

Health and Social Care Committee

Oral evidence: Budget and NHS long-term plan, HC 1712

Monday 28 January 2019

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Johnny Mercer; Andrew Selous; Dr Philippa Whitford; Dr Paul Williams.

Questions 215 - 377

Witnesses

I: Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care; Simon Stevens, Chief Executive, NHS England; Professor Ian Cumming, Chief Executive, Health Education England; and Ian Dalton, Chief Executive, NHS Improvement.

Examination of witnesses

Witnesses: Matt Hancock, Simon Stevens, Professor Cumming and Ian Dalton.

Q215 **Chair:** Good afternoon, and welcome to our second session looking at the NHS long-term plan. For those following from outside the room it is very helpful to know whom you represent. The Secretary of State and Simon Stevens are familiar to most people, but perhaps Ian could start by introducing himself and his role.

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

Simon Stevens: I am Simon Stevens, NHS England.

Matt Hancock: I am Matt Hancock, the Secretary of State.

Professor Cumming: I am Ian Cumming, chief executive of Health Education England.

Q216 **Chair:** We have a huge amount to cover, so brevity would be appreciated. Please don't feel the need to repeat what colleagues on the panel have said if you agree with them.

One thing that has come across loud and clear from our previous session is that there are still many unknowns. We do not have the workforce plan, we do not know how much funding there will be for Health Education England and we do not yet have the social care Green Paper or know how much will be in the future budget—for prevention, for example. Simon Stevens, given all those unknowns, how confident can you be that you will be able to deliver the plan?

Simon Stevens: We have been able to frame the plan knowing what NHS funding for the next five years looks like. We have taken a pragmatic approach to the phasing of the improvements we want to see, and have had the knowledge that, particularly in respect of social care, the planning assumption that we were given by the Prime Minister is that we could plan on the basis that there will be no additional pressures on the NHS as a result of social care pressures over the next five years. That is the basis on which we proceeded. The National Audit Office has had a preliminary look at the planning assumptions used for the plan and determined that they are prudent.

Q217 **Chair:** What is the area that you feel is most at risk?

Simon Stevens: I am sure that one of the conversations we will have today is how we make sure that we are able to expand the workforce to match the increase in funding going into the national health service. There are some detailed proposals in the long-term plan, but we have now embarked on a process with wider stakeholders to put flesh on those bones. Training expansion, return to practice, retention efforts, international recruitment and changed ways of working are all aspects that will be very important in planning the workforce we need.



Q218 **Chair:** For you, workforce is the area you feel most concerned about.

Simon Stevens: That is the principal question. We were able to set out the plan based on prudent assumptions about what needed to happen on workforce, but there is a big implementation process now under way that we will talk about.

Q219 **Chair:** One aspect of the workforce drawn to our attention last week was the bandwidth in the system in terms of management to be able to deal with it. Do you feel that will be deliverable given the management required to implement it?

Simon Stevens: We have been able to frame it as a five and 10-year view of the clinical outcomes improvement we want to see and the service changes to support it. The approach that Ian and I are taking to implementation is to set a fairly detailed implementation framework in the spring—likely to be April—when there will be an opportunity for local NHS trusts, CCGs and our partners in local authorities and the voluntary sector to work together to frame, based on their own starting points, what their implementation plan looks like. We will then bring that together in a national implementation framework after the spending review, when we will be able to feed in the answers we have had on capital investment and other matters. We will be able to stress-test the phasing of delivery against the local engagement processes that will be kicked off in April.

Q220 **Chair:** Ian, is there anything you want to add?

Ian Dalton: No. It sets out the key issues on workforce and talks about the implementation framework. That is fine.

Q221 **Chair:** The implementation framework is when we will start to see whether there is enough bandwidth in the system.

Ian Dalton: Yes.

Simon Stevens: There are certain things that we want to happen everywhere quite quickly. For example, every child with cancer will be offered a whole genome test across the NHS in England this coming year. That will happen everywhere. Other things will take much more joint work: for example, the integration of GP services and community health services, which will arise from the implementation planning that is going to be done locally.

Ian Dalton: The reality is that at the heart of the long-term plan is a series of national commitments that we want to see everywhere. There is also a recognition that there is a complex new care model. That will take time and depends on where you start from. To pick two areas, one in the far north and one in the far south, we need to understand the bandwidth and capability of change and whether we find that to be sufficiently stretching, but ultimately it has to be owned locally by the people who have to deliver the new care model. Inevitably, there is a process of



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implementation that has to be planned locally, and our job is to challenge that but ultimately to support it.

Q222 **Chair:** We will come on to various detailed aspects of the plan, but I know, Ian, that you have to leave early.

Ian Dalton: Thank you for accommodating my twin appointments with parliamentary Committees this afternoon. I appreciate that.

Chair: I want to ask you a question specifically about the workforce implementation plan. What arrangements are being made for the production of that plan? Could you quickly set that out for us?

Ian Dalton: At the moment, there are significant vacancies across the hospital and community sectors. That is not to say patients are not being cared for; shifts are being covered, but we know that the workforce will change and needs to expand to deliver the new care models in the long-term plan.

You will read in the long-term plan many of the ideas about increasing supply, finding new approaches to different professional roles and helping people to work at the top of their licence. You would expect to see all of those highlighted as things we will be delivering over the next period. The challenge now is to populate that with detail and turn it into a detailed quantitative implementation plan, and to pick up on it in such a way that we do not miss 2019-20, because we have things to do in 2019-20, but set a context for planning the subsequent four years.

The chair of NHS Improvement, Dido Harding, has been asked to oversee that. We have brought in a senior chief executive, Julian Hartley from Leeds Teaching Hospitals, to oversee the process. There is a series of working groups, most of which are professionally led; for instance, the chief nursing officer is overseeing the workforce needs of nursing, and Professor Stephen Powis, the national medical director, is overseeing the medical aspects.

The timescale is such that by spring we will publish, alongside the implementation framework for the LTP, an interim report on the actions needed, which will specifically focus on 2019-20. Without going too far ahead of ourselves, I would be surprised if that did not concentrate on areas that included retention of staff, for instance, where we know we can do more and need to get on with it, and possibly on international recruitment. Then we will look ahead. That group will continue to engage with stakeholders so that, by the time we get to the spending review and we know the HEE budget, we will have a definitive report that gives us confidence about workforce growth over the next five years but sets it in the context of the needs of patients over the next 10 years.

Q223 **Chair:** One of the key questions is when you will know how much you have to spend. At what point will you know what you have to spend on workforce before you finish the workforce plan?



Ian Dalton: The key point is that there will be some material focusing on 2019-20. We know we have to expand the workforce now. For instance, we are already seeing very positive results from our retention work with 50-plus trusts. It is likely that we will want to roll that out everywhere. The full analysis will be forthcoming at the time of the spending review and will be in the final report. There will be an interim report in March and then a definitive, costed, detailed report.

Q224 **Chair:** The interim report will be at a stage when you do not know how much money you have to spend, and you will produce the final report afterwards.

Ian Dalton: The interim report will set out in broad terms what needs to be done, but specifically focusing on 2019-20 actions, without which we might lose the first year. It is fair to say that the analysis will then need the spending review to contribute to it, so it will come out in the autumn, after the spending review. That will be the costed, definitive set of numbers.

Chair: We will come back to that later.

Q225 **Dr Whitford:** Ian and Simon, what funding will there be for transformation? Funding was set aside previously for transformation and changing ways of working. You talked about new models of care, and obviously that got used up in debt. It adds up to £20 billion by 2023-24, but it is 3.4%; of itself it is not a big super-charge of money, so will there be additional transformational funds to do the changes while running the NHS?

Simon Stevens: Yes, but not in the way we have done it previously. We are earmarking a local growth fund for primary medical and community health services that will grow each year in real terms and will be worth at least £4.5 billion by the fifth year of the programme.

For the first time in the history of the NHS that will mean that primary medical and community health services are growing faster than the overall NHS budget. That has not been the case over the last five years. We made a start on primary medical, but the community health services element has been squeezed. That investment guarantee provides some headroom but, rather than holding it nationally and allocating it against bids, we are making it available to local areas. They will, however, have to provide an audit trail to show that the extra investment in those services will deliver the service changes set out in the long-term plan.

Ian Dalton: There is a big focus on transformation and improvement. As we have discussed in this Committee before, it is important that we are able to put in enough resource to get the change we need. At the same time, we have been able to create a financial architecture and investment fund that will enable us to make a definitive, decisive move in parallel with that transformation, away from deficits across the trust sector, to



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help to ensure that the NHS remains and becomes more financially sustainable.

We also have to ensure that year by year we reduce the number of trusts in deficit while improving the quality of care. Through the negotiations we have had, we have set a financial framework. We will be writing out to the NHS in even more detail in the spring; we have already given some heads up in the planning guidance that says how from 2019-20 onwards we can see both those things moving forward. It is a balance and we believe we can do both.

Q226 Dr Whitford: How do you propose that the productivity savings that are almost implicit in the plan will be made?

Ian Dalton: They are implicit. One of the key tests was a minimum of 1.1% productivity. That sits in a context. We have to thank the NHS for being probably one of the most efficient and productive healthcare systems in the world. The Office for National Statistics recently noted that 2016-17 data suggested that the NHS was delivering productivity of 3% compared with about 0.6% for the UK economy as a whole, so the NHS is productive. It delivered £3.2 billion of efficiency savings in 2017-18 and is looking to deliver £3.4 billion of efficiency savings this year.

We have a series of 10 areas listed in the long-term plan, all of which we have started work on and are delivering savings. Those will need to be driven hard across all 230 organisations to ensure that we deliver at least 1.1%. This is one of the times when we have a good track record, but every penny we deliver over and above the 1.1% is further investment in patient care. We are asking trusts in deficit to do an extra half per cent, at least. We will help them with that to reduce the number of deficits over the next five years ultimately to zero. In addition, if patches can go further, there are further reinvestment opportunities. Productivity is hard-wired into the implementation of the plan, building on the successes we have had over the past couple of years.

Q227 Dr Whitford: Will the revised standards coming out of the clinical standards review be as challenging as previously? In particular, people are concerned about a change to the four-hour A&E target, which is not a target in A&E itself, but measures that flow through acute services.

Simon Stevens: I do not think we want to prejudge what the national medical director, Professor Stephen Powis, comes forward with in March. We are trying to do several things at once. The first is that we want to lock in short waits for emergency and urgent care as well as for planned and routine care. Equally, Steve Powis is telling us that we need to reflect changes in clinical practice. Since the administrative targets were promulgated, in some cases 15 years ago, the practice of medicine in relation to sepsis, strokes and heart attacks has changed, meaning that the golden hour requires a very early clinical focus on those rather than an average across a four-hour experience for a whole variety of patients.



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At the other end of the spectrum, there is the move laid out in the long-term plan, as you know very well, Dr Whitford, to same day emergency care, where many patients will be on a pathway where they get appropriate medical treatment that avoids the need for overnight hospital admission. Therefore, three hours 59 minutes is not a clinically relevant bifurcation point to decide whether or not they have to be admitted. Those are some of the considerations Professor Powis and colleagues have to take into account. They will make their recommendations and we will field-test them across the health service for the first half of next year, before they are implemented.

Q228 Dr Whitford: But the aim is to implement things that are more clinically relevant rather than move the standard because we are not meeting it.

Simon Stevens: Precisely.

Q229 Dr Whitford: Can I ask about clinical standards? Obviously, the golden hour and the acute waiting time is important; other waiting times are often less clinically important to outcome but are obviously important for the convenience of the patient. Ian, what are the standards regarding how patients are treated for particular cancers and diseases if what you want is to drive up the quality of treatment they actually get?

Ian Dalton: Professor Powis's review will look not only at the existing targets for elective and emergency care, important though they are, but at important areas such as mental health, where we have been making a big investment push and we need to do more. The long-term plan sets out the extra investment in quite a high degree of detail.

We want some standards against which to measure the responsiveness of mental health services and, to pick up your very important point, Dr Whitford, the cancer targets we need going forward. In particular, we have a big aspiration in the long-term plan for more rapid diagnosis, which contributes to positive outcomes. We will be looking at where Professor Powis goes on that and what we need to do, given that we have already committed to tightening up the diagnosis standard from 2020 so that people get more rapid diagnosis of their cancers, and then more rapid decision making and treatment can ultimately ensue.

