

Health and Social Care Committee

Oral evidence: Work of the Secretary of State for Health and Social Care, HC 523

Tuesday 9 July 2019

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

Questions 335 - 533

Witnesses

I: Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care; and Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care.

Examination of witnesses

Witnesses: Matt Hancock and Sir Chris Wormald.

Q335 **Chair:** Good afternoon, Secretary of State, and welcome back permanent secretary Sir Chris Wormald to this accountability session.

Let me start by asking you about NHS funding, and in particular how difficult it is going to be moving forward because we do not know when the spending review will be. On the issue of capital backlog, I am hearing a particular concern from providers of services about the backlog in critical maintenance repairs. Is that something you would like to comment on today?

Matt Hancock: It is something that is on my radar. There is clearly a need for a future capital settlement across the NHS. We have a capital budget for this year and we need to settle the capital budget for next year and onwards in the spending review, whether for new projects that we need, for upgrades, for projects to which we have already committed that are multi-year projects and for maintenance. They are all important.

There is a critical piece of policy work that needs to be done to replace PFI. The cancellation of PFI at the last Budget was an entirely understandable policy decision by the Government. After all, the problems of PFI are something that anybody with a PFI hospital understands only too well. The consequences of that and what it is replaced with are something that needs to be landed in the spending review.

Q336 **Chair:** What impact assessment have you made yourself about the scale of the critical backlog? What impact is that having on things like waiting lists across the NHS?

Matt Hancock: A whole series of different categorisations of backlog are done at local level. Some of the maintenance work that is needed is of long standing and needs to be done but is not particularly immediately pressing. There is other maintenance work that needs to be done.

We have a capital budget, much of which each year goes on maintenance. It is important when we present the case for the capital budget for next year onwards in the spending review that we take into account the need for maintenance, even though it is the less sexy end of capital budgets, as well as the need for new services and upgrades of existing facilities.

Q337 **Chair:** You say it is the less sexy end, but we are talking about high and significant risk. It is not just that buildings have fallen into a bit of disrepair.

Matt Hancock: That's right.

Q338 **Chair:** There is high and significant risk.



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Matt Hancock: For some.

Q339 **Chair:** It is over £3 billion of the backlog. The total backlog is much greater because, as you know, there have been a series of capital to revenue transfers over the past few years, so, in real terms, capital budgets have been falling. Hospital chief executives are deeply worried about the impact that is having. They need not only an ongoing budget for capital but somebody to address the very high-risk critical backlog of over £3 billion.

Matt Hancock: Yes, of course. As I say, the backlog is partly routine and partly time-critical. We have a capital budget this year, much of which goes to tackling the backlog. I will look for the figure while we are speaking.

Q340 **Chair:** The total backlog is £6 billion. That is not just what needs doing, moving forward.

Matt Hancock: The £6 billion is the total backlog. Each year, part of that is dealt with and new maintenance requirements come in. Part of our case to the spending review is that this needs to be dealt with alongside the expansion of facilities, whether that is new facilities or upgrades to existing facilities.

My overall approach to the capital budget is that we need to deal with the maintenance backlog, but we also need to deliver improvements where they best improve service outcomes. I have not pushed particularly hard for lots of big shiny new hospitals. Often, investments in existing hospitals that make them work better—for instance, in Plymouth—are the best way to get value for money in terms of the service improvement that you get in return.

Sir Chris Wormald: Chairman, I think you said that capital budgets were falling. They are not, actually; they are going up. We spent about £4.6 billion on capital in 2015-16, and it is up to £5.9 billion in 2018-19. We do not deny, as the Secretary of State said, that there are a lot of pressures out there and that capital has been constrained while we have been in a period of austerity, but we have actually been investing more each year for the last few years.

You mentioned capital revenue switches. They have been falling. They were £1.2 billion in 2016-17 and that fell to £500 million last year. We hope to move away from capital revenue switches after this year.

Q341 **Chair:** Are there further capital to revenue transfers?

Sir Chris Wormald: We have a capital revenue switch this year, which was planned and has been announced; it is in our estimates and all that. We hope that will be the last capital revenue switch we make. Capital revenue switches have fallen by £700 million over that period. At the same time, our capital expenditure—our total budget—went up by £600 million. The net effect of that is £1.3 billion more—



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Q342 **Chair:** But can I bring you back to this? In 2010-11, the capital budget was 5% of overall spending and it has gone down to 4.2% of overall spending.

Sir Chris Wormald: Over that period, yes.

