are good points and I have a couple of things to say in response. In terms of waiving checks at the border, on the regulatory side to do with approvals and licensing of medicines, you could do that, and in fact the Government have set out a list of checks that they would waive were there to be a no-deal Brexit.

On the customs side, it is much harder because, first, the rules of the WTO say that you cannot just waive customs checks on some countries but not others; you must apply most favoured nation treatment to all your trading partners. Secondly, the logistical difficulties of trying to waive customs for a particular set of imports but not others are quite considerable. Someone would have to declare that an incoming shipment was medicines and not something else. Once you are in that territory, it is not so very different from simply having to declare it in the first place.

On the rest of the world markets point, that is true, but we start from where we are, and that is a world in which 75% of our medicines imports come from the EU. All those supply chains are set up and there are networks of warehouses and suppliers. It is extremely difficult to change quickly, and, of course, even if we did, the volume of customs checks would still rise very highly because the non-EU products would need to be checked under any system, whereas the EU ones now do not, if that makes sense.

Professor Hervey: That is where it would be helpful to have some detailed transparency about the contingency planning, which talked about how we would move from a model where we are reliant for 75% to one where we reduce that reliance, or about what the plan is in detail.

Andrew Selous: We will be asking those questions of our next set of panellists. Thank you.

Q27 **Diana Johnson:** I want to ask about the social care workforce. I understand that for doctors or for those with professional qualifications they are going to set up a new immigration policy to deal with those kinds of jobs, but people working in social care often have limited qualifications, and are not paid very much, and under our current immigration laws, as I understand it, there is a threshold you have to reach. I am trying to get my head around what happens if we have the no-deal scenario and suddenly we are plunged into that. What happens to social care and our ability to recruit those types of people into jobs that we know are needed, and where there are lots of vacancies already? Can you explain to me how that would work?

Mark Dayan: There is a disclaimer, just as Mr Selous said, in that under a no-deal scenario the Government have total freedom to choose their immigration policy. If they wanted to, they could certainly keep allowing through people who wanted, or were suited, to work in social care, but all the indications we have—you may have seen the leaked White Paper recently in the *Telegraph*—are that that will not be the case, and there will be strong impediments for workers with lower salaries and lower qualifications. That is quite a big problem for social care, which has been reliant on EU workers coming through, essentially to try to keep up with rising demand from our ageing population. Even with a steep growth in the number of EU workers, it has not quite been keeping pace.

As you rightly say, it is not that they are a particularly special type of worker that is easy to identify so we could bring in more of them; it is more to do with the fact that social care has to compete against other sectors in the labour market of people without necessarily great qualifications or access to high salaries. The overall size of that pool of people is something to which social care is very sensitive.

Of course, another implication of that is that social care, to an extent, is in a sort of bidding war with other sectors in a way that is not quite true to the same extent for, say, nurses. Unfortunately, following the last decade or so of tough financial years for social care, the social care sector is in an extremely weak position to start raising wages to try to pull in a bigger share of a pool that is not growing as quickly. You are right to flag that up as a concern; for me, it is a bigger one than the NHS workforce.

Diana Johnson: That is helpful, thank you.

Q28 **Chair:** On top of that, there is extra bureaucracy and costs, with the immigration health surcharge, the visa requirements and the immigration

skills charge and the health surcharge.

Mark Dayan: None of which, again, the Government are forced to do, and I hope the White Paper might have slightly less onerous financial and other requirements, but we just do not know.

Q29 **Rosie Cooper:** Brexit obviously is not just about money and products. It is about people, so perhaps we could talk about the nearly 200,000 UK residents, including pensioners, who are resident in the 27 European countries. What are the key concerns about reciprocal healthcare in the event of a no-deal Brexit—the cliff edge?

Professor Hervey: The withdrawal agreement will protect those people for as long as they are in a position that involves more than one member state, potentially for the rest of their lives. That is a pretty good deal for those people. In no deal, their legal position will depend on the country they are in. Spain, for instance, has started indicating that it might make things easier, that it might have new registration systems or whatever. Their practical position depends on whether they have registered their presence in the country they are in, and there is some information that there are a fair number of British nationals in Spain who are not officially in Spain because they live some of their lives here and they are in Spain for the rest of the time.

As far as we have been able find out, every EU member state will give emergency care to anyone who is there. Many of them regard that as a constitutional duty, as a human right to health. Talking in terms of absolute calamity, or a crisis happening for someone, is overstating the negative side of no deal.

In terms of ongoing care, the arrangements that people are used to—some of them are vulnerable elderly people—do not continue, because the UK is outside all the legal and administrative structures that make reciprocal healthcare work in the EU. Those include exchange of information, exchange of resource, a whole bunch of known and recognised forms that people fill in and websites that support them to understand their rights—all the things that make the entitlement that somebody has a reality.

Dr Fahy: There are two things I want to add to what you said, all of which I agree with. One thing is of course that it is not just the people who live there; it is people who at the moment would be able to travel with a chronic health condition, but who will find it extremely difficult, if not impossible, to get medical insurance to replace the reciprocal healthcare arrangement that currently exists. The person who needs dialysis who wants to visit Venice or has family in Italy will find that very difficult or impossible if we end up in a no-deal situation.

Your question was focused on no deal. Shifting to look at the withdrawal agreement, which Tammy also talked about, and thinking about the future relationship and the political declaration, there is a reference to

social security co-ordination, but it is explicitly linked to the extent to which free movement is accepted. That goes back to Mark's point about there being a wide range of possible outcomes from the future agreement. If we read it right, and the basic message is, "We will only consider giving reciprocal healthcare and social security rights if that is part of an agreement on free movement," and if we stick to the current line of what is envisaged in that agreement, which is not including free movement, we will have to plan for, and expect an end to, the reciprocal healthcare arrangements that protect people who are already established in the situation that Tammy described, but will not protect people who move at some point in the future.

Q30 **Rosie Cooper:** Are you suggesting that the Secretary of State would find it very difficult to negotiate anything other than leaving those people to arrange their own health insurance? How do you think the Secretary of State would approach that situation?

Mark Dayan: Are we thinking about a no-deal scenario? In a no-deal scenario, many of you will of course be aware that a Bill was introduced recently giving rights for the Government to negotiate new reciprocal healthcare arrangements. That suggests to me that one option being considered is bilateral reciprocal healthcare agreements with different countries to replace, where possible, the EU-level ones. In some cases, that may be possible.

We have reciprocal healthcare agreements with Australia outside the EU, but they are not as ambitious, and the fact that we only have them outside the EU with Australia and a few other countries suggests that it is really quite challenging to have an agreement where another country has to take on or hold some of the financial risk of treating some of your citizens, without the hard legal structures that the EU provides to make that easier.

Q31 **Rosie Cooper:** The fact that in the last few years we have had difficulties over the reciprocal health arrangements with the Isle of Man does not suggest that such a thing could be done quickly over 27 countries. Do you think the Secretary of State could deliver that in any reasonable time?

Dr Fahy: If we are in a no-deal scenario, I honestly think the other thing we have to bear in mind is that there is not going to be a context of good will and wider political co-operation. It is going to be a context of a great many difficulties across a great many structures. There is legal complexity as well, which Tammy might want to speak to. At the moment, those reciprocal arrangements are EU law, which raises a legal question about how far it is even legally possible to negotiate things that look like the current arrangements on a country-by-country basis. When you put those different elements together, the short answer is that we could only expect it to be very difficult.

Q32 **Martin Vickers:** Could I come back to you on what you said about the

link between social security and free movement? I think you are being a little bit too proscriptive there, aren't you? I asked the Prime Minister a question about this yesterday. Paragraph 54 says: "The parties also agree to consider addressing social security coordination in the light of future movement of persons." That could be interpreted the way you outlined, but I think you have been a bit proscriptive because it is obviously, as the Prime Minister said, open to negotiation.

Dr Fahy: All I said specifically is that the commitment to exploring future social security co-ordination is linked to free movement. That is exactly what that clause says.

Q33 **Martin Vickers:** It does not mention the word "free." It does not say "free movement" at all.

Mark Dayan: It is not just a question of reading one line in the political declaration. It is a principle that the EU has reiterated throughout the negotiating process, and reiterates again and again in this political declaration, which is about the integrity, indivisibility—various words are used—of the single market, and a real aversion to the UK choosing the bits it likes.

Q34 **Martin Vickers:** But we won't be part of the single market.

Dr Fahy: The co-ordination of social security is connected to an arm of the single market. There is aversion to the UK just picking out the bits of the single market that it likes. It is something that the EU has been very reticent to consider as a general principle.

Q35 **Martin Vickers:** But we do not know the outcome of the negotiations.

Dr Fahy: No.

Mark Dayan: No.

Professor Hervey: We simply know the negotiating position that the EU has stated, and the Committee will remember Barnier's steps of doom slide with all the red lines. This is one of those red lines.

Chair: Are there any further questions?