Building on Simon's point, this is a clinically-led review, taking into account the views of the experts, who will then advise us on the way we hold the NHS to account for both prompt and high-quality treatment. That process is the right way to proceed.

Q230 Dr Whitford: I am talking about clinical standards as opposed to waiting times, regardless of whether it is for cancer. Those have largely disappeared across England. Obviously, the getting it right first time programme is bringing them back. Having led on that in Scotland, I know that it is treatment that changes outcomes.

Ian Dalton: Sorry, I misunderstood the question. Let me strongly clarify the answer. The getting it right first time programme, which is a major



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clinically-led change programme that started in orthopaedics, has rolled out through surgery and is now rolling out through medical specialties. It will go on to look at mental health, community services and, potentially, primary care. It is led by Professor Tim Briggs and has already identified best practice and the ways of tackling the variation that we know exists in clinical standards across all healthcare systems. We are no exception to that. There have already been significant improvements in, say, orthopaedic care that we can point to directly as a result.

We are completely committed, as part of the LTP implementation, to that work rolling out across all specialties and informing what actually happens to patients. The reasons for that are twofold. The first is that it identifies fundamentally the way the experts tell us is the best way to care for our patients. As somebody who has worked in the NHS on and off since 1984, that is motivating for me, as it is for others. Every healthcare system has variations. Making sure we minimise them and deliver in other specialties the kinds of benefits we are already seeing in orthopaedics would be helpful. The second point, which is linked to the question on efficiency that you asked, even if it is not driven by that, is that often better care is more efficient care as well. That is a critical part of our change model. It is already delivering results, and we are completely committed to driving it hard over the next five years.

Q231 Dr Whitford: I totally agree that proper clinical audit, not just of the surgical components but of whole pathways, through peer review, can drive up performance year on year.

Ian Dalton: Undoubtedly.

Dr Whitford: I led on that in Scotland.

Ian Dalton: Yes.

Q232 Dr Whitford: The president of the Royal College of Ophthalmologists has raised concern that the national ophthalmology database is going to lose its funding in August. It has run for nine years and has reduced complications by 30%, and suddenly it is losing its funding. That does not really fit with the approach of looking at outcomes, quality and risk stratification within groups of patients with common conditions.

Simon Stevens: I am very happy to get Stephen Powis to have a look at that and be in direct touch with the president of the college. As a general point, though, the clinical audit programmes across England have been a huge success over many years, but sometimes there is frustration that the pace of adoption of the revealed need for improved practice has been rather slow, and the year-by-year improvements might be a percentage point or two instead of much bigger steps.

Part of the conversation is simply about having stand-alone individual specialty-based audits. That has to be hard-wired into a quality improvement process that is mainstreamed across all hospitals, and indeed the primary and hospital interface. Building on what Ian just said,



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part of that is what we are doing in the long-term plan, because it was developed with clinical groups and a number of patient groups, such as the British Heart Foundation, the Stroke Association and Diabetes UK, which have a strong focus on clinical quality improvement. We have a number of specific improvements in the plan that we will implement and track.

Q233 Dr Whitford: Do you not think there is a danger, if there is not acceptance of audit as an integral part of care, which we tried to develop, that that is what will bite the dust when funding is tight?

Simon Stevens: We are spending millions of pounds a year funding those audit programmes. Professor Powis will look at the specific one on the eye audit that you mentioned, but across the piece NHS England is allocating millions of pounds to fund the audits led by the royal colleges.

Q234 Dr Whitford: You do not think they will be under threat when funding starts to get tight.

Simon Stevens: I do not want to comment on that specifically. I will get Professor Powis to do that.

Q235 Dr Whitford: Perhaps I might ask the Secretary of State about opening up genome analysis of healthy people to 5 million. My understanding is that, of the initial 100,000 tests, one in five were found to have something abnormal. Is that not going to suddenly dump 1 million worried well patients into the NHS? Is that not a concern you would have?

Matt Hancock: No. The proposal is that, having achieved the goal of 100,000 whole genome sequences in December last year, which is a world-leading effort, we now have a goal of 1 million whole genome sequencing as part of a wider ambition and expectation that there will be 5 million partial genome sequencing. Partial sequencing is much cheaper and is targeted at specific areas of concern where a presentation is made of a particular risk or concern.

The million is split into two. We already have a biobank of consented clinical records, and the genomes of those on the biobank will be sequenced, which will provide an internationally significant research bank for the link between clinical and research data and genomic data. The other half a million will come through those who need NHS treatment and whose whole genome sequence is part of that treatment. For instance, there is early evidence from a trial at Addenbrooke's, where they regularly sequence the whole genome of children who have conditions, that it changes the clinical pathway and treatment of those children in around three quarters of cases, so it is very positive.

Q236 Dr Whitford: There is no issue about using it, particularly in childhood cancer, which Simon referred to. In the article you are quoted as saying that healthy people would be able to pay a few hundred pounds to have their genomes sequenced, and they would get the result. Anyone in



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primary care knows that when people go privately to get a whole-body scan, they turn up at their GP saying, "What does this mean?" Surely, bringing the worried well to look at their genomes completely out of context is going to add enormous pressure without our having solved the basic needs of the NHS first.

Matt Hancock: It needs to be done in context.

Q237 **Dr Whitford:** This talked about healthy people—healthy volunteers.

Matt Hancock: Yes, but healthy people who have their genomes sequenced can find problems they did not know previously existed.

Q238 **Dr Whitford:** It is one in five within the 100,000.

Matt Hancock: That allows them to change behaviour, have preventive treatment or otherwise take action that can reduce the long-term pressure. The key is that it has to be done properly and carefully in the correct context, as you described it, to make sure it is done properly, but ultimately it will reduce demand by supporting the prevention of illness.

Q239 **Dr Whitford:** I am not necessarily convinced of that. Their first stop will be going to their GP to ask them to interpret what it means and, depending on how quickly it is done, that could put in a huge additional burden of worried well in a relatively short period.

Matt Hancock: Not necessarily. You refer to it being done out of context.

Q240 **Dr Whitford:** They are not ill; they are not doing it because they have an illness.

Matt Hancock: If part of the package that is put together to allow for this is to include counselling and appropriate understanding of the results, you can get the upsides while mitigating those concerns.

Q241 **Chair:** Have you looked at the possible widening of health inequalities as a result of the tests?

Matt Hancock: There is also the ability to save people's lives. You have to look at both.

Q242 **Dr Williams:** Secretary of State, that would be screening of healthy people. Would the National Screening Committee have a role to play before something like that was rolled out?

Matt Hancock: We need to take a broader look at the whole approach to screening. The Mike Richards review of cancer screening is mostly because the process of delivering screening has been imperfect and has had problems. We need to make sure that the way it is organised is good. We also have health checks for healthy adults aged between 40 and 75, and there are questions about whether they are being delivered locally and differently in different places.

Q243 **Dr Williams:** My question was specific to the proposal for genomic screening of 1 million healthy people. Will the National Screening



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Committee have a role to play before that is rolled out?

Matt Hancock: Potentially. That idea has been brought up and is being discussed. The reason I answered the way I did is that there is a whole different series of actions that are broadly in the preventive space. Some are called screening, with a capital S, and are done by the NHS; others are done by Public Health England and others are done by local authorities. The genomics are new and not yet operational. At the moment, some of them are done through contracts. One is done through a Capita contract; others are done directly. They all need to be looked at in the round to make sure there is a strong clinical basis behind them.

Dr Williams: I think we would take reassurance if the National Screening Committee looked at genomics first.

Q244 **Chair:** We have a huge amount to get through. One further aspect of funding is the huge maintenance backlog. We have been given evidence that it is around £6 billion, of which over £1 billion is high risk and over £2 billion is significant risk. In itself, that is starting to have an impact on local services. My local hospital has two theatres out of action—it had three out of action until recently—because of inadequate extraction systems. Are you able to give the Committee an assurance that we will make progress on tackling the maintenance backlog as it affects the estate and equipment?

Ian Dalton: We discussed this the last time I was before the Committee. We have seen a rise in maintenance backlog of a couple of billion over the last couple of years. The UK is spending a smaller proportion of its health expenditure on capital than an OECD mean by quite a significant amount. Those two factors are potentially linked. It will be important to support the implementation of the long-term plan so that we can both ensure that current facilities are fit for purpose in 2019 and over the next five years, and that we have sufficient access to capital, from whatever source, to invest in the new services we will need to deliver the new care model. That would include new services in the community, for instance, for people who otherwise would have been cared for in hospital.

At the moment, we can clearly reference the additional £3.5 billion that the Government put in and has now been committed. The question is whether we can go further and bite into that and, at the same time, develop a range of new hospitals and facilities while also addressing the backlog, given the ageing estate and a rising backlog. That is something we will have to discuss when we see the capital settlement we get as part of the spending review. As I mentioned last time, my perspective is that a significant build-up of capital demands has grown over the past few years and has resulted in ageing facilities. That is both buildings and some forms of equipment, like scanners, so there is more to do.

Q245 **Chair:** Secretary of State, are we going to see more of the capital to revenue transfers that we have seen over the last four years?



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Matt Hancock: I very much hope to avoid that. The fact that we have a five-year cash settlement means that the NHS can now plan its revenue budget over those five years. That planning is under way. It is already set out for 2019-20, and after that we will have a settlement for the last four years of the five-year cash settlement that is agreed.

Q246 **Chair:** The plans for the Naylor review were dependent on private finance of £2.8 billion. I understand that has now been ruled out, so will there be a gap?

Matt Hancock: We will need to address that in the spending review. There is not much more we can say before the spending review. The fact is that the collapse of some of the PFI projects has added to pressures on the capital budget, because we had to bring two hospital building projects on to the balance sheet this year. That was necessary to get the hospitals finished in Liverpool and Birmingham. They are absolutely critical hospitals and they will be brilliant when they are completed. They will be completed because we are now paying for them directly from the NHS capital budget.

Q247 **Mr Bradshaw:** Mr Stevens, how will your ability to deliver the plan be affected by Brexit, if it happens?

Simon Stevens: We have been able to frame the plan in the knowledge of the referendum result and the Brexit planning that is under way. As we have discussed before, we now have revenue certainty for five years. We have, therefore, been able to be pragmatic in the way we have thought about the improvements we will see. As you know, there is a lot of work under way on operational contingency planning, depending on the precise scenarios that face us. There is a set of issues around workforce that we are preparing for very carefully, and then there are broad consequences around research collaborations and so on. Frankly, the situation has not changed relative to our previous discussions as far as the Brexit aspects of delivering the long-term plan are concerned.

Q248 **Mr Bradshaw:** When you came before us before Christmas, before the Prime Minister called the vote on her deal, you were very clear that the contingency plans that you had ready to go would have to be activated by Christmas or early January if there wasn't a deal. As we all know, there wasn't a deal and there still isn't. Have those plans been activated, and could you tell us what they involve?

Simon Stevens: They have. In the first instance, they involve the work that the Department of Health and Social Care is leading with the medicines and devices supply chains to size buffer stocks and ensure that the Department for Transport knows the contingency requirements of the NHS. In addition, we have been looking at the non-clinical supply requirements for the health sector and making sure they are factored into the transport logistics that would be needed in a no-deal scenario. As both Matt and I have said, provided everybody does what they are supposed to do, particularly the transport infrastructure—we are



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completely reliant on the Department for Transport infrastructure—we expect the availability of those supplies to continue.

Q249 Mr Bradshaw: The supermarkets have made it quite plain today that, in the event of a crash-out no deal there will be a serious shortage of vital foodstuffs, and prices will go up. Why should we expect any difference when it comes to vital medicines and medical equipment?

Simon Stevens: I believe that planning for food supply is being led by DEFRA. The Department of Health is working closely with other parts of Government, but as far as the NHS is concerned, obviously we have a different set of supply chains, with the pharmaceutical industry, devices and other medical supplies. We are having very detailed company-specific and product-specific conversations about uninterrupted flows.