Matt Hancock: But over that period the overall spending has gone up significantly, more than offsetting that.

Sir Chris Wormald: As I say, we do not deny that capital has been constrained during the period.

Q343 **Chair:** It has been downgraded as part of what you were doing.

Sir Chris Wormald: We have been completely clear that, during the period of austerity, we emphasised frontline services in our spending. As the Secretary of State says, that went up and the capital position has been tight. However, we have been putting more into capital over the last few years. As the Secretary of State set out, these questions in future will become part of the spending review settlement.

Q344 **Chair:** To give you an example from my local hospital, they had three theatres out of action because of ventilation or extraction systems going down and needing major upgrades; it is currently two. That starts to have an impact on the day-to-day running of the hospital.

Secretary of State, you mentioned that you want to prioritise the things that improve the efficiency of hospitals, but if your capital spending means that your hospitals are in such a poor state that they cannot function properly, do you accept that this is now having a major impact on the performance of hospitals around the country?

Matt Hancock: I am glad that one of the three theatres has been brought back into use. I absolutely accept that there is a £6 billion backlog and that the capital budgets have been going up over time, and that the future capital budgets need to be resolved in the spending review. It is a complicated picture because some of the capital expenditure is decided on in the Department, and some of it is decided on at local level by a foundation trust that is in financial balance without recourse to the Department. It all comes out of the same budget. Handling the capital budget is complicated, but at least it has been going in the right direction.

Q345 **Chair:** What is your best estimate of when we will actually see the spending review?

Matt Hancock: I do not know because it is a decision for the next Prime Minister, and we do not even know who that is going to be yet.

Q346 **Chair:** The other issue we have is what is going to happen to the HEE budget. You have your NHS people plan, but it is very difficult for people to make a people plan without knowing how much they are going to be able to spend on the workforce.



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Matt Hancock: Up to a point. If I could answer that in two parts, there is a whole series of departmental budgets that need to be settled in the spending review: capital, public health, training, and of course social care. The HEE budget is only one part of the training budget because all NHS organisations need to consider the training needs of their staff. The system as set out in law has HEE separately managing training budgets from the institutions that employ people. We are bringing those together because, especially in hospitals, and in primary care to a lesser extent, it needs to be the hospitals that have the primary duty for training up the staff they need. Training budgets come both from HEE and from internal resources.

More than that, the people plan is not just about headcount and the HEE budget, important as they are. It is much broader, about making the NHS a great place to work. I think a big fault in the past, to tell you the truth, is that, within the NHS, workforce planning has been about numbers and what I think of as tractor production figures, as opposed to thinking about people as the main asset of the NHS. To characterise the people plan as only about exactly what numbers we are going to need in 10 years' time is a very narrow view of the much broader change of culture that we are trying to promote.

Q347 **Chair:** I do not take that view. One of the things that this Committee heard very loud and clear in our nursing workforce inquiry was the importance of continuing professional development budgets, and that is very much a core part of the HEE budget. Is that something you are—

Matt Hancock: Hold on. It is partly about the HEE budget and it is partly about the hospital budgets. If you are running a hospital and you are the chief people officer for a hospital—not all hospitals have chief people officers, and they should—of course you get some of the training budget from HEE. The big training budgets, especially for doctor training, go through HEE. Yes, some of your CPD can come from HEE, an external source, but you can do an awful lot of it on your own balance sheet.

If you are running a hospital, the most important resource are your staff and you need to be training them up. Of course the people plan is about what we do with the HEE budget; hence we can only publish the final people plan after the spending review. There is a big culture change that needs to take place across the NHS, and which the best trusts already deliver and are brilliant at, which is not to regard your people as something that somebody else looks after but as an absolutely core resource to each hospital.

Q348 **Chair:** What is your position on nursing bursaries, and particularly having some flexibility for mature students and making sure that we get more students coming into particular key shortage specialties? Are you going to be making any changes there?

Matt Hancock: Yes, we are looking at some changes there to make sure that we have the right incentives, especially to go into the areas of



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nursing that are in particular shortage at the moment. There is an overall shortage. It is not as big as the vacancies figure, which is often the figure used, because an awful lot of vacancies are filled, for instance, through bank and agency. That is a different problem that also needs fixing.

Nevertheless, there is a shortage overall, but the biggest shortage is in specific areas such as community nursing, and mental health nursing in particular. The biggest drop-off in applications after the introduction of the bursary was among mature students, as we have discussed before.