Q36 **Mr Bradshaw:** I have one final question. On the no-deal contingency planning, weren't those plans supposed to have been activated by now?

Professor Hervey: That was in the evidence in the previous session, wasn't it? NHS trusts, from memory, were specifically forbidden at one point from activating stockpiling plans. Does anybody else remember? We can certainly check and come back to you.

Q37 **Mr Bradshaw:** I thought Simon Stevens and the pharmaceutical industry said to us that by now they would have to be activating them. As it is clear that this deal is going down, I imagine they would be activating their no-deal contingency. We can ask the Minister.

Professor Hervey: The pharmaceutical industry for sure had already been asked to activate various plans and were buying warehouses and doing those things.

Q38 **Mr Bradshaw:** They have run out of warehouse space, so that is no good.

Mark Dayan: It was on a sort of saving space basis. That is a question for your next panel.

Chair: Yes, it is. Thank you all very much for coming this afternoon.

Examination of witnesses

Witnesses: Matt Hancock, Simon Stevens, Sir Chris Wormald and Ian Dalton.

Q39 **Chair:** Welcome to our second panel. You are familiar to everyone in the room, but could you introduce yourselves to those following from outside?

Simon Stevens: I am Simon Stevens, the chief executive of NHS England.

Sir Chris Wormald: I am Chris Wormald, permanent secretary at the Department of Health and Social Care.

Matt Hancock: Matt Hancock, the Secretary of State for Health and Social Care.

Ian Dalton: I am Ian Dalton, chief executive of NHS Improvement.

Chair: Thank you very much for coming back again this week, Ian.

Ian Dalton: My pleasure.

Q40 **Andrew Selous:** We heard in the previous evidence session that, if the House of Commons votes down the withdrawal agreement, it will be much more problematic—I think that was the quote—than if the withdrawal agreement goes through. Secretary of State, could you give us your assessment of what a no-deal scenario would mean if the withdrawal agreement is voted down on 11 December? What does that look like for the NHS? What is keeping you awake at night, should that happen?

Matt Hancock: We do not regard the no-deal Brexit as the central likelihood. We regard it as unlikely, but nevertheless, as a responsible Government, we think it is important to plan for all possible eventualities. Indeed, in the rest of life at the Department we plan for all sorts of eventualities that we do not want to happen but that are possible, even if unlikely.

A no-deal scenario for the NHS will be difficult, but we are confident that, if everybody does everything they need to do, we will have an unhindered supply of medicines, we can make sure that we get the talent we need from around the world, and we can have a medicine and medical devices regulation system that provides for access to the best new medicines. An awful lot of work needs to be done, both in the Department and with industry, to make sure that all that happens, but we retain the position, as we explained when the permanent secretary and I were here a month ago, that we are confident that, if everybody does what they need to do, we can ensure this will happen.

Q41 **Andrew Selous:** There were reports that you put it rather more strongly than just being difficult last week. Can you unpack "difficult" and lay out in a little bit more detail for us what no deal looks like in terms of the challenges facing the NHS, perhaps people worrying that they will not get medicines? I know one elderly lady who is concerned that she is not going to have her Tramadol, which she relies on to be out of severe pain, and there are diabetics worried about insulin and those types of issues.

Matt Hancock: Yes. It is very important that we have a continuous supply of medicines and medical devices. That is the most difficult of the issues. Of the three issues I raised, the workforce issues can be dealt with and they are slower burn, but maybe we will return to those later. As we discussed last time, the number of people from the EU in the NHS has gone up since referendum day, but that is a slower-burn issue.

The supply of medicines and medical devices is the more immediate concern in the event of no deal. Under the deal negotiated by the Prime Minister, that will not be a problem because in the implementation period things will continue as now on the medical and medicines supply front, and in the future relationship there is a clear commitment to work on the relationship with the EMA. I am confident that we will be able to come to a positive outcome. That is a good reason to vote for the deal.

Work is under way for a no-deal scenario. First, we have a planning assumption of six weeks of delay should there be blockages at the border. That is a cross-government planning assumption, and of course we review those planning assumptions all the time. That assumption has to make assumptions for how others will respond as well. It is not just about what happens in the UK; it is also about what people with responsibilities on the continent do. We have an invitation out to tender for more refrigeration capacity, which we have talked about before. I can update the Committee and tell you that the response to that invitation to tender has been good. I know that there were concerns in some quarters that the capacity would not be available. I am confident enough, having seen the process that the invitation to tender has reached, that we will be able to fulfil that requirement.

Then there is the requirement to ensure that short-term and short shelf life medicines, especially the degrading isotopes, can be brought in. Even if there is no access through a short sea border, we will be able to do that

by air. Their size and weight is relatively small, meaning that it is practical to do it by air. There is further work, should there be constrictions to sea supplies longer than six weeks, on how we would be able to prioritise the supply of medicines and medical devices to ensure that they can be delivered and that we get an unhindered supply to the NHS.

We have been very clear to leaders in the NHS that the stockpiling will be done by pharmaceutical companies, and we will support them and are supporting them in doing that. It does not need to be done, above the normal levels of supplies, by NHS trusts or by individuals. That is very important, because, if too many people try to stockpile, you end up with more demand for stockpiling, when what we need to do is stockpile within the pharmaceutical companies so that they can fulfil their contracts in the normal way, and if you are an NHS trust or a pharmacy, or you are in primary care or you are an individual, supplies are available to you in the normal way. We are doing the work to ensure that supplies will be uninterrupted.

Chair: It would be useful to come back and respond to some of those points.

Q42 **Andrew Selous:** On workforce issues, we have the earn, learn and return scheme for nurses at the moment. Have there been preliminary discussions with countries, maybe the Philippines, on nurses? Where are we looking outside the European Union to bolster the social care workforce should the withdrawal agreement get voted down and workforce issues become more problematic from the European Union?

Matt Hancock: I will say a word and then bring in Ian, who has been doing work on ensuring that our ability in the NHS to recruit from abroad is expanded outside the EU. Of course, with the end of free movement of people, we will have the sovereign capability to decide on our immigration system. We have already, in July this year, removed the cap on numbers of doctors and nurses. That is from outside the EU, obviously, because it is under existing free movement with EU rules. It means that we have access to more people from around the world. There is work under way now, because, as you are well aware, there are already gaps that we need to fill, especially in the nursing workforce, and with the extra £20 billion going into the NHS we will need more nurses and doctors. That is a good thing. We want to look for the brightest and best around the world.

Ian Dalton: Under all scenarios, we look to continue to offer good, rewarding jobs looking after our patients to very valued colleagues from the European Union. The NHS currently has 60,000 staff who come from the European Union—20,000 nurses and 10,000 doctors in our hospitals—and they are making a very valuable contribution. The first thing we look to do is to continue to encourage that.

In addition, as I was saying to the Committee last week, we know that at quarter one this year, in common with many other countries, but obviously we are interested in our country, we have around 43,000 nursing vacancies in the national health service. Work is already under way across the country to reach out to a range of countries that have high-quality nursing staff, to encourage them to come here. The removal of the tier 2 cap is clearly very much to be welcomed in that regard.

Going forward in the NHS long-term plan, one of the things we have to do, as I mentioned to the Committee last week, is to build on that. My hope and expectation is that we will be doing more, including more centrally, to bring in staff from non-EEA countries, but clearly we also hope that we continue to value, support and retain the current staff who are working day in, day out to look after our patients, and are our valued colleagues from the European Union, and that we still keep an option open for new cohorts of EU-registered staff to come to work here.

Q43 **Andrew Selous:** This question is to Simon Stevens, if I may. There was a letter from the chief executive of NHS Providers over the summer, which I think was leaked, expressing some concern that the system was not preparing sufficiently on the ground. What should responsible chief executives of hospitals be doing at the moment? Has it all been taken care of by the pharmaceutical industry? What planning are you expecting hospital chief execs to do now?

Simon Stevens: Yes. I think she gave evidence to your Committee on 23 October, by which time, obviously, things had changed quite substantially. She said there had been progress since the letter was written, and, "It is fair to say that it is the Department of Health and Social Care's responsibility to be communicating with the sector." She said that had been speeded up, and there had been lots of communications and things had improved. That is what she told you on 23 October.

Q44 **Andrew Selous:** I think it was a letter from Chris Hopson that I was referring to.

Simon Stevens: Yes. He is her boss. As she reported to you, things had changed a lot by 23 October.

To get to your question, we have asked trusts to review their supply lines and their contracts and to produce information for us by the 30th of this month. Work is going on with NHS supplies, and the Department of Health is leading directly work with the pharma, devices and life sciences sector more generally; and we will be making a comprehensive assessment in the first 10 days of December—next week—as to what that is telling us. I emphasise the answer that the Secretary of State gave, which is that, from the NHS's point of view, the single most important thing post 29 March, in the event of a no-deal scenario, will be transportation links in connection with supply chains.