Q250 Mr Bradshaw: The pharmaceutical industry has been quite clear with us in the past that, in the event of a crash-out no-deal Brexit, there would be problems. They and you rely on the same transport routes in and out of the country as the people who provide our food, so I do not understand why it is all so rosy when it comes to medicines and medical equipment compared with food.

Matt Hancock: Medicines will be prioritised in the event of a no-deal Brexit.

Q251 Mr Bradshaw: Medicines will be prioritised over vital food.

Matt Hancock: Medicines of course will be prioritised. We have been through detailed line-by-line analysis of the 12,000 medicines licensed in the UK. We had our latest meeting on it this morning—the three of us were there—in order to ensure that there is a plan for continuity of supply for all medicines in the event of a no-deal Brexit. The pharmaceutical industry has risen to the challenge and done its duty thus far. A lot more work still needs to be done in the remaining time, but we have the time necessary to do what we need to do.

Q252 Mr Bradshaw: By your answer, you seem to imply that it will not be possible in a crash-out Brexit to guarantee both medicines and food, and that, with your colleagues in DEFRA, you have prioritised medicines over food.

Matt Hancock: Of course medicines should get priority over food, but, as Simon says, the amount of work going into no-deal planning for medicines is very significant. For food, the lead is DEFRA. The explanation in terms of food is that the proportion of food that is imported is much smaller than for medicines. For imported medicines, about half have some touch point with the EU, in terms of the number of medicines, not necessarily by volume. Just over half have some touch point with the EU and, therefore, we need a plan to mitigate the challenges in the event of significant disruptions at the border. That is the work we are undertaking.

Q253 Mr Bradshaw: Your former ministerial colleague Ben Gummer said today



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that it is impossible to have all the necessary legislation in place, whether or not there is a deal for us to leave at the end of March, to deal with all of the contingencies. Is he right?

Matt Hancock: No.

Q254 **Mr Bradshaw:** So, in spite of the quagmire in both Houses of Parliament, when it comes to the statutory instruments, you are confident that you will get all the legislation through both Houses of Parliament by the end of March to deal with the contingencies of a crash-out no-deal Brexit.

Matt Hancock: We have a clear plan to ensure that all the legislation that the Department of Health and Social Care needs will get through.

Q255 **Mr Bradshaw:** You might have a plan, but it is not happening in reality.

Matt Hancock: Yes, it is. We have taken a number of SIs through in the past couple of weeks.

Q256 **Mr Bradshaw:** You are on schedule to get them all through in time, are you?

Matt Hancock: Yes.

Q257 **Mr Bradshaw:** In that case, why did you say to Andrew Marr yesterday that you may have to consider curfews, martial law and emergency legislation to deal with some of these contingencies?

Matt Hancock: I did not.

Q258 **Mr Bradshaw:** When he asked you what you meant by emergency legislation to deal with these contingencies if you did not get legislation through, you said, "I wouldn't put the stress on that, but you're looking at all options." That does not sound to me as if you are exactly ruling out martial law and curfews.

Matt Hancock: There is no such thing as martial law in the UK; there is the Civil Contingencies Act. In the Department for Health we look at that Act. It is an option all the time for all sorts of considerations. We are always planning for things that we do not want to happen; that is part of the nature of a health department. As I said yesterday, it is on the statute book but it is not what we are planning to use.

Q259 **Mr Bradshaw:** It does not really matter what you call it; it is what it would mean in effect. What would those emergency measures be under the civil contingencies legislation? What sort of things were you talking about?

Matt Hancock: We are not planning to use that legislation, but it is on the statute book. That was what I said yesterday and it is what I repeat today. I can see what you are trying to encourage me to say, but we have planning for a no-deal Brexit.

Q260 **Mr Bradshaw:** I am just seeking clarity on behalf of a very worried



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public in this country about what on earth you are going to do in the event of these things happening. You may not like to think they are very likely, but at the Committee we have spoken repeatedly to experts from the medicines industry, who are responsible for supplying medicines and medical equipment to the public, who think it is perfectly possible they will happen.

Matt Hancock: I am giving you the absolute assurance that, if everybody does what they need to do, the continuity of supply of medicines will be in place no matter what the Brexit scenario.

Q261 **Mr Bradshaw:** Mr Stevens, would it make your life easier if Parliament ruled out no deal tomorrow?

Simon Stevens: That is a discussion we have had before. I repeat what I said in response to the same question last time. The NHS is here to provide care for patients when they need it and we would not seek to trespass on Parliament's territory, which is to answer that question.

Chair: We come to Andrew and an examination of the shift from hospitals to primary and community care.

Q262 **Andrew Selous:** I want to start by asking what lessons have been learned from the 2016 general practice forward view in terms of the GP workforce, because that plan committed to 5,000 extra GPs by 2020. On current numbers, it does not look as if we will get there, so what have we learned? I have the 2016 review before me. It was very positive and upbeat, but we have not achieved it in this absolutely critical area, so what are we going to do differently?

Matt Hancock: Maybe I should give an overview and then I am sure that both Simon and Ian and maybe Ian Cumming will want to add something. There is a clear need for greater provision of primary care, and that is at the core of the long-term plan. It is a core part of the prevention agenda, and it is very important. The provision of primary care is changing to make sure that it is delivered by a broader range of practitioners, not just GPs but others who can provide the services and healthcare people need in primary care, whether that is a physio or a nurse in certain circumstances, and the GP where that is necessary, and a stronger link to community services. To deliver that, we clearly need more people and use of technology, and to make sure that the provision is fair across the country.

Within that, we have been successful in the target for hiring more health professionals other than GPs. We have been successful in getting the number of GPs in training up to record levels; in fact, we overshot the target for GPs in training. The problem has been that the number of GPs either retiring or going part time has been higher than was expected at the time of the five year forward view, and we have a whole load of work to try to change that.

Q263 **Andrew Selous:** GPs leaving in their mid-50s because they are hit by



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some of the implications of the current pension scheme is something that the Department has been exercised about for a while. In the survey information you get back from GPs who are retiring early, is that a significant issue and, if so, have you made any headway with the Treasury?

Matt Hancock: As you know, and as reported in the magazine *Pulse*, I have been in conversation with the Chancellor about that particular issue. It is not the only issue, but it is one.

Q264 **Andrew Selous:** On international recruitment, what sort of numbers are you looking at? The 10 year forward view still commits to 5,000 extra GPs, but it just says as soon as possible, rather than by 2020.

Matt Hancock: Yes.

Q265 **Andrew Selous:** As you say, 3,400 medical students are going into general practice this year, following 3,100 last year, so that is excellent. But the net figure, as I understand it, in terms of full-time GPs, was minus nearly 1,800 between 2015 and 2018. What sort of scale of international recruitment are we looking at for GPs specifically, to get up to the 5,000 figure?

Matt Hancock: We have a stated target only for the overall figure, because how we achieve that depends on the level of success in retention of GPs. Ian has been leading the charge on international recruitment.

Ian Dalton: Simon, one for you I think.

Simon Stevens: Sure. We have been working on recruitment from the EU, obviously, but have been ramping up in recent months the offer in Australia as well, working with Ian Cumming and NHS Employers. All this needs to be seen in the context of some very big changes that are about to be introduced across general practice.

I do not want to prejudge the announcements that we hope to make shortly, but we have been in discussion with the BMA around a new GP contract to give life to the primary care network, to have practices working together as described in detail in the long-term plan. That will provide much more opportunity for mutual support between practices so that practices that individually are struggling will get extra staff and support from other practices in their area, linked to community nurses, serving a 30,000 to 50,000 population. That is backed by their share of the extra £4.5 billion for primary medical and community health services.

We are hopeful that that package will send a clear signal to precisely the people you are talking about—the very hard-working GP partner in their late 50s or 60s who thinks, “Shall I stick around for another five years or shall I head off?” There are issues around pensions, but if people can see that the cavalry is arriving, that will supplement the good news you described—the extra GP training that is coming into the system as well.



Q266 **Andrew Selous:** On the training point, there seems to be a little bit of confusion about the Health Education England training budget, whether it will be subsumed into a departmental budget and quite what that would mean in terms of placements for doctors and other health professionals developing training practices and so on.

Matt Hancock: Could you explain what the confusion is a bit more? It is news to us.

Q267 **Andrew Selous:** I have a brief from the Royal College of GPs. They are concerned about what is going to happen to the education and training budget—a point I raised in Prime Minister's questions a couple of weeks ago. They do not feel that they have clarity on how it is going to be increased, and what place it will have as part of the long-term plan, particularly to support GPs through the mix of other clinicians around them, and in making their own working lives more significant. That is a key part to go alongside the new contract; it is separate from the new contract, as I understand it. I understand from the Royal College of GPs that that is the issue they are most exercised about.

Matt Hancock: The training budget and the Health Education England budget will, of course, be set in the spending review. It is not going to be subsumed into the Department at all; in fact, quite the contrary. As Secretary of State, the HEE reports directly to me formally and by statute, but I am very clear that I want Ian and his team to report to the NHS and deliver on the business needs of the NHS. The plan will then come to me to make sure that it is entirely tied into the delivery of the long-term plan for the NHS. Of course, the quantum will be set in the spending review, but the structure and how we deliver it is very clear.

Professor Cumming: Specifically in terms of numbers, we had a record number of GP trainees recruited last year, and it is our intention to go for a similar record number and beat the target again this year. We have factored that forward in our budgetary expenditure over years to come. Yes, we will look as part of the spending review to attract additional income to be able to fund that, but we are certainly not reducing it.

Q268 **Andrew Selous:** I am raising a slightly different point. The issue that current GPs are concerned about is the training budget for practice nurses, physios and all the rest of the team in primary care. They do not think that is there. They say it is critical to help them do their job, and the fact that it is not there is quite a big part of why so many are leaving, and why the net figures are down.

Professor Cumming: This is investment in lifelong learning and continuing professional development. Over the last few years, that budget has reduced in real terms. We have, however, increased it by 50% from last year to this year, and we are seeking to put more resource into it next year. Just last week, we agreed to put £22 million into funding community education hubs, which allow education and training to be delivered for groups of GP practices around particular localities. It is



much harder delivering education in the community than it is in a hospital, for example, where you have everybody working in the same place. Bringing GP practices and community providers together in a hub for ongoing education, training and development, which we have committed to fund, allows the community workforce to have access to the same level of education and training as their hospital counterparts.

- Q269 **Andrew Selous:** It was put to me by someone pretty senior in the health world last week that some GPs quite simply get bored with their work. We are talking about the brightest 1% educationally of the population; anyone who is in medical school is in that category. Hospitals can seem more exciting and, sometimes, the pure repetition of the work can sometimes be a reason why they leave.

Matt Hancock: I don't know what your Chair thinks about this question.

- Q270 **Andrew Selous:** Indeed. I rest my case, looking at the career choices of two of our distinguished colleagues either side of me. But it is a serious point. We are not a dictatorship; we cannot force people to do any job in the NHS. People have to enjoy doing their work.

Simon Stevens: That absolutely could be said of being a dermatologist, an ENT surgeon or a gastroenterologist. What we need is flexibility over the course of professional careers. Medicine is constantly changing—that is certainly true for general practice—but the specialty of generalism is increasingly important in an era of multimorbidity. The flexibility of primary care, in that practices can develop and expand their services, is in some ways far greater than an individual consultant would have in a hospital setting.

The fact is that people are increasingly choosing to combine their clinical sessions with other work as GPs, whether it is leading the redesign of services, or the big change programme that we are going to unleash for out-patients, which will change the interface between specialists and general practice, supporting teaching and research in primary care as well. That concludes my advertorial for general practice in the national health service.

Matt Hancock: We are going to see an unparalleled level of excitement in primary care over the next 10 years, heralded by the long-term plan. If you are a GP, no longer is the partnership model the only way forward. Primary care networks will allow GPs to be leaders of their profession in their locality and, with a whole range of other care providers working in their team, I can see it being far more dynamic.

Simon Stevens: Which is why young doctors are voting—

Matt Hancock: With their feet—

Simon Stevens: And in increasing numbers, to sign up for general practice education.