Q45 **Andrew Selous:** You are satisfied with the level of planning so far in relation to that. You have a degree of confidence, do you, that those plans are robust?

Simon Stevens: We will obviously, as I say, review the situation comprehensively post 30 November. Frankly, this side of Christmas, alongside the plans, were we to be in a no-deal scenario, some of those plans would need to be enacted.

Andrew Selous: Thank you.

Q46 **Chair:** Secretary of State, can I come back to the issue of supply chains in the event of no deal? You must be aware that there is a very high risk that the Prime Minister's deal will not go through, because you were using the terms "if" and "unlikely" in your previous response. The fact is that we are looking at the distinct possibility of the deal being voted down, us running out of road in 122 days and being in a no-deal scenario. If we take that prospect very seriously, looking at supply chains, specific concerns have been raised with me about blood products and around access, for example, to immunosuppressive medication for people who have transplants. We have had specific concerns raised about the availability of drugs for HIV. Across the board, we are hearing from various sectors that want specific detail about how the supply chains are going to work. I have also written to you, last week, asking for a list of all the drugs you have concerns about. Are you going to respond to this Committee with the areas and the products that you feel are at the highest risk?

Matt Hancock: I got your letter, thank you very much. On the question of blood, the UK is largely self-sufficient in our supplies of blood and blood components. We import from the EU per year around 6.5% of plasma units, but that is a small subset of the overall supply of blood that we use.

Q47 **Chair:** But it is extremely important.

Matt Hancock: Yes, it is.

Q48 **Chair:** If you cannot have fresh frozen plasma, do you realise what the impact would be across the NHS?

Matt Hancock: Yes.

Q49 **Chair:** What would it impact? What are you planning for if we cannot get it?

Matt Hancock: We will have contingency plans in operation to ensure that, as with medicines, the goal is to have an unhindered supply. I was slightly surprised that in the letter you picked out blood as the area of highest concern.

Q50 **Chair:** Blood products. An area that has been specifically raised with me is that there could be issues in terms of blood products. I did not just say

whole blood. I am talking about blood products.

Matt Hancock: Right. We regard blood products, along with medical devices and medicines, as an important area where we need to make sure we have unhindered supply. As I say, it is only 6.5% of the total, but it is important to make sure that we have that total unhindered supply. There is the availability of supply from lots of different places.

Q51 **Chair:** Secretary of State, when you say it is only 6.5% of the total, that totally misses the point, if you do not mind my saying so. If you do not have access to fresh frozen plasma in a timely manner, it is extremely important.

Matt Hancock: I think we are violently agreeing with each other. It is very important that we have those supplies, and we are doing the planning for blood plasma as we are with medicines.

When it comes to the question of the list of medicines, we are concerned to ensure the unhindered supply of all medicines. We are currently engaged with 481 companies that supply medicines and 350 companies that supply medical devices, and that covers 8,400 medicines and 17,000 product lines within medical devices.

Q52 **Chair:** I guess what we are looking for now is more transparency about which of those medicines you are most concerned about. We would like to see much more detail about what contingency planning is in place, because the role of this Committee is to hold you to account, making sure on behalf of the public that we do not run into difficulties in the event of no deal.

Matt Hancock: Right. There is a bit of a challenge because, for those companies, the nature of their supply chains and the nature of their contracts is commercially confidential. I very much respect the request that you have made and your role in scrutinising that we ensure that we get this right.

Q53 **Chair:** We cannot scrutinise you unless we have the information we require.

Sir Chris Wormald: The challenge is as the Secretary of State says. This is work in progress. We have been in contact, as the Secretary of State said, with a wide range of companies. They have shared with us information that they would not normally share as it is normally commercially confidential, and we have agreed to treat it as such. We are now working our way, with our colleagues at NHS England, through the entire list with the aim that there is nothing interrupted anywhere.

Clearly, if we reach the point where we are having to issue instructions to the sector to do something different, to use drug A rather than drug B, at that point we would have to make it public, but I am afraid we are not in a position to give a running commentary on where we have reached in that work, because the information we received has been given to us, as

I say, on a confidential basis and we are working through it at the moment. I understand everyone's desire to have lists, but it is, unfortunately, not practical at the moment.

Matt Hancock: I wonder if we can do a bit better than that and write to the Committee in response to your letter with as much information on the planning as we think is feasible, given that we need to maintain the confidence of the suppliers to give us the information to plan effectively. We do not want to undermine that confidence and, therefore, undermine the process of delivering the unhindered supply.

Q54 **Chair:** It is not just the issue about what products might have difficulty getting across borders in the event that we have a lot of friction at the borders. There are also issues around, for example, brand switching. We heard from one of our previous panels that there might need to be emergency legislation to allow brand switching to happen through pharmacies. If we see that there are supply chain issues across multiple products, it would be very difficult for GPs and hospitals to manage that, but there are some products where you cannot safely switch brands easily—for example, anti-epileptic medication. We are trying get a feel for the scale of what we might be facing, and to understand it. It is impossible for us to hold you to account if we are not able to see the range of issues we are facing.

Matt Hancock: I feel pretty held to account right now, and I might bring Simon in to be held to account in a moment—just a forewarning, Simon. Your point about the need to change regulations, whether they be statutory regulations or NHS regulations, is perfectly reasonable. We do this as a matter of course, because having shortages of either devices or drugs happens on a regular basis in the NHS. We discussed the shortage of epipens.

Q55 **Chair:** Indeed, but the point is that it does not happen across the board with hundreds of products at the same time.

Matt Hancock: I agree. I was coming to that. We had the discussion about the shortage of epipens, to which we responded by changing some regulatory approaches, as well as ensuring that we work with the companies to bring the supply back on stream.

We laid a new regulation on 19 November on the supply of blood products, so that demonstrates that we are making sure we have the statutory regulations in place to allow for the supply of blood products. NHS England manages the clinical decisions that are needed to ensure safe supply when a regulation needs to change, as opposed to the logistical organisation with the pharmaceutical companies to ensure that pharmacies and others get their unhindered supply.

Q56 **Chair:** Can I ask you about the issue of stockpiling? I have been told by some sources that in fact you are now planning to stockpile for more than six weeks. Is that true?

Matt Hancock: That is not our approach. Our plan is to introduce stockpiling for six weeks, in the event of a no-deal scenario. We have further contingency work on a range of contingencies, should the disruptions go on for longer than that, but our planning assumption is that we will then need a range of other options, such as prioritisation, rather than stockpiling. There is only so much stockpiling you can do.

Q57 **Chair:** If you are stockpiling, and the value of sterling collapses, are you concerned about the possibility of parallel imports, meaning that the companies then export the products that you have stockpiled? Are you going to be putting in place measures to prevent that happening?

Matt Hancock: We will not be stockpiling in the large part. It will be the pharmaceutical companies that are stockpiling, and they have contracts to supply. Our support for them to stockpile is to enable them to deliver on the contracts to supply that will be in existence post Brexit day.

Q58 **Chair:** But you will make sure, within those contracts, that they cannot then use parallel supplies to move them out if the exchange rate changes.

Matt Hancock: No, because they will be contracted to supply, and under contractual obligations to do that.

Q59 **Chair:** The last time you came before this Committee, we touched on clarity for small and medium-sized drug companies that are having to stockpile, about how quickly they will be reimbursed for their extra costs, because of concern about the impact on them. Is that something you have now had a chance to review?

Matt Hancock: The negotiations for any support we give are very much company by company. The large pharmaceutical companies in fact had started stockpiling even before we came forward with a formal policy, which I think I first announced to this Committee back in July. In over 800 companies in total, if you include devices, there is a full range of the market, as you would expect, from global giants to small businesses. We are in engagement with all of them.

Q60 **Chair:** Right, but it was particularly small and medium-sized companies that there was concern about.

Matt Hancock: Yes, of course, exactly. The bigger ones obviously find it easier to cover those sorts of costs.

Q61 **Chair:** That was the question to you last time. Are you now providing clarity to them about how they will be reimbursed, and how quickly?

Matt Hancock: We are having different levels of conversations with different companies according to need, the scale of their operation and all sorts of different things. There is quite a detailed piece of work going on.

Chair: Before we go any further, I apologise to the panel. I have to slip down to the Commons Chamber as the Minister finishes winding up, to

move something on behalf of the Liaison Committee. Ben will kindly take over in the Chair for me. Thank you.

In the absence of the Chair, Mr Bradshaw was called to the Chair.

Q62 **Chair:** Secretary of State, you are reported as having told the Cabinet that in the event of a no-deal Brexit, you could not guarantee that people would not die. Is that your view?

Matt Hancock: We do not comment on leaks. That is not exactly what I said, and we have been very clear that if everybody does what they need to do we can ensure continuity of supply.

Q63 **Chair:** You can guarantee in front of this Committee that nobody will die as a result of a no-deal Brexit.

Matt Hancock: As my permanent secretary tells me, we should not use words like guarantee. We can say that we are confident that, if everybody does what they need to do, there will be the continuity that I have talked about.

Q64 **Chair:** You said a little while ago that you thought no deal was unlikely, but your fellow Cabinet Minister Amber Rudd said last week that no deal would not happen because Parliament would stop it. Do you not agree with her?

Matt Hancock: I think Parliament should vote for the deal that is on the table because it is the best deal.

Q65 **Chair:** But my question was that you say it is unlikely and she says it will not happen because Parliament will stop it.

Matt Hancock: I think that people should vote for the deal. That is Government policy; it is the Government's position.

Q66 **Chair:** Secretary of State, don't waste our time. Everyone knows this deal is doomed; it is going down. When we are facing a no-deal scenario, do you agree with Amber Rudd that Parliament would stop it?

Matt Hancock: I am planning for all eventualities, and that of course includes no deal.

Q67 **Chair:** In that eventuality, would you join your fellow Cabinet Ministers in making sure that no deal did not happen?

Matt Hancock: I am going to vote for the Government's deal because I think it is the best way through this. I am not going to get into, "If this happens, then what happens?" because I support the Government, and the Government position is very clear. It is not only the Government position; it is actually the right thing to do.

Q68 **Chair:** I assume that Amber Rudd also supports the Government. She is one of your fellow Cabinet Ministers, and she said categorically that no deal will not happen because she and others will help stop it.

Matt Hancock: Maybe you should call her before the Committee. I am telling you my position.

Q69 **Chair:** You would be relaxed about no deal in that event, would you?

Matt Hancock: We are planning for all contingencies and that involves no deal, and if everybody does what they need to do then we can have the unhindered supply of medicines. I could not be clearer about my position on this.

Q70 **Chair:** The fact is that the two most likely scenarios, given that it is almost certain that the deal will go down, are either a pivot to Norway or another referendum and no Brexit. Are you making contingencies for those two scenarios as well?

Matt Hancock: I do not really understand what you mean by a pivot to Norway. We will be leaving the European Union on 29 March.

Q71 **Chair:** It is the idea that has been mooted by one of your former ministerial colleagues, Nick Boles, and is said to have considerable support from within the Cabinet in the event that this deal goes down, so I imagine you are at least thinking about it.

Matt Hancock: What I am doing in the Department is, first, supporting the best deal that is available, which is the one that the Prime Minister brought back, and that will ensure that we leave on 29 March in a way that, during the implementation period, keeps the existing systems of medical supplies exactly as they are now. We are also doing contingency planning for no deal. There is endless speculation on, and indeed argument for, different positions, but there is a Government position, and the Government position is that we back the deal and, as a contingency, prepare for all eventualities, including no deal. No deal is the one for which, clearly, we have to do the most preparation.

Q72 **Chair:** You just said you were prepared for all contingencies, including no deal. That would imply that you are preparing at least—

Matt Hancock: There is a whole range of options in between that people are discussing.

Sir Chris Wormald: I could probably add helpfully, not on the politics—

Q73 **Chair:** Before you do, Permanent Secretary, there is a whole range of options that people are discussing, and we all know what they are: a pivot to Norway or another referendum. Secretary of State, as you are responsible for the national health service and our health service in this country, you must be making contingency plans for those two far more likely scenarios than no deal.

Matt Hancock: I disagree with the premise of your question. I am telling you what we are doing, which is preparing for the deal that the Prime Minister has brought back, which is the best option, and also preparing

for no deal. You and other MPs are perfectly entitled to put forward other scenarios. That is your right.

Q74 **Chair:** Would you be able to keep time in your diary to come back for an emergency session before Christmas, in two weeks' time, to give us an answer to the question?

Mr Stevens, you just talked about contingency planning for no deal. When will those plans have to be activated?

Simon Stevens: In my view, the planning has been extensive, in the way the Secretary of State has set out, but aspects of the plans would need to be given the go-ahead this side of Christmas and some of them early in the new year.

Q75 **Chair:** Which are the ones that would have to be given the go-ahead this side of Christmas?

Simon Stevens: The contingencies that have been drawn up by a number of the pharma and other companies are, as both Chris and the Secretary of State have said, pretty well advanced, but there are particular instructions that we would need to issue to GPs, NHS hospitals and others, and in fact I think we intend to have further communication this side of Christmas.

Q76 **Chair:** As the person responsible for the smooth running of the NHS, you would not welcome a scenario where Parliament, having voted down this deal in 10 days' time, is then asked to have another go two weeks later, because by then you will have had to activate the contingency plans.

Simon Stevens: How Parliament chooses to approach this is, of course, a matter for Parliament, and, over time, the NHS will adjust to any new arrangement. In terms of transitions, there is a set of decisions that need to be made this side of Christmas, or very shortly after, to mitigate some of the supply chain issues that we have discussed.

Matt Hancock: This is ongoing work. I first wrote to frontline colleagues in the NHS on 23 August on preparations for no-deal planning. I then wrote on 12 October. We issued the invitation to tender for refrigeration and storage recently, and will shortly be concluding that. That will involve spending the first money in preparation for no deal, in the low tens of millions. The exact figure will depend on the response to the invitation to tender and which of the bids we choose. It is not that there is a moment when we suddenly start planning for this. We have been planning for contingencies since the summer.

Sir Chris Wormald: That is what I was going to say—planning and activation.

Simon Stevens: That is the key point. The planning has been—

Sir Chris Wormald: There are some aspects that we have already activated, such as asking pharmaceutical companies to develop the

stockpiles, and there are other things, as Simon says, that we would need to activate over the coming months if we are in that scenario.

The point I was going to make earlier, which goes to your question—obviously not the politics in your question but the administration of it—is that what we are in fact preparing for is not related to particular options. We are preparing for how we would deal with friction at the border caused by whatever circumstance, as it were. Whether it is caused by one type of deal or another, it is the same friction at the border.

The question for us, administratively, is whether there is friction at the border that causes us to do something different for the supply of drugs than we would do otherwise. Wherever Parliament comes down on this, the question is whether it causes that sort of friction at the border, and does that cause Simon and I to activate the plans that we need to do?

Q77 **Chair:** Is it at that stage that it becomes more expensive? Secretary of State, you just talked about tens of millions of pounds, so the main cost of the no-deal contingency is when the plans are activated rather than at the planning stage. Is that right?

Matt Hancock: There are different costs at different points. The low tens of millions of pounds will be activated when we sign the tender to start building refrigeration capacity. I am quite prepared to spend reasonable amounts of money, if it is deemed good value on a value-for-money basis by the permanent secretary, the accounting officer, in order to plan for those eventualities. We demonstrated that we are prepared to ensure that we do what is necessary and we have a set of timelines along which we get to the point at which we have to make decisions, whether or not the outcome and shape of the final deal is clear, and, as we reach those hurdles, we are prepared to make the decisions. I would rather not spend money that is not going to be used, but there are endless areas of the health service where we spend money that we do not want to be used, because it is contingency planning. That is what we do.

Sir Chris Wormald: Just to be clear on what those additional costs are, they are not the costs of the drugs themselves, because of course if you stockpile and then sell to the NHS we are paying in the usual way. The additional costs are around transport and warehousing, not the cost of the drugs, which is the massive cost in this system and is rightly borne by organisations themselves. You will have seen, from a number of public announcements, that companies are choosing to stockpile things both inside health and outside. It is actually quite a narrow set of costs that we are talking about.

Q78 **Chair:** I am pleased, Secretary of State, that you would rather not incur these costs. If Parliament in 10 days' time, or perhaps the day after the deal has gone down, passes an amendment or a motion against no deal, would that give you the confidence to deactivate those no-deal contingency plans and save us all this money?

Matt Hancock: We will cross that bridge if we come to it. I am not going to answer a conditional question. We follow the policy of the Government.

Sir Chris Wormald: I refer to my answer earlier: our assessment is on the question of whether there is going to be friction at the border that causes us administratively to do something different. The assessment will be that.

Q79 **Luciana Berger:** On the very specific question about providers of warehouse space for stockpiling, I asked a parliamentary question that was answered on 31 October. The response was that you had launched an invitation to tender to providers of warehouse space to bid for Government funding, to cover the costs that the providers of warehouse space would incur by providing additional storage space for stockpiled medicines. It is a technical point, but, forgive me, in response to the answers that you gave the Chair of the Committee, I do not understand how you are going to hold everyone to account to ensure that you have the medicines we might need in the eventuality of a no-deal Brexit.

Matt Hancock: How do you mean?

Q80 **Luciana Berger:** The tenders have gone to the providers of the warehouse space, so how are you co-ordinating with the providers of warehouse space and the pharmaceutical companies to ensure that the medicines we need in this country—

Sir Chris Wormald: We talked to both and there were two issues. First, is there the physical capacity of warehousing to do this? That is what we are dealing with. We have already done something on the NHS supply chain for consumables, and we are doing, as you say, the tender on pharmaceuticals. That is about the total capacity of the system. Then there are the individual organisations using that capacity, where there are the company-by-company discussions that the Secretary of State referred to earlier. There are two separate questions.