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Q271 **Andrew Selous:** Can I get a question in edgeways on the back of your enthusiasm, which is wonderful to behold? I hear what you say; it is a very good story, and I am encouraged by it, but by when will we have a net increase in the GP workforce? The current figure is, unfortunately, heading down. You say as soon as possible, but—

Matt Hancock: That is just what I was going to say, yes.

Q272 **Andrew Selous:** But would either of you like to mention a date as to when we will have a net increase?

Simon Stevens: We are seeing a couple of things happening. First, we see the upturn in the number of new doctors coming into general practice and, of course, we have an increase in the overall number of doctors coming through. To that extent, with the expanding number of medical school places, we are able to sustain the enthusiasm for general practice and deal with some of the factors that mean there is early retirement. Within the next several years, we hope to see that corner turn, but I do not want to make spurious predictions, because that is not the kind of fact-based evidence you expect.

Chair: I do not agree with the stereotype of general practice either, but you would expect me to say that.

Q273 **Johnny Mercer:** All of that sounds fantastic, but in Plymouth we still have a GP shortage, of 30 GPs. What are you going to do to try to attract GPs into areas where, for one reason or another, they may not want to go? There may be factors specific to a community that make it very difficult to recruit GPs. We have just been on a massive recruiting surge and we got two, which does not scratch the surface of the problem. You have just clearly advertised how important GPs are to access to health and the NHS as it stands. What are you doing to encourage them to come to specific areas and cities like mine?

Professor Cumming: There is a direct correlation between where people train and where they end up working, so the first thing we need to do is to attract more trainees into areas where we need to recruit more staff. That is why with the allocation of new medical school places we specifically went to parts of the country where we were under-doctored, because we know that there is a correlation between medical school and postgraduate training and consultant or GP contracts.

There are other things we can do. One of the more successful schemes that we have piloted was to offer people an additional year of training after they become a qualified GP to gain extra clinical expertise in an area that may interest them, such as psychiatry, care of the elderly or whatever it may be. We have co-funded that in return for people taking a job in a part of the country where it is particularly hard to recruit. They may come to your constituency, where they would work as a GP, but, for a day a week, we would fund them to go into the local hospital or work with some of the specialists in the area to gain extra knowledge and expertise, which they would continue to be able to practise for the rest of



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their career. Those are just two examples of things that are having a real impact on some of the hard-to-recruit areas.

Q274 Johnny Mercer: Is there anything else? That is good, and the number of places is great. We have 40 new places at Plymouth University, and in eight years' time we will see the benefit. What are we doing to alleviate the challenge that directly impacts getting more GPs into Plymouth at the moment?

Professor Cumming: Prior to last year, we had 3,250 GP training places in the country. We have increased that, because we were able to over-recruit. We have gone out and identified an extra 220 training places. Those people will then move through to the second year, and we hope that we will be able to over-recruit again this year. By putting those training places where we have particular shortages of GPs, we start to feed the pipeline. There is no solution through the training pipeline to this happening overnight, because we need to build people and they need to go through their three-year training.

The other options are around what we can do to attract people. You mentioned the expansion at your local medical school; colleagues in some of the new medical schools have been saying that, simply by expanding the medical school and creating teaching jobs, they have been able to attract doctors to the area who want to be involved in teaching as well as in delivering services.

Q275 Johnny Mercer: With all that money going into projects like that, in the short term, why don't you just pay them a bit more? Why not incentivise them through their pay packets to go to some of the really difficult areas to try to get a handle on what some people would perceive as almost a crisis level of GPs?

Professor Cumming: In some training posts—bearing in mind that we are responsible for the training side—we have incentivised GP trainees to go to areas where they have never had a trainee before. That has been very successful, and we will continue to do it.

Q276 Johnny Mercer: Simon, are you thinking of rolling that out further across GP practices?

Simon Stevens: We are. By definition, this is to some extent a zero-sum game within a given supply, but we want to improve the fairness of the distribution of GPs across the country. As Ian has just said, we have been offering £20,000 bursaries for trainees to work in practices that have historically had difficulty in filling places, which has been very successful in the parts of the country where it has been tried. We are looking to expand that, yes.

Johnny Mercer: Okay.

Simon Stevens: I take that as a bid for Plymouth.

Johnny Mercer: Thank you. Excellent.



Chair: You also wanted to ask about mental health.

Q277 **Johnny Mercer:** I do. On the issues around mental health that have been brought up by the plan, it sounds fantastic—lots of money, a long-term plan with a strategic direction of change. But those going through the system, such as constituents I had coming in this weekend, say, “This all sounds great, but my son has schizophrenia and is still on the waiting list.” The CAMHS list is still at 12 to 16 weeks, and 32 weeks in some areas. How will NHS users see a fundamental change in their experiences of going through the system? Up here, we are very good at saying that we will put billions of pounds into this and do X, Y and Z. But what is your plan actually going to mean for Mr and Mrs Smith, who struggle to get their son mental health treatment in some of our poorest communities in this country?

Simon Stevens: It is going to mean another 345,000 children and young people getting the services they need over the next five years. That ties right back to the question we began with, which is the phasing of workforce expansions, with extra trainees, including the psychologists and counsellors who are needed to do that expansion. We are doing work with schools to see whether more schools-based support reduces the feed-through into the need for specialist CAMHS services. That will not be the case for conditions such as schizophrenia, where, obviously, there is the early intervention for psychosis service, which we have begun implementing. Meeting the waiting times that we have initially set for that across the country will be very important.

There is a big programme for the expansion of children and young people’s mental health services, but there are some things we do not know. We do not know, frankly, what the right balance should be between schools-based support versus specialist CAMHS services, which is why we are testing the new models in between a fifth and a quarter of the country to answer that question.

Matt Hancock: There is another change that we are bringing in that has come to me through my own constituency cases. When children become adults, with the current gap between CAMHS and adult mental health services, children who have access to CAMHS lose access to mental health services because they reach their 18th birthday. That is clearly wrong, so changing the pathway for those already in CAMHS to continue to get access up to 25 is a very important part of the change in mental health provision.

Q278 **Johnny Mercer:** You are testing mental health support in schools. What is that actually going to look like? Are you looking to do it in a quarter of the country at the moment?

Simon Stevens: Yes, between a fifth and a quarter. The mental health prevalence survey published in November is the most recent authoritative look at how much mental illness, stress and other mental health problems there are among children and young people, and what the



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service availability looks like in the round. What it said, roughly speaking, was that about a third of young people with mental health distress were getting support from schools, counsellors or other non-NHS services, about a third were getting support from specialist NHS services and about a third were not getting any support at all. We obviously want to make sure that the third of people who are not getting support, but would like it, get it. We are testing what proportion of that third should be getting it through counselling or schools-based support versus specialist mental health support.

Q279 Johnny Mercer: In gathering that evidence, have you looked at other countries that face similar challenges? Have you looked at some of the work they have done in Trieste in Italy, or in any other places where they are looking at how to cross-pollinate support from schools into communities and so on?

Simon Stevens: We have, and it was instrumental in shaping the Green Paper proposals. As you know, there is something called the international mental health benchmarking service, which looks at different service structures. There is obviously a lot of research literature that has been developed in young people's mental health services as well, and we have been working closely with the Royal College of Psychiatrists, the Royal College of Paediatrics and Child Health and various children's organisations, as well as the Children's Commissioner, on what the package of support should be.

Q280 Johnny Mercer: How would you judge, if you were sitting here in five years' time, what success looked like? With mental health, more people become aware of it, and so on, and it is about getting a handle on the problem. We hear about the massive growth in mental health problems, and we try to get a balance of whether that is about more awareness or more people actually presenting. We were sitting here a year ago, and you mentioned that we were going from meeting one in four to one in three mental health needs. What would progress in five years look like?

Simon Stevens: To underline the point, that one in three is one in three getting NHS support. It does not mean that the other two thirds of people are getting no support at all; it means that half of the two thirds—the one third, as it were, who are not getting looked after by the NHS—are getting some other support.

The straightforward answer to the question is that, over the coming five or, certainly, 10 years, everybody who needs specialist NHS support should be getting it, but exactly what the balance looks like between NHS support and other support will arise from the pilots. In the meantime, we want to use the pilots to test how quickly we can introduce waiting-time standards; for routine services, we will test a four-week waiting time, but we will have a more fast-track waiting time for the most urgent cases. We have begun with eating disorders, where we are doing well with service expansion.



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In a nutshell, we will have appropriate services, some of which may be specialist NHS but some may not. The balance is right, and everybody who needs access will be able to get it, and there will be clear waiting-time standards for doing so. That is what success will look like over the next five and 10 years.

Q281 Johnny Mercer: We have talked before about having a dashboard where you can see how much CCGs commit to mental health and so on. Is there any way to make that information public so that individuals suffering from a mental health problem have confidence that they will be treated? For a lot of them, the difficulty is in coming forward. If the service is not there, it compounds the difficulty. Is there any way of making it public, whereby if you come forward with a mental health problem around depression in Plymouth you are likely to get treated in X number of weeks?

Simon Stevens: There is. That is exactly what we are going to do. The mental health dashboard will get more specific around children and young people's mental health services. The new news in the long-term plan is that, as well as saying that overall mental health spending has to grow faster than the NHS budget, within mental health spending children and young people's services have to grow even faster. We will have an audit trail and transparency on that, which we have not had before.

Johnny Mercer: I am talking literally about the measurability of that, because people have become cynical about hearing—

Simon Stevens: Yes, we do not just want to track the pound notes; we want to track the services.

Q282 Johnny Mercer: No, you do not want to track the pound notes, but you want to see a distinguishable difference, if you live in one of our most deprived communities. People see all the millions of pounds being thrown at it, but you should speak to Mrs Miggins down the road, whose son has just waited for 12 weeks for CAMHS, and wants to know whether there is a place that tells them that the wait in Plymouth is five weeks.

Simon Stevens: Yes, it will be the mental health dashboard, which will publish those data.

Matt Hancock: You cannot manage what you cannot measure. In the big picture, one reason why in the past we have seen more rapid increases in funding go to, say, A&E compared with mental health services, has been that that is where the targets were. Having transparent, clear targets that the local NHS, national leaders and indeed politicians are held accountable for is a very important part of getting this right.

Q283 Chair: We are running very behind. We have a lot to get through, but before we leave communities I want to raise the question of dentistry, which is absent from the 10-year plan. I had an email from one of my constituents who was told that no practices in Devon and Cornwall were taking on new NHS patients, including children. That is clearly a



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desperate situation. Can you update us on what is going to happen on dentistry? Why is it not in the 10-year plan?

Simon Stevens: Dentistry is referenced in the NHS plan in various places.

Q284 **Chair:** But it does not really feature significantly, does it, as the rest of the health system does?

Simon Stevens: Some people have said that 133 pages is already quite long. We do reference dentistry. The fact is that the availability of dental services has been either stable or slightly improving. When you ask people whether they have been able to get NHS dentistry, at the England level that has remained a solid result. There are parts of the country where pressures arise, so our local teams have to use their flexibility to go and commission alternatives. That is not the same as saying that you need to throw up in the air the whole of dentistry across England to solve some of the particular pressure points.

Q285 **Chair:** We have been talking about access to primary care in Plymouth. If there are entire areas of the country where people are being told that there are no dental practices taking on NHS patients, what is going to be done through the NHS long-term plan to address that?

Simon Stevens: Our local teams will certainly look at that. People can phone NHS 111 and get advice on the nearest dentist that would accept patients. If there are particular geographies that you want to raise—

Q286 **Chair:** The particular geography is Devon and Cornwall. That is quite a large particular geography, isn't it?

Simon Stevens: Let us take a look at it and compare notes on the actuality.

Chair: We can correspond separately about that.

Q287 **Rosie Cooper:** Does the Department of Health in any of its guises have access to any of the dentists' patient lists? I was told that you guys had cured this, so I am testing it. When dentists in my area said that they were going to go private and were not taking on more patients, and that the patients had to go private or find another dentist, the Department of Health in any of its guises could not write to those patients because they did not know who they were, unless the dentist gave you the list.

Matt Hancock: I would not expect the Department to have individual data about where everybody's dentist is.

Q288 **Rosie Cooper:** If you wanted to access a dentist's patient list, could you do so? If the Department of Health wanted to try to contact a dentist's patients, for whatever reason, could you if the dentist did not give you that list?