Lots of companies, including pharmaceutical companies, are stockpiling already. What we are not going to do, and what underpins all of this, as I said, is meet the costs of what people have already done or would do in the normal course of their business. That is why we split it into two: whether there is the capacity; and then a company-by-company discussion about what support pharma companies need to make use of that capacity.

Matt Hancock: To be clear, as I said earlier, the response to the invitation to tender, which we will be deciding on very soon, shows that the capacity is available. We went to market with an invitation to tender and people have come back and bid in to provide that capacity.

Q81 **Luciana Berger:** Secretary of State, in your earlier remarks, you said you wanted colleagues across the House to support the Prime Minister's withdrawal agreement. Can you share with us what you believe are the benefits to our NHS from that withdrawal agreement, above and beyond

what the NHS already benefits from?

Matt Hancock: Yes. It provides for a smooth exit from the European Union, therefore delivering on the Brexit vote while ensuring that we have that smooth exit.

Q82 **Luciana Berger:** In terms of all the other challenges that colleagues have already raised on issues around access to drugs and medicines and availability of staff, is the net benefit of the withdrawal agreement greater, in your view, than what the NHS enjoys today?

Matt Hancock: It allows us to deliver on the result of the referendum while ensuring that we have a smooth exit that protects the supply chain for medicines, and ensures that we can continue to grow and fund the national health service. It provides for delivering on the result of the referendum while protecting our NHS.

Q83 **Luciana Berger:** Perhaps I can ask the question in a different way. Will our NHS be better off as a result of the withdrawal agreement?

Matt Hancock: It will be better off because we are putting in an extra £20 billion.

Q84 **Luciana Berger:** On that point, the letter we saw from the Prime Minister that was published in the press at the weekend said that, when we leave the EU, the NHS will receive an extra £394 million a week, which makes up the £20 billion she promised earlier this summer. The Prime Minister has said that this post-Brexit money would come from the money we would have spent if we were still in the European Union.

There are many organisations, including Full Fact, the independent fact-checking charity, that have demonstrated that, even with a deal, there is no such thing as a Brexit dividend for the NHS, when you factor in the cost of the divorce from Europe and the economic impact of Brexit, on which there have been many reports—one just in the past few days alone—and the fact that the Government will have to spend money on areas where the EU currently gives us funding. Can you tell us where this Brexit dividend for the NHS is going to come from?

Matt Hancock: Yes. There is money that we directly pay to the European Union that, instead, we will be able to pay over to domestic priorities like the NHS. Of course, there are economic forecasts for all sorts of eventualities. Having been an economic forecaster myself in my time, I have a healthy scepticism towards economic forecasts, but there is money; there is cash flow that we pay into the EU now as members that we will not have to pay at the end of the implementation period.

Q85 **Luciana Berger:** I hear that point, but there is equally money we benefit from as a country that we receive from the EU that we will no longer receive. Is there any economic forecast to which you can point that shows that we will get a Brexit dividend for the NHS?

Matt Hancock: It is a matter of accounting that, if you pay over money and then you do not have to, it is available for other things like putting it into the NHS.

Dr Wollaston resumed the Chair.

Q86 **Luciana Berger:** It is not just a case of paying money into the EU and getting money back. It is also the impacts that leaving will have on our wider economy. Is there any forecast that you can give us? If you say there is nothing you—

Matt Hancock: The forecasts I can point you to are the forecasts that people made on Brexit day, when the referendum result came through, that there would be a recession, and that did not happen. For somebody who has created economic forecasts in a former life and relied on economic forecasts for a political argument that turned out not to be accurate, I have a healthy scepticism of economic forecasts. Accounting facts—the payment of money—are more concrete than that.

Q87 **Chair:** I am sorry, but that was completely debunked by those who regulate our official statistics. The idea that there was this Brexit dividend is surely nonsense, isn't it? You are not seriously sitting here telling us that you think there is going to be a Brexit dividend for the NHS, are you, Secretary of State?

Matt Hancock: I am saying, very clearly, that there is money that we currently pay to the EU that we will not have to pay after the end of the implementation period that we can then, instead, spend on our domestic priorities. Others have added economic forecasts to all sorts of different scenarios around that, but I have a scepticism for economic forecasts that is born of experience.

Q88 **Chair:** Can you point to any credible economists who are saying that there is going to be an economic dividend?

Matt Hancock: I have pointed to what I thought were credible economists in the past and they turned out to be wrong, so it is just not a line I go down.

Q89 **Chair:** Right. Can you point to some of the Brexit penalties for the NHS? What do you think the Brexit penalties are, for example, in terms of recruiting staff—the financial penalties?

Matt Hancock: I hope we are able to recruit staff from around the world to work in our NHS. That is one of the reasons why we have removed the cap on visas.

Q90 **Chair:** Do you recognise the extra costs for that? Are you aware of the assessment that has been made by the Royal College of Physicians, for example? When you are employing staff from the EU at present, it is a very low cost to the NHS. They set out very clearly their concerns about extra costs, be it the immigration health surcharge or the fees for visas that are involved. There is a whole host of different charges that we will

face. There are the immigration skills surcharges, and we know that the health surcharge is going up to £400 per family member and so on. Do you recognise those extra costs around recruitment?

Simon Stevens: Maybe I can have a go at that, Chair. There is nothing God-given about those facts. It is for the country, having taken back control of its immigration policy, to decide whether it wants to continue to welcome, not just from the rest of the world but from the European Union, highly qualified and devoted nurses, doctors and therapists. As you know, right now, we have more nurses from outside the European Union than from inside. The net effect of the changes will hinge on whether, in taking back control of our immigration policy, we make smart choices about what that new immigration policy is.

Q91 **Chair:** Yes, but would you recognise, Mr Stevens, that there are extra costs involved for NHS organisations when they recruit from outside the European Union that are not there when they recruit at the current time?

Simon Stevens: There are at the moment, but there is nothing intrinsic about a new immigration policy as to why that should be the case.

Q92 **Chair:** Okay, so perhaps the Secretary of State would like to give an assurance to this Committee that we will see an end to the immigration health surcharge, the skills charge and the visa costs.

Matt Hancock: No. The immigration health surcharge is important. Residents of the UK have a right to use the NHS free at the point of use, according to need, not ability to pay, because that is one benefit that you get from being resident and paying your taxes here. People from abroad who do not do that contribute through the immigration health surcharge towards the costs of running the health service.

Q93 **Chair:** But what if they are coming to contribute to our health service by working in it and what if they are employed on a relatively low income? Do you think that is going to deter them from coming? Say you are coming to work in social care in the future and you are required to pay a health surcharge for yourself and £400 for each family member, and an immigration skills charge and visa charges. All those things will add to the cost, surely. This is not a Brexit bonanza for the NHS. It is a Brexit penalty, isn't it?

Matt Hancock: That is slightly muddling because the immigration health surcharge is applied to non-residents, so, if you were coming to work for the NHS, you would not pay it because you would be resident, unless you were non-resident and working in the NHS, but there is nobody I know who is non-resident but working for the NHS.

Q94 **Chair:** Somebody from the European Union currently coming to work in a job that is essentially a minimum wage job does not have to pay any of those charges at the moment, do they? There is not an immigration skills charge applied, or the costs of visas and so forth. Do you accept that this is going to put extra costs on the health and social care service?

Matt Hancock: As Simon has said, these are matters for policy. We have been clear that we want to see the future immigration system be more efficient than the current operation.

Q95 **Chair:** Yes, but I am talking about the costs.

Matt Hancock: In some cases, with the rest of the world, we have brought visa costs down. Also, when people become resident, they stop paying some of those costs. All in all, our ability to hire people from the rest of the world is a big one. The NHS is a very attractive place to work. We are very supportive of and grateful for the work that current EU citizens do in the NHS, more of them than on referendum day. They do a great job; they are welcome and they can stay, but there are more people in the NHS today who are from the rest of the world, and I am a fan of that.

Q96 **Chair:** Yes, but I am talking about the extra cost, because we started this discussion around costs. We are looking at the costs for the NHS of employing people in posts that are paid less than £30,000.

Sir Chris Wormald: There are some choices for individuals, employers and the Government. A number of the things you are quoting, particularly the health surcharge, are income for the Government, whether that is a cost to the individual or whether employers choose to pay the cost on their behalf. What the Government choose to do with the extra income they are getting from visa charges is a question of future policy.

Q97 **Chair:** What about things such as the immigration skills charge, visa costs and all the extra costs involved?

Sir Chris Wormald: I can talk in detail only about the health surcharge, but my understanding is that all those things are choices for Government, as Simon was describing, and how you use the income created is also a choice for Government. In the case of the health surcharge, those resources flow back to the Department to cover the usual costs.

Q98 **Chair:** There is that but there are also other costs. It is not just about the health surcharge. There are other costs involved, aren't there, that are much greater if you are then going to start—

Sir Chris Wormald: Yes, but they are still all income to Government and then there are choices for Government about how they use that income, and there are choices for individuals.

Q99 **Chair:** Perhaps the question for the Secretary of State is: will all that money be ploughed back into the NHS?

Matt Hancock: At the moment, we are getting an increase that is far greater than the sorts of sums of money raised by any of those issues, which is the extra £20.5 billion. You could argue that those funds should be hypothecated. That would be a perfectly reasonable policy position for the Committee to take. However, our position is not that they should be

hypothecated, but rather that we should fund the NHS with the money that it needs, hence the £20.5 billion.

Chair: Lots of colleagues want to come in.

Q100 **Diana Johnson:** I want to follow up the Secretary of State's vision for social care in the future. Because of the exchange you have just had with the Chair, what is your thinking about how we are going to meet the need for recruitment in the social care sector? It is low-paid work. If we are recruiting from around the world people who are not highly skilled doctors and professionals, what is your thinking about how we are going to manage to do that in terms of Government policy?

Matt Hancock: First, I do not recognise work in social care as low-skilled work. It is highly committed and the people who work there—I am sure you have met many—do so with great dedication. That should be our starting point.

I have been a big supporter of the national living wage, which has had an impact on increasing the pay of people who work in social care, perhaps more than any other sector. That is good for the sector, as well as obviously good for those who are paid at the national living wage. We have seen some of the fastest pay rises for people right across the economy in social care because of the relatively high proportion of people who were on the national minimum wage and now are on the living wage, and the living wage is going up very rapidly. That is my starting point.

Q101 **Diana Johnson:** If we have a no-deal scenario, what is your policy for recruitment to social care in the future? How are you going to deal with that?

Matt Hancock: Recruitment for social care, both domestically and internationally, is very important. As in the NHS, there is a higher proportion of people in social care who come from outside the EU than from inside the EU. Again, it is a question of making sure that we train people locally and give people from the UK opportunities to work in social care, which can be a very rewarding career. We need to make sure that it is yet more of a rewarding career—there will be a lot more on that in the Green Paper on social care—and that we recruit people to be able to do work in social care. Those things are all part of trying to make sure that social care can give the dignity that it ought to. It is something that we care a lot about getting right.

Q102 **Johnny Mercer:** People outside this place who are not involved in the NHS want to know whether the NHS is going to be okay after Brexit. Simon, as a man who has been working in this field for 20 years, do you have total confidence that the people who use the NHS, the people of Plymouth who use it sometimes every day, will see no change and their service will continue as normal?

Simon Stevens: In principle, there is no reason why we cannot have an excellent NHS regardless of our relationship with the European Union, but

the key question is about the transition. That is the discussion we were having earlier this morning.

Q103 **Johnny Mercer:** What does that look like for people queueing to get into the hospital in Derriford?

Simon Stevens: We have talked about some of the staffing issues, which it is possible to solve. There are other questions that people raise around research links, but there is no reason in principle why, just because we are not members of the European Union, we cannot continue research links with hospitals and scientists in Europe.

The key question of the immediate period after 29 March will depend on the nature of the transition. To some extent, it will depend on how other countries react as well. If we are talking about the supply of medicines from France into Britain, I am sure the French Government will take account of the fact that there are nearly a third of a million French people, families, living in this country, and they would not want to see disruption for British people in the national health service just as much as they would not want to see it for French people living here either.

Q104 **Johnny Mercer:** People want to know, whatever happens in the maelstrom that goes on, that, ultimately, the NHS will be okay in the near term. We are surely not that fragile. Some of this stuff about people dying and running out of water seems insane for most right-minded hard-working people in this country. Isn't that right?

Simon Stevens: The position is as the Secretary of State set out, and obviously the Government lead on the overall planning. The national health service itself is not able to shape precisely what the transport links and the supply chains look like, but we are moving heaven and earth to do everything we can to ensure the smoothest possible transition.

Q105 **Johnny Mercer:** Exactly, so having had two years to prepare for this, with the skillset you have in NHS management and all the rest of it, if people were to be worse off because of any outcomes of Brexit, people like me would be quite surprised. It would be quite a strategic error from some pretty capable people.

Simon Stevens: It would be very undesirable.

Matt Hancock: Hence we are doing the planning to make sure that in any scenario, if everybody does what they need to do, we are confident that everything will be fine and, more than that, we are putting an extra £20 billion into the NHS in all Brexit scenarios in order to make sure that it is there for the long term.

Q106 **Johnny Mercer:** The health service, by that measure, will be better off after Brexit, whatever happens.

Matt Hancock: The health service will be better off after we leave the European Union on 29 March under any deal because we are putting in an extra £20.5 billion.

Johnny Mercer: Thank you very much.

Q107 **Chair:** Would you be putting that in anyway even if we did not leave? That is the question.

Matt Hancock: We are putting the £20.5 billion into the NHS come what may.

Q108 **Chair:** Come what may. That is the point. It is not dependent on it and it represents an uplift that is still—

Matt Hancock: That is right, so—

Q109 **Chair:** The idea that all of this is contingent on some mythical Brexit dividend is not—

Matt Hancock: No. The money going into the NHS is happening no matter what the Brexit outcome

Chair: Quite.

Matt Hancock: Therefore, it is correct and right to say, in answer to Johnny's original question, which was whether the NHS is going to be there for us after Brexit day and able to treat the patients who are walking into his A&E, that the NHS will be better funded after we leave the European Union because the money comes on stream next year.

Q110 **Chair:** It is irrelevant to whether we leave. My question to you, Secretary of State, is: are there going to be extra costs to the NHS as a result of Brexit? The money is going in regardless. Are there going to be extra costs after we leave the European Union?

Matt Hancock: Not that we can foresee.

Q111 **Chair:** Really? You cannot see any costs for the NHS.

Matt Hancock: The NHS faces costs that change all the time. For instance, exchange rate movements have an impact on the price of drugs.

Q112 **Chair:** What is Brexit going to do to that?

Matt Hancock: We do not know. Crikey. Anybody who is sceptical of economic forecasts should be even more sceptical of exchange rate forecasts. Anybody who tells you that they know what the exchange rate is going to be in the future is making it up. There are all sorts of costs that change. When you run an operation that costs today, this year, £115 billion, and those costs are going up to just under £150 billion over five years, that is the scale of the increase of funding in cash terms that we are talking about.

Q113 **Chair:** Tell me, do you have an estimate—

Matt Hancock: The NHS is going to be better funded than ever before.

Q114 **Chair:** That is irrelevant.

Matt Hancock: No, it is not irrelevant; it is absolutely central.

Q115 **Chair:** What I am saying is it is irrelevant to the issue of Brexit because you are saying that that money will be going in irrespective of Brexit.

Matt Hancock: I see. Correct.

Q116 **Chair:** Are you confident that there are no extra costs? In other words—

Matt Hancock: That is not what I said. I said there are all sorts of costs that change over time. For instance, last week we concluded the renegotiations of our five-year drugs arrangements, and we saved £930 million.

Q117 **Chair:** Yes, I know, but we are talking about Brexit.

Matt Hancock: Simon renegotiated the move from some patented drugs to biosimilars and that saved £300 million.

Q118 **Chair:** Can I stop you there, Secretary of State? You have said there is the same amount of money going in irrespective of whether we leave. I ask you again: do you think there is any form of Brexit that will produce lower costs for the NHS overall?

Matt Hancock: Many of the future costs in the NHS are uncertain, so there are scenarios in which costs are higher and there are scenarios in which costs are lower. We make sure that the NHS is there for the long term by giving it the money it needs. That is just the truth of the matter.

Sir Chris Wormald: Yes. It is useful to split the question in two, drawing on what Simon said. There are clearly costs in a transition, and we have already referred to some of them. When we look at the long-term costs of health systems across the OECD, the cost drivers are pretty common regardless of whether you are inside or outside the European Union; they are the costs of the western health service. You have worked across several jurisdictions, Simon, and those are the long-term drivers of health. As I say, they are common, regardless of whether you are Canada, Germany or whoever. Those are our big cost drivers.

There are clearly costs, and we have mentioned some of them, depending on the type of transition from one state to the other, but the overall costs of health, and this is very well documented in the literature, are driven by technology, demography and the things that affect western society as a whole.

Q119 **Chair:** Yes. I think we all accept there are all sorts of other inflationary pressures.

Sir Chris Wormald: Those are of course the big drivers of what the health service will cost in future, as opposed to what we have been talking about here, but, as I say, we have already referred to some of the money we have spent in terms of transition, so there will undoubtedly be

some costs in that area, as we have already mentioned. Is that fair enough, Simon, in your international experience?

Simon Stevens: Yes, exactly. The fundamental drivers of health costs are bigger than anything relating specifically to Brexit.