Matt Hancock: I would not expect those data to be held within the Department, because dentists' contracts are held by the NHS.



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Simon Stevens: And I do not know the answer to your question, Rosie, so let me find out. I am sure you will have investigated thoroughly, as you always do, but let me get back to you.

Q289 **Rosie Cooper:** The question I leave in the air is that, if you ever needed to make any changes or do anything to contact those patients, you cannot. Ergo, you are at a serious disadvantage.

Simon Stevens: Let's find out specifically what the situation is in respect of dental lists and patients as against general medical practice. I'll get back to you.

Q290 **Dr Williams:** I have a quick specific question, following Johnny's questions around mental health. There are some great things in the plan about perinatal mental health treatments. There is still an issue with identification of perinatal mental health problems, which the plan does not say anything about. Survey data suggest that half of women with perinatal mental health problems do not have them identified. Is there anything that can be done about that?

Simon Stevens: As you know, Paul, the initial focus of the expansion of perinatal services has been on women experiencing maternity-related psychosis or severe mental illness. To expand services, we need to layer some of them into general maternity services. Part of the question is about whether there are cross-training opportunities for midwives, as well as specialist support. In the parts of the country that have begun the more general perinatal expansion, that is what they are doing. I am racking my memory, but I think Plymouth, although Johnny is not here to hear it, is an example of a service that has done well in that. The need is acknowledged, and part of the perinatal expansion has to address it.

Matt Hancock: There are also examples where the midwifery team and the community trust have linked together well, and it is all part of a more integrated service provision. In Medway, for instance, there is that integration, meaning that the follow-up through midwifery and health visitors also has a mental health aspect in spotting postnatal depression and signposting treatment. There are examples of good practice that I am sure could be spread more broadly.

Q291 **Dr Williams:** I have a few questions about the system that is going to deliver the plan. How important is it to the delivery of the plan that the current STPs become ICSs—integrated care systems—by 2021?

Simon Stevens: We think it is important. As you say, that is why we have declared our hand: every part of the health service should be operating in that way, with our partners in local government and the voluntary sector, having a shared approach to improvement for a whole population, rather than each individual institution or each part of the health service just ploughing its own furrow. We know enough now about what works and how to get there, based on the fifth or so of the country that is doing it, to be clear that that is what needs to happen everywhere.



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Q292 **Dr Williams:** Why aren't you planning to make ICSs legal entities? Why will the CCG continue to be the legal entity, rather than an ICS?

Simon Stevens: CCGs will continue to be the legal entity while the law remains as it is. We have proposed some possibilities for Parliament and the Government's consideration. One discussion to be had at that point is what clarity there needs to be for the new integrated providers we are proposing on their ability to work jointly on planning and funding. It is perfectly coherent to have a situation where you have a CCG per ICS. You still need a bit of grit in the oyster. For example, if you are trying to move money to support additional mental health services, rather than just continuing to reproduce the status quo, it requires you to be able to stand back from day-to-day service delivery and make those judgments. That is one of the questions we will want to test with you and colleagues as part of the legislative proposals.

Q293 **Dr Williams:** It is not quite the end of purchaser-provider split, but a change in the relationship.

Matt Hancock: That's right. Commissioning remains important, because you need to get value for money and to be able to make changes based on an objective assessment of what is needed outwith the provider delivering those services. Whether that is done by a CCG, which has essentially the same geographic boundary, or through the commissioning of a whole area, including primary care, by NHS England, the question is where exactly to put the commissioning relationship. It has to be somewhere, otherwise you are just giving an area a large amount of money and saying, "Do your best." The key is how to get the best integration you can while retaining the accountability and constructive challenge that comes from a good commissioning relationship.

Q294 **Dr Williams:** You talk about accountability and constructive challenge. Does that include a bit of competition, Simon?

Simon Stevens: Between whom for what?

Q295 **Dr Williams:** I do not know. What is the role for competition in this new NHS?

Simon Stevens: We have just completed a successful procurement for biosimilar medicines, which involved a competitive procurement process between different pharmaceutical companies. I think we will continue to want to use vehicles such as that. However, that is not the same as saying that, if in a local area you are trying to get GPs and community nurses working together, the GPs should be there in perpetuity, and every three years you should be breaking up the team as you think again about how integration works. We are proposing that the NHS, subject to best value tests, should have the flexibility to determine how to drive efficiency while getting integration, rather than having a more mechanical, reflexive process.

Q296 **Dr Williams:** I will try to interpret that. Will there still be a role for non-



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NHS bodies in delivering NHS care?

Simon Stevens: I do not think we are suggesting that we should retreat from the idea that patients should still have choice for the aspects of care where they have had choice for more than a decade, but there are ways of doing that which are not the inflexible, periodic transactional procurement processes that currently operate through the system.

Q297 **Rosie Cooper:** There are people who think that the move towards simplification actually makes privatisation of the health service more rather than less likely. In response to your questions to Paul, you have both been dancing around that, so I thought I would ask the question that most of the public will be thinking about. People will say that it makes it more likely that bits will be privatised, and others will say not. I am going to ask you the reverse of that question: how can you assure them, and what work have you done to ensure that that work continues really to be done by the NHS, or is the NHS just going to become a badge?

Simon Stevens: No. The answer to the question is that you as a Committee looked at this question very carefully last summer, and you made some recommendations as to how we could ensure that there was appropriate public provision and accountability. In the light of that, we went away and kicked the tyres and we have come back and said that we agree. Here is the proposal.

We are suggesting that the integrated care should be from public providers. Frankly, it would be a strange situation if, having been accused of one thing, when we come forward and respond very concretely to those concerns, people do a 180 degree turn and say, "That's exactly what we were worried about in the first place," when it is the precise opposite of what they were previously critical of.

Q298 **Rosie Cooper:** Simon, I absolutely appreciate that. But having done that, can you express, and enable people to understand, that you have put something in place, whatever it is, that will assure them that this is not likely to happen? I am giving you the floor to say that this is so much more not likely to happen, instead of just giving blanket reassurances that, depending on their original belief, people either do or do not believe.

Simon Stevens: That is the key: some beliefs are not shakeable by any empirical evidence. We have put this on the table in black and white in chapter 7 of the long-term plan and, frankly, the reporting of it has confirmed that what you say is what we are proposing.

Matt Hancock: I am going to be much more concrete. There is no privatisation of the NHS on my watch, and the integrated care contracts will go to public sector bodies to deliver the NHS in public hands.

Rosie Cooper: Voila.



Matt Hancock: That is what Simon was saying. Isn't it?

Q299 **Chair:** Wonderful. Of course, it was what we recommended.

Matt Hancock: It was based on your recommendations. Let me be a little bit clearer about the history of how we got here. GP practices are largely private organisations; they always have been. That was a decision by Bevan, and it is how the NHS always operated. We want the possibility for primary care to lead integration in some cases where that is most appropriate. Following your analysis, which we agreed with, we have come forward with a proposal so that GPs could potentially bid in, but through an overarching body that would be a public NHS body.

Q300 **Dr Williams:** Simon, earlier you used the phrase, "integration of GP and community health services." Potentially, for you, that therefore means that GP and community health services are integrated in an NHS body.

Simon Stevens: That will certainly be an option. When you see the new GP contract, with the primary care networks, you will see that it means that we will be able to continue to support practices that want to continue in their current guise, while nevertheless strengthening their joint relationships.

Q301 **Dr Williams:** But there will be alternative routes.

Simon Stevens: There will be alternative routes, with public accountability, to achieve integration without going through the procurement processes that have given rise to concerns in some parts of the country.

Matt Hancock: It is not just concerns; it is money going to lawyers that should be going to the NHS frontline.

Q302 **Chair:** That is very helpful. We were very encouraged by the response to the recommendations in our report, and it would be helpful to set out now how we are going to take those proposals forward.

Matt Hancock: I will go first on the high level. The NHS has made recommendations on changes to the law. We are open to considering them, and potentially to making Government time available for a Bill, but they very much emanate from the NHS and we want them to go forward on the basis of further work from the NHS. We would be enthusiastic if you as a Committee were heavily involved in that work, too. As to the exact process for how that occurs, I am very much in your hands in taking that forward.

Q303 **Chair:** We are very keen that it is an NHS-led process. Perhaps, Simon Stevens, you could set out how you envisage that.

Simon Stevens: Yes. In responding to that invitation, we will set out more detail from the NHS point of view of the proposals in the long-term plan to ensure that there is proper engagement across the health service and publicly. We will do that in February, and would then hope to have



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the opportunity to engage directly with you as a Committee either this or the other side of Easter. We will put the flesh on the bones of the proposals, so that people can see the detail and have a chance to contribute to it; then the NHS will say, "Here are our recommendations for Parliament and Government."

Q304 **Chair:** In putting more flesh on the bones of what is in the 10-year plan, will you definitely engage with patient groups and the voluntary sector and across the NHS and local authorities?

Simon Stevens: Indeed.

Q305 **Chair:** It will be at that stage that, hopefully, the Committee come back to look at it.

Simon Stevens: Absolutely, as we did when forming the plan in the first place. We had patients' organisations representing more than 3.5 million people, with over 200 engagement events and 2,500 submissions from a whole spectrum of people, for the long-term plan, and we will absolutely continue with that.

Q306 **Chair:** Thank you. We look forward to seeing those proposals and engaging with you on them further.

Before we move on to the next section, can I touch on the issue of local system reviews? How helpful have the CQC's local system reviews been in encouraging the sort of integrated working that we want to move towards?

Simon Stevens: The geographies chosen for those reviews were a cross-section of places that were thought to be doing quite well and those where, frankly, the opposite was the case. The CQC helpfully laid that bare, which served as a bit of a catalyst for improvement in parts of the country where it pointed to dysfunctions that existed, and produced broader lessons more widely. In their own terms they were helpful, but, by itself, just doing inspections or reviews does not constitute the change we need to see.

Q307 **Chair:** They were to highlight best practice and chivvy along people who were falling behind. In that case, how helpful were they in improving practice in areas that were falling behind?

Simon Stevens: They were a contribution to that. There are many other ways in which we are trying to do that as well, but they certainly were a contribution.

Q308 **Chair:** Right. There is some concern from the CQC that its funding for local system reviews is not going to continue. Is that the case?

Simon Stevens: The CQC has not been tasked with adding a new layer of inspection on top of the inspections it was previously doing. It was specifically commissioned by the previous Secretary of State to do those in particular geographies for a particular purpose. It was funded to do that and has done that, and we are grateful to it for doing so.



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Matt Hancock: I am very open to doing further such system-wide inspections in future. I think they have been very valuable.

Q309 **Chair:** At the moment, they have to be directly commissioned. The CQC cannot decide to initiate them itself. Sometimes it will go into an area and see that there is a system issue; it is inspecting one part of the system, but it can see that it is a whole system issue.

Matt Hancock: Yes, but it can always come to us and have that discussion.

Q310 **Chair:** When the CQC comes to you and indicates that something is a more system-wide issue, will you still commission it to carry out the more system-wide cross-cutting work?

Matt Hancock: I am reluctant to answer a counterfactual, because we have not actually been asked, but I am very open to that, should the CQC do it, because I see the value that it has brought.

Chair: Can we turn to prevention and health inequalities, Paul, because Luciana is not back yet?

Q311 **Dr Williams:** Secretary of State, we know that there are £85 million-worth of public health cuts next financial year, and then there is the investment in the NHS. You have the health budget to play out, you are increasing the proportion of it that goes to NHS England, and there is a reduction in the proportion that goes to local authorities for public health. What is the strategy behind that?

Matt Hancock: The public health budget was set in the 2015 spending review, so the changes from this year to next year are simply that playing out. I have not made any changes to that. The thrust behind prevention is much broader than public health, although, of course, it includes public health; public health is important. What matters in public health are the outcomes, and many local authorities will argue that they have been able to put the public health money to better use because they were able to integrate it with their other services. The NHS budget is going up by £6 billion next year and I want to put the entire £148 billion of the NHS, as much as possible, as a shoulder to the wheel preventing ill health, of which public health is one part.