Q120 **Andrew Selous:** Secretary of State, you mentioned earlier tens of millions—I think that was the figure you mentioned—in respect of additional refrigerated warehouse tendering. Can I put the question another way? If the withdrawal agreement is accepted, how much money will be saved and what are the other benefits for health generally?

Matt Hancock: If the withdrawal agreement is voted through, as I believe it should be, there are costs that we would otherwise have to start spending in preparation for no deal that we will not have to spend.

Q121 **Andrew Selous:** Can you give us an indication of that?

Matt Hancock: I cannot put a figure on it.

Q122 **Andrew Selous:** None of us wants to see money wasted, do we?

Matt Hancock: Absolutely.

Q123 **Andrew Selous:** This is quite a relevant factor.

Matt Hancock: I cannot put a figure on it.

Q124 **Andrew Selous:** Even a ballpark figure.

Matt Hancock: Currently, the expenditure in these areas is in the low tens of millions. I would put it in that broad ballpark. We have had to decide already to go to tender for the refrigeration and warehousing, and the costs of that will be made clear shortly when we decide on the bids that we accept. That is in the low tens of millions. There are further costs that we will have to start accruing quite soon—some before Christmas, as Simon says. Again, it is in the same ballpark, but we are not able to put precise figures on them because we want to get the best possible value for money. If we put figures on them, people will bid up to the figures we say.

Q125 **Andrew Selous:** Okay. Maybe the tens of millions sounds low in comparison with the extra £20 billion, but—to cut to the chase—that is money that is desperately needed in the NHS now, isn't it?

Matt Hancock: Clearly, spending money on contingencies is sometimes necessary but you hope not to have to do it. It is better not to have to spend taxpayers' money if you do not have to. We have to spend money on contingencies; we minimise what we have to spend, but there are times when we have to spend it, as a responsible Government.

Sir Chris Wormald: In the health service, this is not unusual, as Simon and Ian both know;, we spend money the entire time on contingencies

for things we hope will never happen. That is what a well-run health service does.

Matt Hancock: One other little point on this is that the money is not coming from the £20.5 billion extra. It is coming from the departmental budget outwith the NHS budget. That, in turn, comes from the £1.5 billion that the Treasury has set aside for Brexit contingency planning.

Q126 **Andrew Selous:** Of that £1.5 billion, has a certain amount specifically been allocated to the Department of Health and Social Care?

Sir Chris Wormald: A very small amount, around some of our extra staffing and the money we have just been talking about.

Q127 **Andrew Selous:** Going back to the second part of my question, what are the other health benefits of the withdrawal agreement being voted through and implemented?

Matt Hancock: There are significant health benefits of the withdrawal agreement and the future economic framework being voted through. First and centrally is the transition, getting the transition and the implementation period so that we have a smooth exit on 29 March, so we can deliver on the vote and do so smoothly. Clearly, it is those transitions that we are most worried about when we are talking about no deal.

The second thing is making sure that we can then build on the political declaration that could not be put into legal form before we exit, because we are not a third country, to make sure that we have a positive, engaged, close relationship, for instance on the European Medicines Agency, which is specifically referenced in the text, to make sure that our life sciences industry is as world-beating as it is today, and more world-beating in the future. The withdrawal agreement and the political declaration lay the foundation for a strong NHS and a strong life sciences industry and for being able to take advantage of the amazing new technology that is coming down the track from which we are very well placed to benefit.

Q128 **Andrew Selous:** Thank you very much. To follow up a little further on a point that Mr Mercer mentioned earlier, there were reports last week of concerns about drinking water in the United Kingdom in relation to our inability to stockpile certain slightly volatile chemicals. Has Public Health England given you any advice or raised any concerns with you in relation to no deal? I think those points were reported to have been raised by the Department for Environment, Food and Rural Affairs.

Sir Chris Wormald: I am sorry; you would have to ask our colleagues there.

Q129 **Andrew Selous:** Public Health England have not raised any concerns about drinking water issues with you. There were reports in the press last week.

Sir Chris Wormald: Not to my knowledge, but it would not be their responsibility to deal with the questions. I have no idea whether what was reported is correct. I make no comment on that at all; that is a matter for them.

Q130 **Andrew Selous:** I am a bit surprised. I would have thought Public Health England would have taken a very strong interest in clean drinking water.

Sir Chris Wormald: The responsibility for the water system lies with DEFRA.

Q131 **Andrew Selous:** But it has big health implications.

Sir Chris Wormald: Yes, in the way that an awful lot of what DEFRA does has public health implications—air quality, for example.

Q132 **Andrew Selous:** That issue is not on your radar at all.

Sir Chris Wormald: No. As I say, you would have to direct those questions to my colleagues at DEFRA.

Q133 **Chair:** Could I return to one of your previous remarks, Secretary of State, about the European Medicines Agency? The political declaration is 26 pages of wish-lists. I am looking at the comments on the EMA: "The Parties will also explore the possibility of cooperation of the United Kingdom authorities with Union agencies such as the European Medicines Agency."

Matt Hancock: Yes.

Q134 **Chair:** Explore the possibility.

Matt Hancock: That provides the basis, once we are not members, and therefore a third country, for putting in place arrangements so that that is successful. The MHRA is a world-class regulator in this space. It provides a significant number of the EMA's registrations and licensing now. Making sure that we remain close to the EMA is important for the UK.

Q135 **Chair:** There is no guarantee. It just says that we will explore the possibility.

Matt Hancock: The nature of the political declaration is that it cannot be a legally binding text on areas where the EU does not have legal competence to go into a legally binding agreement with an existing member state. It provides for the negotiation of that in the future.

Q136 **Chair:** During the transition period, we are just relegated to observer status, aren't we? To imply that this is going to be in any way equivalent, even if we see the deal voted through, is not correct, is it?

Matt Hancock: Both under the deal and under a no-deal scenario, there will be no additional barriers to companies wanting to make sure that their drug gets approval in the UK market.

Q137 **Chair:** We are talking about the EMA.

Matt Hancock: Yes.

Q138 **Chair:** We are just relegated to observer status. That is right, isn't it?

Matt Hancock: In the implementation period, the EMA remains an EU organisation and we will not be members of the EU.

Q139 **Chair:** No, but that was not my question. My question to you was that the MHRA will be relegated to observer status, so it will be a very significant downgrade to our existing situation. Would you agree?

Matt Hancock: I would agree that the MHRA will not be a member of the EMA because we will not be a member of the EU, but the reassurance I can provide is that for companies wanting either to get new drugs on to the market or to have batch testing arrangements, we will ensure that happens smoothly.

Q140 **Chair:** If there is divergence over time, that will not be the case, will it? We will be like Switzerland and end up having a much delayed access to new medicines.

Matt Hancock: No.

Q141 **Chair:** You do not think so.

Matt Hancock: That is not the case. These will be future policy decisions that can be taken, but I am absolutely clear that we will make sure that there will not be additional burdens. There are a number of ways you can do that. For instance, we are committed to ensuring under no deal that the application process—the paperwork and testing needed to make applications for a drug to be licensed in the UK—will be the same in the first instance as the EMA, meaning that there is no additional burden for companies.

There is an alternative way of delivering on that, which we are proposing for batch testing, which is simply the unilateral recognition of EMA batch testing. Therefore, it is absolutely not necessary. In fact, it is possible outside the EU for the MHRA to accelerate licensing arrangements in the UK. This is not an area where I see a problem for access to new drugs, because the MHRA, as I say, is a world-class regulator.

Q142 **Chair:** The batch testing is carried out by a group of people called qualified persons. Are you aware of the concerns around the loss of QPs to Europe if that arrangement is not reciprocal?

Matt Hancock: I entirely understand the need to ensure that we have adequate and high-quality qualified persons, yes.

Q143 **Chair:** Are you aware of the concerns about the QP workforce itself?

Matt Hancock: I am aware of concerns around the workforce in the regulator, and that is important. The purpose of the regulator is to make sure that drugs are available to people in the UK, obviously when they

are safe, and that they are properly licensed and tested. On that, we can provide reassurances that there will not be additional barriers.

Q144 **Chair:** You do not think there will be any shortage of the actual people whose job it is to carry out the batch testing.

Matt Hancock: In the future, we will be a highly desirable place to do that sort of testing because we are one of the most advanced drug markets in the world.

Q145 **Luciana Berger:** Further to those questions, the European Medicines Agency has already moved its headquarters to Amsterdam, and we have lost hundreds of people to Holland who had expertise and were based in this country. Further to that, can you point to any pharmaceutical company—I have had representations from many, and people who work in the field who are very concerned about this—that thinks we will be at the front of the queue or even in the middle of the queue if we are no longer part of the EMA? I certainly have not had such representations from anyone.

Matt Hancock: Actually, I have had exactly those sorts of discussions. They are, I am afraid, commercially confidential in some cases. I can write to you with more details once I loop back on which ones I can be clear about. I am not saying that that is true across the board, but there is absolutely the opportunity for us to remain at the front of the queue under any of these scenarios.

Q146 **Luciana Berger:** You will know that there are many research organisations connected to many of our universities that are world-leading, and we see many drug trials initiated in this country, in particular because of our connection to, association with and membership of the European Medicines Agency. I have had countless representations from bodies that represent all those organisations and individuals who work in the field themselves who say that that is not going to happen; if we are not part of the EMA, we literally will be at the back of the queue. We will not be the instigator and the country that currently leads by example. Currently, we are still just No. 1, but closely behind us follow Germany and Holland in terms of drug trials. Can you guarantee to this Committee that we will maintain our position across Europe as No. 1 in terms of drug trials?

Matt Hancock: As my permanent secretary has explained to me, using the word "guarantee" is not sensible. The reason I am optimistic in my tone in this area is that, absolutely, I recognise the challenges. I recognise the difficulties, in terms both of individuals and of access to market. However, these things are in our gift to get right, and we have the research, clinical, scientific and regulatory capability to have one of the best regulatory systems in the world.

In fact, the work that Simon has been doing with the MHRA to speed up access for very impressive new drugs is the sort of work that we should be doing in whatever Brexit scenario. For instance, the CAR-T cancer

treatment, which Simon got across the NHS within 10 days of it being licensed, is something for which we should applaud NHS England. It is incredibly impressive work. It demonstrates that, if you put your mind to it, you can have a high-quality licensing system with rigorous bars, both for medicines and for medical devices—for medical devices there is a question of whether the bars in some cases need to be tougher—that allows for both rigour and speed of access. This is a really important area, but it is essentially one that we can deliver in any Brexit scenario.

Q147 **Luciana Berger:** I am sure all members of this Committee would welcome that excellent work, as you pointed out, but can you understand that members of this Committee lack confidence in what the future holds when, as our Chair pointed out, the actual text of the withdrawal agreement gives us no certainty whatsoever about what the exact arrangements will be?

Matt Hancock: We can give certainties in areas where we are willing unilaterally to recognise the decisions of the EMA in order to ensure that those drugs can be provided for, but there is work we can do domestically to make the outcome even better than that.

Simon Stevens: The underlying point is: can the UK continue to be an attractive place for the life sciences sector after 29 March? We are all determined that it should be.

Chair, you referenced Switzerland. It is noteworthy, of course, that Switzerland has a very strong pharmaceutical industry, with Roche, Novartis and many others, notwithstanding its non-membership of the EU. In fact, our competition for clinical trials and early-stage development work is less Germany and the Netherlands, and more Singapore, China and the US. We are doing a lot of work with the research community, with the scientific infrastructure in this country as well as the life sciences sector, on figuring out the things that, given the post-29 March situation, will ensure that we continue to be a very attractive place to work. One of those things, of course, will be the stability we now have on the medicines bill for the next five years, and the successor to the PPRS is a very important part of that.

Matt Hancock: Can I add one thing to try to persuade you that you should share our enthusiasm in this area? I want to bring a parallel to the example of NICE. NICE is regarded across the world as first-rate. It is a UK institution and is not fully part of a European-only system; it is a UK institution. Because they are very good at what they do, when NICE approves something—this is for value for money rather than for licensing and safety reasons—it often triggers similar acceptances around the world. We have capability in the UK to get this right and we are determined to do that.

Chair: Thank you.

Q148 **Andrew Selous:** How much more preferable are the arrangements

under the withdrawal agreement than a no deal in terms of reciprocal healthcare?

Matt Hancock: The deal will make it much easier to deliver on reciprocal healthcare arrangements with the EU. It provides for the recognition of social security matters. Social security includes healthcare, and that will allow us to be able to arrange reciprocal healthcare. In no deal, we still can arrange reciprocal healthcare, but we will have to do it on a bilateral basis. Those conversations have already started, and, of course, the Bill currently before the House provides the opportunity for this to continue under both scenarios.

Q149 **Andrew Selous:** Isn't that bilateral process quite slow? I believe we have relatively few reciprocal healthcare arrangements outside the EU; I think we have one with Australia and only very few other countries. Isn't it going to hit people who want a holiday in Europe and perhaps cannot get dialysis if they are in Italy, for example?

Matt Hancock: We are already under way in communications with other European countries in the case of no deal. Of course, the scale of bilateral travel and reciprocal residency is quite broad. There are some countries, such as Ireland, where there is a huge amount of travel and residency in both directions, and there are some European countries where the numbers are very low. You have to get a sense of proportion. In the case of Ireland, we are clear that under any circumstances we will make sure that there are reciprocal healthcare arrangements in place.

Sir Chris Wormald: One of the reasons we need the legislation is that our ability to do reciprocal healthcare deals not outside the EU is severely limited at the moment, because we cannot actually exchange—

Chair: You are quite softly spoken. Can you speak up slightly?

Sir Chris Wormald: Our ability to do reciprocal healthcare outside the European is severely limited at the moment because we cannot exchange cash, so the only ones we have outside the European Union at the moment are where we agree to waive costs for each other, which I believe is what we do for Australia and New Zealand. The Bill gives us powers to intervene to have proper reciprocal healthcare where both sides pay, regardless of whether you are in the European Union or not, so it is probably a power that we would quite like to have regardless of the Brexit discussions. In Brexit, it will allow us to have proper negotiations, if we are in no deal, with our European colleagues about creating proper reciprocal arrangements. We do not have one outside the EU, because we do not have the powers.

Q150 **Andrew Selous:** In terms of the uncertainty and length of time it might take to get those reciprocal deals, is that not another reason why the withdrawal agreement would be preferable in this scenario?

Matt Hancock: The reciprocal healthcare Bill will allow us to do more outside the EU. I was listening to your previous session where the

argument was that we do not have any outside the EU and therefore it will be very difficult with the EU. The reciprocal healthcare Bill will solve both those problems, but there is no doubt that it will be easier to provide for reciprocal healthcare arrangements under the deal as agreed by the Prime Minister. That is a reason both to vote for the reciprocal healthcare Bill and to vote for the deal.

Q151 **Chair:** To clarify, it is just for the transition, isn't it? It is in the withdrawal agreement; it does not continue into the future.

Sir Chris Wormald: It does two very important things. It deals with the stock, that is, people who already live abroad and they—

Chair: Could you speak up, Chris, please?

Sir Chris Wormald: I am too far from the microphone. It deals with the stock, people who are already resident abroad, and then it deals with the flow for the length of the transition period. What happens to flow after the transition period is a matter for future negotiation, but for people already living abroad, the withdrawal agreement is extremely important.

Q152 **Chair:** But it is vague.

Sir Chris Wormald: The only other thing I would add, which I think I may have said to the Committee the last time I was here, is that very few—actually, none—of our discussions with our European partners on any of these health issues have been at all vexed. Particularly around reciprocal healthcare, we all have a lot of mutual interests, and that has underpinned all our discussions. It is why you do not see a lot of health issues come up in the negotiations very much. Both we and our European partners have come at this with the attitude "How do we secure the position for vulnerable people?" I would expect that to go on regardless of which scenario we are in. We would expect everyone to behave in a civilised manner towards people who need healthcare, regardless of what happens with the negotiations.

Q153 **Chair:** In the event of no deal, could you clarify, though, that you would be conducting bilateral arrangements with 27 other nations? It would not just be negotiating with a single entity.

Sir Chris Wormald: Yes. We would have to do bilaterals with all 27. Of course, where we pay for people who are resident, it is a large number of people in a small number of countries: Ireland, France and Spain.

Q154 **Chair:** But there would be very serious complications and consequences for them if there was no deal.

Sir Chris Wormald: Yes. We are taking the powers for which we are seeking Parliament's approval in the legislation because of the importance of that.

Q155 **Mr Bradshaw:** Returning briefly and finally to political reality, Mr Stevens, from everything you have said about no deal, I assume that

when this package is defeated in 10 days' time, as it will be, you would welcome Parliament passing a motion to rule out no deal.

Simon Stevens: That is obviously a matter for Parliament, not for the national health service.

Q156 **Mr Bradshaw:** You do not want the uncertainty of no deal, do you? You do not want to have to spend all this money and have all the uncertainty we discussed.

Simon Stevens: The national health service is democratically accountable to Parliament and will respond to whatever Parliament produces for the country.

Q157 **Mr Bradshaw:** You do not think you have a responsibility to protect the NHS and express a view as to whether you would rather stop no deal than allow it to happen.

Simon Stevens: I have expressed views on a range of topics in the past, but, as we have said today, the responsibility of the national health service in this situation is to do all we can to ensure that the NHS is there for people when they need it under any scenario.

Chair: Thank you. Are there any further points from colleagues? No. Thank you for coming. I know, Secretary of State, that you have kindly agreed to stay on because we have some other questions for you on our Budget inquiry.