Q312 **Dr Williams:** Some clinical services are delivered through the public health budget. If somebody had a gynaecological problem caused by a non-infectious cause, that might come under gynaecology, which is keeping its funding, whereas, if it happened to be an infectious cause, it comes under sexual health, which is having a reduction in funding. What is the logic behind reducing the funding for one type of service and maintaining funding levels for another?

Matt Hancock: As I say, the funding level on the public health side was set in the 2015 spending review.

Q313 **Dr Williams:** Was that a mistake?



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Matt Hancock: It was the right decision at the time. Now the right decision is to increase the focus on prevention right across the NHS budget. There are also potentially some structural changes around the boundary between public health and NHS-provided services.

Q314 **Dr Williams:** The plan talks about the NHS potentially taking responsibility for sexual health services and health visiting, taking over some of the clinical public health services.

Matt Hancock: I cannot remember exactly which paragraph that is in. Simon is looking at paragraph 2.25, or something like that.

Dr Williams: It is in the section on health inequalities.

Matt Hancock: Yes, that's right. The plan puts forward the fact that we are going to look at the commissioning of those services. It is right that the broad public health budget is held by local authorities, because of the links to other local authority functions, not least social care, both for children and adults, and housing, which is very important. Sexual health services are at the boundary of that, as are health visitors and district nursing, which are actually much closer to the NHS. In fact, most sexual health service money that goes through the Department to local authorities gets procured back into NHS services, so it seems sensible to look at the commissioning of those services.

Q315 **Dr Williams:** Is it the same logic for drug and alcohol services?

Matt Hancock: Drug and alcohol services, we think, are more closely aligned with core local authority activity, so the benefits of their commissioning directly through local authorities are clearer. They are much more rarely commissioned straight back into the NHS.

Q316 **Dr Williams:** Watch this space for, potentially, the NHS having responsibility for health visiting, district nursing and sexual health services.

Matt Hancock: Don't take that as necessarily the presumption. In many parts of the country, there is now joint commissioning of those services, and often that is the best way forward. Hence, instead of merely saying that we would move that back inside the NHS boundary, we are looking at the detail of how it is best commissioned.

Q317 **Dr Williams:** That is very sensible. Simon Stevens, what level of funding will be needed in the spending review for public health functions to ensure the success of the plan?

Simon Stevens: That is the discussion we will be having with the Government as part of the spending review process. What we have done in the long-term plan is underline the importance of the contribution that local authorities make to prevention more generally and show how the NHS will step up and do what only the NHS can do.



In one or two places, there has been a bit of misunderstanding about that. The reason why we are focusing on alcohol care teams for people in touch with the NHS is not that we think it should be the totality of what drug and alcohol services look like; it is just that it is a specific touch point for the NHS. The reason we are saying that we are going to fund, as recommended by the Royal College of Physicians, the roll-out of smoking cessation services for in-patients and for mums during pregnancy and their partners is that those are touch points that the NHS has. That is without prejudice to the fact that we need wider smoking cessation, drug and alcohol services, and so forth.

Q318 **Dr Williams:** If public health cuts continue, will you be able to deliver the plan?

Simon Stevens: We point out specifically that, "funding and availability of these services over the next five years which will be decided in the next Spending Review directly affects demand for NHS services." I am quoting from paragraph 2.4.

Q319 **Dr Williams:** I am just trying to turn that around to see whether you will be able to deliver the plan if public health cuts continue.

Simon Stevens: There are clearly implications and read-acrosses, and that is the dialogue we are having.

Q320 **Dr Williams:** We know that health inequalities, which narrowed in this country until about 2011 or 2012, have widened again. How much does the success of the plan depend on some of the wider Government actions to tackle poverty and inequality?

Simon Stevens: On one hand, we reference academic research suggesting that the broader determinants are part of what is putting £4.8 billion-worth of extra hospitalisation demand on the NHS. On the other hand, we have been particularly guided by the work of the "Global Burden of Disease" study, published in *The Lancet*, which Public Health England and others have done. That looked specifically at the drivers of changes in healthy life expectancy and pointed out that differences, particularly among older people, in cardiovascular disease and other major risk factors explain a disproportionate number of the changes in projected healthy life expectancy. That is not a phenomenon confined to the UK. It has also been the case in a number of other European countries, including some with vibrant economies even post-2008.

It is fair to say that the root explanations for the change in healthy life expectancy are still being discussed by epidemiologists, but, based on what we know, we have put our chips on the board to ensure that NHS resources are allocated to high inequalities areas, and we are getting more precise about how that is done; and we are ensuring that the extra funding going in is used for evidence-based best buys that will help to reduce health inequalities in those areas and between groups.

Q321 **Dr Williams:** Are those evidence-based best buys going to be



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recommended centrally?

Simon Stevens: Yes.

Q322 **Dr Williams:** Are you recreating the health inequalities national support team that the last Labour Government had, which was disbanded in 2010?

Simon Stevens: I have not received a specific proposal to do that, no.

Matt Hancock: This has to be, and will be, the core business of the NHS. It is not just about having a support team; the focus on tackling inequalities is from the chief executive down.

Q323 **Andrew Selous:** What should we do about food manufacturers who put sugar in baby milk and baby food?

Matt Hancock: We should make sure that the prevention agenda includes not just the NHS or the public health budgets but the whole activity of the Department and the Government. There is clear action needed right across the board, as set out in both the first and second chapters of the obesity strategy.

Q324 **Andrew Selous:** Would the prevention agenda include things like trying to make fresh fruit and vegetables more affordable, as the chief medical officer was suggesting before Christmas?

Matt Hancock: I would love to make good food more affordable. How to do that is quite a challenge, to say the least, when most of it comes from a global market. I am a big supporter of the sugar tax that was introduced, albeit for sugary drinks. I am successfully concluding a commitment to the deputy leader of the Labour party not to drink any fizzy or sugary drinks during January, which is quite easy because I don't at any point in the year.

Clearly, there are fiscal measures that can be taken. Also, as I have discussed quite a lot, there are ways to have more targeted approaches, both within the NHS and more broadly.

Q325 **Andrew Selous:** There is no reason why we could not extend the sugary drinks industry levy to other projects—perhaps baby food with sugar in, or other types of confectionery, and so on—if there was good evidence, perhaps making some of the more nutritious and healthy food more affordable.

Matt Hancock: Tax is a matter for the Chancellor.

Q326 **Andrew Selous:** Okay. What about active travel and planning policy in terms of the reams of unhealthy takeaways near schools? We are building a lot of houses. Shouldn't every new housing estate have a cycleway and a decent footpath to the local school? How much clout do you have as a Cabinet Minister to get those sorts of policies adopted around the Cabinet table?



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Matt Hancock: Again, that is a matter for a different Department. The point about the obesity strategy is that it is a cross-Government document, so there are parts of it that I am directly responsible for, and I have discussions, in that case, with James Brokenshire and others. There are decisions for local councils. It has to be an effort across the board.

Andrew Selous: Okay.

Simon Stevens: As you know, we have been running a programme called the NHS healthy new towns programme, whereby health experts work with planning authorities and developers on designing in the kinds of initiatives that you describe, on the obesogenic environment and easy access for older people to local services. We are in discussion with the Ministry of Housing, Communities and Local Government about the extent to which that scheme could be extended more broadly for kitemarking developments as they occur right across the country.

Matt Hancock: It not just about action for Government. Action for business has a role, and for individuals. The fact that sugary sweets are so regularly given to children, not by their parents but just offered up as rewards, is extremely frustrating.

Q327 **Chair:** Are you going to act as a champion for health in all areas?

Matt Hancock: Yes, I am. But I hope to jump in in a way that brings people with us. You can enjoy life and be healthy at the same time; you do not have to stop doing all things that are fun—all things in moderation.

Chair: Right.

Q328 **Dr Whitford:** Simon, in the five year forward view, it was very much put forward that public health, prevention and social care were critical to the NHS moving forward, so how important is action on social care to the NHS long-term plan?

Simon Stevens: It is important not just for the join-up of services for older people but for the changes we need to see in support for people with learning disabilities. It is important for the special educational needs and autism services, together with education departments, and for the work we need to do more generally with local authorities.

We tend to think of the social care debate as about adult social care, and within adult social care we tend to think of it principally around frail older people and the support they need. Vitally important as that is, of course, the social care agenda goes much wider. That connection is well understood. There will obviously be a process that will be kicked off with the Government's social care Green Paper around more fundamental reform. In the meantime, over the next several years, we will continue to need proper public funding of the system as it currently exists. That is the basis on which we have set out the long-term plan.



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Q329 **Dr Whitford:** There has been a reduction in social care funding over many years, against an ageing population. I recognise that social care is right across the age range, but the aspect putting pressure on the NHS, particularly the acute side, is the frail elderly. What will you be looking for when the Green Paper finally comes out? What would make you say, "Brilliant"?

Simon Stevens: I would distinguish between the Green Paper proposals, which, even with the best will in the world, are not going to have an impact next year, the year after and the year after that, and the work that needs to be done with the Government to size the social care funding questions that, ultimately, will have to be settled in the spending review. The Prime Minister has given the important commitment that social care will be available such that there are no additional pressures on the NHS. Now we need to work to put the practical flesh on the bones of what that commitment means.

Q330 **Dr Whitford:** With an ageing population, that means expanding social care, rather than it not being diminished. Is that view allowed for in the long-term plan? You will actually have expanding elderly social care.

Simon Stevens: As I say, we are planning on the basis of the important commitment that the Prime Minister made, and we will now work with the Department and Government on how to turn that commitment into the consequences that flow from it.

Matt Hancock: The commitment is that there will be no further pressure on the NHS from social care. It is actually not true to say that the amount of spending power on social care has fallen. Many councils have taken the opportunity to use the social care levy to increase their ability to fund social care locally, and we have put in more money from the centre.

Nevertheless, having said all that, there are clearly pressures, which I fully acknowledge, and we are committed to ensuring that those pressures are not higher. In fact, through integrated services and integrating the social care element better, both for ensuring that people can leave hospital when they do not need to be there, and pre-emptively making sure that we get care into care homes so that people do not have to go to hospital and secondary services in the first place, we hope to be able to reduce the pressure, through organisational reform, although of course an appropriate level of funding has to go in as well.

Q331 **Dr Whitford:** When we look back over the last nine years, the funding through local government to social care has gone down, and that has created enormous pressure, which has all landed on the NHS.

Matt Hancock: The funding has increased in the last couple of years, although I do not have the figures.

Q332 **Dr Whitford:** But not to reverse to where it was in 2009, or equivalent.



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Matt Hancock: There have been savings over a longer period, of course. At the same time, there are pressures on social care because of an ageing population. My point was simply that, in the last couple of years, and certainly since I have been Secretary of State, in the last six months, we have increased funding to social care in terms of spending power. But it is not just about money going in; the Green Paper will talk about both the finances and the ways we can improve delivery of services.

Q333 **Dr Whitford:** The Age UK estimate of people who have insufficient social care is that between 400,000 and 500,000 who require it do not have any. Is that taken into account in the equations? That is currently unmet need; it may be provided by a frail partner but there is not actually a sustainable service for those people.

Matt Hancock: The eligibility requirements and rules around social care, which were set in the Care Act 2014, are the basis on which we make all these decisions.

Q334 **Dr Whitford:** When do you think, Secretary of State, that the Green Paper will actually come out?

Matt Hancock: Soon. I said before April. Soon.

Dr Whitford: In all my time here, I have been hearing, "Soon."

Q335 **Luciana Berger:** Perhaps you could comfort me, Secretary of State. To go back to the very important question that Dr Whitford just asked you, if there is all this additional resource going into social care, why is it that cities such as Liverpool now provide social care to 5,000 fewer people?

Matt Hancock: Well, of course demand has gone up—

Q336 **Luciana Berger:** No, no; 5,000 fewer people now receive social care packages in Liverpool. Why is that, if there is all this additional resource going in?

Matt Hancock: Compared with when?

Luciana Berger: Compared with 2010.

Matt Hancock: The Care Act 2014 made changes to eligibility for social care, and that is the basis on which we now provide social care.

Q337 **Luciana Berger:** That means that fewer people are receiving social care. Demand is going up and fewer people are receiving it, not just in Liverpool but in other places right across the country.

Matt Hancock: The provision of social care is increasing at the moment.

Q338 **Luciana Berger:** So more people are receiving it since when?

Matt Hancock: I do not have the figures in front of me, but the spending power on social care has gone up, certainly in the last year and I think the last two. I can write to you with the figures.



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Q339 Luciana Berger: But there are obviously inflationary costs and increased wages. An increased budget does not necessarily translate into more people receiving social care. Can you give us the number of how many additional people are, as you indicated before, receiving social care support in the last either one or two years?

Matt Hancock: I can absolutely write to you with that. The provision for an increase in the social care levy, in addition to council tax, came in only after 2010, obviously.

Luciana Berger: Indeed. I am reflecting my experience as a constituency MP, and fewer of my constituents now receive that vital support than they did previously.

Q340 Dr Whitford: That is the evidence of Age UK as well.

Matt Hancock: As I said, it boils down to the provisions of the Care Act 2014, which made sure that the money available was targeted on those with a greater need.

Q341 Dr Whitford: But with the pressure of things like delayed discharges, it will not always just be those defined in 2014. Is it not a poor way to save money, if someone actually ends up in an NHS bed at hundreds of pounds, instead of having personal care in their own home?

Matt Hancock: That is where the integration comes in. A decision over the care package that can support somebody to help get them out of hospital is obviously best made on a value-for-money basis. We should not be leaving people stranded in an expensive hospital setting when they could be in a social care setting that is better value for taxpayers, and better value for them, especially if they can get into their own home, and that is what we should be trying to achieve.

The fact is that the 1948 settlement, which left social care the responsibility of local authorities, and the NHS the responsibility of the Secretary of State, means that the two systems look financially to different legitimate masters. We all know that, and the challenge is how to get integration working in practice on the ground, given those constraints. We have proposals in the long-term plan for different models to achieve that integration, four different options that work well around the country; and the social care Green Paper will reflect and put more meat on the bones of what those options mean for better integration.

Q342 Chair: Do you recognise the figures we have had that say that social care will see an estimated 2.9% real-terms increase, but the problem is that the rising pressures are at 3.9%, so it continues to fall behind relative to the rising demand?

Matt Hancock: The question of future short-term funding is, of course, for the spending review, alongside the longer-term measures that will be proposed in the Green Paper. We have already put forward funding



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proposals for next year—a £650 million increase in funding; and the year after will be settled in the spending review.

Simon Stevens: I have two points. The first is that where we have seen the extra investment in social care, over the last year or two, we are getting a result. The number of in-patient hospital bed days from delayed transfers of care is down by 29% over the last two years—November to two years prior.

Secondly, there are things that the NHS will do as a result of the extra investment in community health services that will help moderate demand in social care. Very importantly, in the long-term plan there is a chart, figure 5 on page 23, showing that on some analyses probably too many people have to go to a care home because they are not getting the community support or reablement they need; if they did, they would be able to stay independently at home. That would relieve some of the additional funding pressure on social care. This is mutual aid between social care and the NHS; it does not just flow one way.

Q343 **Dr Whitford:** Would you ever see free personal care being delivered to people in their own homes to allow them to stay there, as we have north of the border, as cost-effective?

Matt Hancock: Absolutely. In some cases, people get free personal care. Yes.

Q344 **Dr Whitford:** Some people, but the numbers are relatively small in comparison with the generality. I mean widespread being the norm.

Matt Hancock: It is not relatively small numbers. A large proportion of people are eligible for free social care provided by their local authority.

Chair: We must move on to the section on the workforce.

Q345 **Luciana Berger:** Secretary of State, can you provide us with any reassurance that the accountabilities for delivering the necessary expansion and improvement of the workforce will be clear in any plans that come forward?

Matt Hancock: Yes.

Q346 **Luciana Berger:** Great. Can you expand a bit further on that?

Simon Stevens: Another comprehensive answer.

Matt Hancock: You asked for short answers: yes.

Q347 **Luciana Berger:** We are specifically looking at the issue around accountabilities. It has been clear thus far that it has been a murky area. We are looking for some clarification.

Matt Hancock: Part of the reason for ensuring that Ian's job of delivering a large proportion of the training needed in the NHS is tied up more closely with Simon and Ian's job of delivering the business plan for



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the NHS is in order to get that accountability straighter. There is no other very large organisation where the training arm and the business arm are kept completely separate, as was the case. The aim is to have a tighter join-up. For instance, an individual trust should have far more say over the training that goes on within that trust than historically was the case, with HEE reporting separately to the Department.

Having said that, there is also clearly a national co-ordination task to be undertaken. We cannot ensure that we deliver on the total workforce we need without an element of national co-ordination. We need a body that looks across the country as a whole providing the training budget, plus individual trusts. A lot of trusts spend money on training outwith what they get from HEE, because training your people is a core activity of running a good organisation.

Q348 Luciana Berger: Sure, but if you are that serious about the joined-up approach, isn't it remiss that we are discussing a 10-year plan and we have not yet had the workforce strategy?

Matt Hancock: No. That would be putting the cart before the horse. We have written the plan for what we want the NHS to be over the next 10 years. There are a huge number of consequentials from the plan. Every page has actions that somebody in the system needs to undertake. One of the big actions is how we deliver the workforce to deliver the plan. You cannot write the workforce strategy before you have written the plan. That would imply that the workforce should be a constraint on our hopes for the NHS. On the contrary, it is through the workforce we are going to have that we will deliver the plan, wouldn't you say, Ian?

Professor Cumming: Absolutely. We consulted on the draft workforce strategy last year, and we could have published a workforce strategy for the NHS around the summer of last year. We felt it would be fundamentally wrong to produce a workforce strategy for the NHS in advance of a long-term plan setting out the future direction of travel for service delivery for the NHS. We said in the opening paragraphs of the draft workforce strategy that one of the key things we needed to do was to bring much closer together the financial planning, the service delivery planning and the workforce planning.

The reason we have some of the challenges that we have with workforce at the moment is that historically some of those were done in isolation. The group that Baroness Harding is chairing is looking at the implementation of all aspects of the workforce, of which HEE is fundamentally a part. It is looking at education and training, retention and lifelong learning, but it is fundamentally building on what is in the long-term plan. That is the right time to produce the workforce strategy for the NHS, not in advance.

Q349 Luciana Berger: You may have already said this, but can you confirm when we should expect that plan to be delivered?



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Professor Cumming: The expectation is that the summary workforce implementation plan will come out by the start of the new financial year. Later in the year, once we are clear about the outcome of the spending review and we know what HEE's budget is, the more detailed plan will come out.

Q350 **Luciana Berger:** Thank you. People watching this will be concerned about the time it takes to train various professionals and clinicians in each different discipline to meet that, when it is catching up with each point you set out.

Matt Hancock: Yes, but we can only start from here.

Professor Cumming: Bear in mind that a number of initiatives are under way. HEE is not stopping work while waiting for the production of the workforce implementation plan. We are training 7,500 nursing associates in this year, and the extra 1,500 medical students who are already starting will be making their way through the system. We have already talked about GPs and the expansion in GP trainees. We are continuing with those activities, but once we see the settlement in the spending review and the output from the implementation plan, we can add to that as necessary.

Matt Hancock: Also, a bit like seeing prevention as much broader than the public health budget, important as that is, the future of the NHS workforce is broader than just the training budget. It is about morale, and having the right people, with the right leadership and management, as well as the core training activities of HEE, hence putting the whole thing together: how do we deliver this, what is the workforce going to look like and how are they going to be trained?

Q351 **Luciana Berger:** I could not agree with you more on the prevention side, and I am only sorry that you have not yet responded to my correspondence on that.

To go back specifically to social care and the social care workforce, where do you see that fitting in with the NHS workforce implementation plan? We heard from a previous set of witnesses that separating the two is very much a mistake. Would you agree with that, and, if not, what are you going to do to contend with the challenges they raise?

Matt Hancock: There is an overlap between the two, but there is also a difference. The difference is that because social care is largely provided in private settings, and where they are public settings they are owned by local authorities rather than by central Government, we do not have direct levers, whereas within the NHS there are 1.3 million people who work for Simon.

Simon Stevens: Plus or minus. I think I work for them.

Matt Hancock: You work for me.



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Simon Stevens: I work for so many people.

Matt Hancock: And, Chair, we all work for you.

I have completely lost track.

Q352 **Luciana Berger:** It was about the social care workforce.

Matt Hancock: The point I was trying to make before we got side-tracked is that we have fewer direct levers over the social care workforce, but that does not mean that we should not also have an overview of the approach.

Q353 **Luciana Berger:** In your previous answers you talked about how important integration and working together were, so you need to ensure that you have the levers over them to make sure you are working hand in glove.

Matt Hancock: You cannot take a lever, other than contractual, over a private sector organisation that delivers services. Between 80% and 90% of—

Q354 **Luciana Berger:** You contract private services right across the NHS.

Matt Hancock: Not at all on the scale that it is in social care, where 80% to 90% of social care provision is through private sector organisations. The remainder is through organisations that are owned by local authorities, and none of it is owned by me, whereas in the NHS it is the other way around.

Q355 **Luciana Berger:** But it is all paid for, essentially, through Government, so you can determine what the levers are, can't you?

Matt Hancock: In social care, it is paid for through local government with accountability to local taxpayers, so that accountability means there is more distance. I am not getting away from the point. I agree with the premise—where you are coming from—which is that you have to look at the wider social care workforce as well as the NHS workforce to have an adequate plan.

Q356 **Luciana Berger:** Thank you. Can we focus specifically on the community and primary care workforces, where many concerns and challenges have been raised? You have heard them rehearsed on many occasions. Can you share with the Committee how you intend to contend with the challenges that the primary, community and social care workforces are facing?

Simon Stevens: While you had to be elsewhere, Luciana, we talked a bit about the GP aspects of that. If we go broader than that—

Q357 **Luciana Berger:** Yes, I was here when you were talking about GPs, but I want to go beyond that.



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Simon Stevens: Sorry. More broadly, we have had some success over the last several years in expanding the non-GP primary care workforce. We had aimed to have 5,000 more people by 2020. We already have more than 5,000, so we are doing well on expanding the primary care workforce.

The community health workforce has suffered in part because of the relative squeeze on community health spending relative to GPs, acute hospitals and the extra investment we have had in mental health. That is why the new guarantee around the primary medical and community health service growing faster than the overall budget will provide the purchasing power and funding streams for that workforce, and the new primary care network contract that we are in discussion with the BMA about will have a significant targeted increase in the workforce using a focus on disciplines where we know there is workforce availability. We hope to have that concluded and to publish it quite soon. I do not want to prejudge that, but you will see that it has targeted workforce expansions in professional groups where we know there is supply.

Q358 **Luciana Berger:** Can I focus on the barrier of the difficulties of moving between different sectors and to what extent, if at all, you are addressing that in your plans?

Simon Stevens: Do you mean barriers specifically around employment terms and conditions or other things?

Q359 **Luciana Berger:** That is just one of them, but, yes, there are several.

Simon Stevens: Historically, part of the barrier has been that the funding for general medical services, as you know, has been a completely different stream from the funding for community health services. In fact, over the life of the NHS, the community health services stream has moved backwards and forwards between local government and the NHS. We were talking about health visitors and school nurses earlier, but even in some of the other community nursing areas there was a big shift in 1974. That ended up with different organisations having responsibility for different parts of the community and primary care workforce and with different funding streams. That is what we are overcoming with the blended arrangements set out in the long-term plan.

Professor Cumming: As we said earlier, there is a correlation between the sort of training we give healthcare professionals and where they end up working. That is very true when it comes to community services. We have already talked about it with regard to GPs. If you get medical students out into GP practices, if you get foundation trainees out into GP practices, they are more likely to choose a career in general practice. We have been working with colleagues from the Nursing and Midwifery Council, who, as you may be aware, recently launched their future nurse standards, which make specific reference to nurse training, and nurses being based in the community as part of their undergraduate training to make it more likely that they choose jobs in the community in the future.



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One area where we have been particularly disappointed by the reduction in the workforce is district nurses. There is a joint piece of work by NHS England, HEE and the Queen's Nursing Institute on the foundations programme that specifically looks at taking nurses who express an interest in working in the community and giving them a proper structured programme around an introduction to district nursing, rather than what we may have done in the past, which was to leave it up to individuals to develop their career choices and how they made particular decisions around ongoing education and training. We will actually give them a bespoke programme so that we can boost interest, boost applications and therefore expand the workforce.

Q360 Luciana Berger: Moving on to international recruitment, what action are you taking to support the NHS in recruiting staff internationally, both within Europe and beyond?

Matt Hancock: Maybe I should start, because it interacts with the immigration rules. Clearly, the relaxation of the immigration rules in July was helpful, removing the cap on the numbers of doctors and nurses we can recruit from abroad. The new immigration White Paper and the Bill before the House today make provision for that to continue. That is very positive. We now need to turn international recruitment from something that individual trusts and NHS organisations do separately to something more co-ordinated, so that we can be more effective at it.

Professor Cumming: If we are trying to address the workforce crisis that we have now in the NHS, there are only three ways we can do it. One is encouraging people to come back into practice as healthcare professionals; the second is keeping the staff we already have in the NHS; and the third is bringing in people who trained elsewhere. We have been working on an ethical framework for doing that because we do not want to go to countries where they desperately need their clinical workforce and take them to come and work in this country. We are working in close partnership with a number of countries where they themselves have a desire for postgraduate education of their own clinical workforce.

We are recognised around the world as a centre for excellence in healthcare education and training. The concept is "Earn, learn and return," bringing clinicians to this country for a defined period of time; in the case of many nurses, it is a three-year period. We give them postgraduate education and training while they are here and they take those skills back to the country they came from, but while they are here they give a service to the NHS and to the population. We see a significantly growing level of interest in those schemes, and we are looking at boosting the numbers coming in through the ethical recruitment route to several thousand a year.

Q361 Luciana Berger: I was talking to a GP the other day who was trying to bring into her practice a GP from South Africa. She talked, even now, about the challenges—the onerous nature of the paperwork she has to



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complete and the cost that she incurs at that practice. What more, if anything, is being done to address those two issues?

Simon Stevens: The barriers have been lower, obviously, for recruitment from the rest of the EU, given the mutual recognition of qualifications. We have been working with the RCGP to expand the number of countries where we can have fast-track recognition. There is work that I mentioned earlier going on with Australia, and we are looking to expand that with their support and that of the GMC.

We need to bear in mind Ian's point about ethical recruitment. We do not want to take staff from lower to middle-income countries where they are needed, unless it is by agreement with their Governments as part of a well-structured training programme such that they return subsequently. In the case of South Africa, that might be some of the additional consideration that would apply, as compared, say, with Australia or New Zealand.

Matt Hancock: GMC and NMC requirements for practice in the UK are set independently. The NMC has recently updated its standards, at the end of November, to make sure that they are both rigorous and easier for potential nurses to comply with.

Q362 **Luciana Berger:** On nurses, can you share with us how, if at all, you are going to address the issues relating to language testing, which we heard about quite comprehensively in the evidence to our inquiry into the nursing workforce in 2017?

Matt Hancock: Yes. That is specifically what I was referring to. Those requirements changed in November to make sure that the language requirements were more appropriate. They changed in two ways. The first was so that the language requirements for nurses coming here are reasonable for them to be able to operate in the NHS in English. The second was so that they align more closely the English language test needed for the NMC, to operate in the NHS, with the Home Office's English language requirement. Hitherto, there have been two separate language tests, and that is clearly an extra burden and unnecessary.

Q363 **Luciana Berger:** I have a final question for Professor Cumming. In your remarks a moment ago, you touched on retention. Can you and the Secretary of State, and perhaps Simon, share with us what you think are the first actions you will be taking to improve retention right across the workforce? You touched on GPs, but what about more broadly beyond that?

Professor Cumming: NHS Improvement is leading that important piece of work. We are very much partners with them. There are many factors that lead to retention of the clinical workforce in the NHS. Access to ongoing education and training is one of them, as is access to simple things such as the Secretary of State talked about previously. Can people get access to a cash machine at their place of work, or can they get access to an Amazon locker in their place of work? How do we become a



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modern model employer in the NHS and recognise what has happened in wider employment over the last few years, where perhaps in some cases the NHS has not caught up?

It is multifactorial. There are a number of things we need to do, and a number of people need to play a part in doing them. We also need to recognise that, as millennials come through into the professional workforce, they want a different offer from their employer, compared perhaps, dare I say it, with people like myself in generations that have gone before. There is not an expectation of the same linear careers. People want more flexibility; they want to move between different roles. We need to allow people to plan their careers with that flexibility in mind, and to plan more career breaks than perhaps we would have done in years gone by, for reasons other than having a family. People are choosing. Young nurses and doctors want to go abroad for a year and then come back. We want to approach that by trying to facilitate a placement abroad, because if we facilitate it and keep in contact with them, we can make sure they come back at the end of it.

Q364 Luciana Berger: Do you want to add anything, Secretary of State?

Matt Hancock: There are so many facets, and we have talked about a few. The big one I would pick out in addition is workplace culture, valuing everybody's contribution. It is about making sure that people feel not only that they can contribute in the direct way that their job description requires, which is a given, but that they can contribute to the continuous improvement of where they work, so that it is enjoyable to work, and their seniors recognise the value they bring, and, if they can improve the way something is done, it is seen as a welcome intervention rather than dismissed. Essentially, a just culture with strong management and leadership leads to a more highly motivated workforce, and morale and retention are incredibly strongly correlated.

Chair: Thank you. The final questions are on digital, which is a large part of the NHS plan.

Simon Stevens: Do we have to do this face to face, or can we do it online?

Q365 Dr Williams: I am going to ask a general question in a minute, but I have a specific question first. I wonder if you are able to comment. There has been quite a lot written in the last week about Juliet Bauer, the chief digital officer of NHS England, who wrote an article in *The Times* promoting the organisation LIVI, to which she is moving. She is currently serving her notice. The public will want some assurances that she did not inappropriately use her position to influence the plan, which heavily promotes video consultation, as she is moving to an organisation that does video consultation software.

Simon Stevens: The case for enabling patients to have the choice of video consultation is a strong one, and the evidence laid out in the report



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shows that a significant proportion of patients would like that option. It will also help us with GP retention, because it is another way in which people can work flexibly without having to be physically in the face-to-face practice.

It was, I think, very regrettable that the article was written. It was not written with our agreement and we have asked *The Times* newspapers to withdraw it. Juliet Bauer was not involved in shaping the specific recommendations in the LTP and is not working on these issues during the period between now and being able to take up her new employment, and, even when she does, she will not be able to have an interaction with the NHS on those matters.

Q366 **Dr Williams:** The chief digital officer was not involved in writing any of the digital section of the NHS long-term plan.

Simon Stevens: The proposals were formulated across NHS England and were not some specific proposition that she came up with.

Q367 **Dr Williams:** There is a wider issue about links between people working in the public sector in the UK and private sector organisations. I was contacted last week by an alternative UK-based provider of video consultations who said that they had been categorically ignored by Juliet Bauer. Is there a possibility that she has been promoting the organisation she is going to work for at the expense of other UK-based organisations?

Simon Stevens: The approach to procuring the systems for primary care networks and practices will be set out as part of the implementation work. Obviously, she will not be in any way involved with that as she will not be working for us at the time.

There is another aspect, which is that, if the NHS is to be able to benefit from people who have deep experience in the technology sector and IT, we have to be able to recruit from those sectors, and we have to be able to do so in the expectation that at some point in their career people may want to return to those sectors. What we need, however, is to make sure that there are very clear conflict of interest rules, and that when people leave there is a clear partition before they have further engagement with the NHS. That is what we are doing in this situation as well.

Q368 **Dr Williams:** If she had been promoting the organisation she is going to work for ahead of other organisations, clearly that would be a breach of the Nolan principles.

Simon Stevens: Yes.

Q369 **Dr Williams:** I have received these allegations. Can I pass the allegations to you to look at in more detail, please?

Simon Stevens: Certainly, but the point, Paul, is that, going forward, it will be a completely level playing field. NHS England has not done any national procurements on any of these systems. That process is about to kick off and everybody will be able to have a level playing field



opportunity. A lot of the people they will have to persuade will not be NHS England; it will be groups of GP practices because they will be the ones running the systems. To the extent that they are able to offer a better service in the eyes of those GPs, individual organisations will do better than those that are not.

Q370 Dr Williams: In the meantime, Juliet Bauer is continuing to work for NHS England.

Simon Stevens: She is working her notice, but entirely separate from anything to do with technology or digital.

Q371 Dr Williams: Thank you. A broader question, Secretary of State: how will the health sector be supported to deliver some of the proposals around technology and digitally enabled care?

Matt Hancock: The most important thing to say about that is that the use of technology to deliver better care has to be done with the focus on the needs of the user, where the user is, essentially, the patient or the clinician. The true answer, in generality, to your question is that it will be the users who define what is needed. That is how good technology is built.

When new technology comes along, it often disrupts the way current services are provided for. A classic case in point is in primary care where a lot of primary care is increasingly using phone and video consultation in order to give a better service to patients and make life easier for GPs. A huge amount of that happens with existing GP practices and existing GP lists in the normal way, and in one celebrated example they moved patients to a different list. Clearly, the GP contract will have to change to take into account the impact of that different model for delivering care. The focus has to be on making sure that the users of the technology benefit from it, because at the core of delivering technological improvement is making sure that clinicians and patients are the ones who benefit, otherwise there is no point.

Q372 Dr Williams: There are still some significant issues around interoperability, in that there are a few large monopoly providers of systems and a reticence—at least a very slow pace of change—in allowing new providers to operate. What steps are you taking? You made some comments quite soon after you became Secretary of State. To paraphrase, you said that either they are going to have to change voluntarily or they will no longer be able to contract for services.

Matt Hancock: We are going to mandate the standards of interoperability, yes. This is an area where a change in pace is required, and a change in the attitude we take from the top, because the developments of the last few years are now mature enough to be ready for us to push on the accelerator.

The contracts that are directly signed off at the top, in the Department or at the centre of the NHS, will mandate standards of interoperability, open



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standards publicly declared and published. There will be standards of interoperability, cyber-security and privacy and some additional standards; for instance, to make that concrete, the GP IT contract will mandate standards of interoperability. There are currently four providers in that contract. If they do not meet the standards of interoperability, they will not be providing services from 1 January next year. That is absolute and clear. We have engaged with them, and they have all said yes, they will update the way they manage their systems.

Outside primary care, trusts buy their IT and we have different capabilities to be able to mandate open standards of interoperability. Anyway, there is a big drive for interoperability by clinicians and by the managers of organisations. In the past, you had to buy the same system from the same IT provider to be able to get the data to talk to each other. What these standards of interoperability mean is that we will be able to get the right data to the right person irrespective of whether the systems for where the data is and where it needs to be are written by the same software company. That will be required right across the NHS.

Q373 Dr Williams: That is very positive. Thank you particularly for defining the date by which interoperability will happen.

Matt Hancock: That is in primary care specifically. We then have to cascade it through thousands of contracts with IT companies, but we are clear that there will not be new contracts, and then we will have to work through the old existing ones.

Q374 Dr Williams: My final question on this area is to Professor Cumming. There are clearly some people working in the NHS who will easily adopt new technologies and some who will find it harder. What support is going to be given to the people who find it more difficult?

Professor Cumming: We have a programme running called creating a digital ready workforce, which is targeted exactly at what you describe: how we give people the skills they need so that they do not feel frightened by technology and do not create a paper alternative to technology but actually embrace it. That is a national programme and it is being led by our director of innovation, working closely with a team in NHS England, to roll it out across the country.

Q375 Chair: Thank you. Are there any final points that any of you want to make to the Committee?

Simon Stevens: I don't think so, no.

Q376 Chair: In closing, I should just say, Simon Stevens, that you are an employee of the board, not of the Secretary of State.

Matt Hancock: You are quite right. I was over-enthusiastic.

Simon Stevens: Thank you, Chair, for clarifying the constitutional position, which we all hold dear.



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Chair: Thank you very much for coming.