We get the new figures on nursing degree applications later this week. I have not seen them yet. The last figures out, six months ago, showed a rise and showed that the number of applicants still exceeds the number of places. That implies that the biggest barrier to growing the nursing workforce is still in the number of training placements. Since the most urgent priority is to get more nurses, the best use of resources is in expanding the number of training places, given that we still have more applicants than training places. We want to take action on incentives to get people into the areas of particular shortage, but we also have to be clear-headed about where it is best to use the firepower we have.

Q349 **Chair:** Because there was not enough thought given to the training places as this started, you are looking at that now.

Matt Hancock: Very much so. Absolutely.

Chair: Johnny has a question about mental health and funding.

Q350 **Johnny Mercer:** Secretary of State, I am interested in funding disparities per area. The reports that have just come out on this talked about quite significant differences between certain areas of the UK. In the Surrey heartlands, it is only 10% of its budget—£124 per person. In South Yorkshire, it is £220 per head. I know that it can be a slightly misleading way of calculating spend, but how are you going to use the money that is coming down with the new settlement to level up and make sure that we move on from coming out with big policy announcements around money to looking and judging ourselves by how it actually feels to live in one of the communities where the mental health spend is significantly less than elsewhere?

Matt Hancock: That is a really important point. We are in the middle of fixing it, although it is by no means fixed. The way we are doing it is as follows.

As you know, the long-term plan commits mental health services to receiving a £2.3 billion a year uplift by the end of the five-year period as a minimum. The way we ensure that happens is by having a rising minimum spend that will then be broken down at CCG level, or in due course at ICS level once they are a legal entity in each geography. That means that there will be a rising baseline minimum spend in a particular geography. Some areas are already above where that minimum spend will end up, but lots are not. They will be picked up through that. The



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trajectory in each geography is being worked out during this financial year and will come into force from April.

- Q351 **Johnny Mercer:** The long-term plan is only one part of the picture. One of the things we have focused on in this Committee is a health in all policies approach to how we are going to tackle mental health. The single biggest factor in improving an individual's mental health can often be a job, and that would be outside your Department.

Will you be making a pitch for a comprehensive cross-Government approach to mental health? If so, how has that been received so far either in the Treasury or with any of the candidates who are looking to become Prime Minister?

Matt Hancock: There is a cross-Government committee on this. Jackie Doyle-Price leads on it within the Department. It is already happening in some areas, but there are other areas where there is much further to go.

You said that it is not the Department's remit to tackle mental ill health at work, but actually we now have a joint unit with DWP to look precisely at the health impacts of work, both what the NHS needs to do in order to help people get into work and what the incentives of the DWP policies are to help people get back into work. We have a joint team, and Amber and I put out a joint announcement on that a couple of weeks ago, as part of a wider DWP announcement.

Likewise, we have made loads of progress with DFE on mental health support in schools, which has gone well. There has been real enthusiasm in those two areas. They are probably the two areas where we have made the most progress.

Another area where I would like to see more progress is on links to the MOD and the mental health of veterans. Yesterday's announcement by the Defence Secretary on broadening the statutory basis of the policy areas that the MOD is allowed to get into by law will really help. Until now, that has been entirely an NHS issue. There has been progress, but not as much as I would have liked. Now we will be able to do much more joint work, should the proposals that the Defence Secretary made go through.

- Q352 **Rosie Cooper:** On the workforce, an area you mentioned that would be short of nurses is in community nursing and that sort of thing. I have two very quick questions. One is on the bullying at LCH. We have the Kirkup inquiry. I seek your assurance that that will be set up and up and running by the recess, so that we know we are good to go by then.

Matt Hancock: Yes. I have said it now, so we will make that happen. I am very keen to see that the new Kirkup report into the issues that you raise gets up and running fast, and also up and running on an independent basis, with the secretariat supporting Bill to do that work in the way he proposes.



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Q353 **Rosie Cooper:** Excellent. I have a very short second question. Where are we up to with Kark?

Matt Hancock: Two of the proposals from the Kark review I accepted immediately. The rest were taken forward in the people plan. Several of them require legislation. At the moment, we are looking at a whole series of different legislative options, proposed both as consequences of the Kark review and through the NHS long-term plan itself. We are considering how to take those forward.

Q354 **Rosie Cooper:** Do you have a rough timescale?

Matt Hancock: In the autumn. The new legislative priorities have to await the new Prime Minister, but we are committed to having NHS legislation. There is a question over the scope of that legislation.

Chair: We come now to pensions.

Matt Hancock: I thought that might come up.

Q355 **Andrew Selous:** Secretary of State, could you tell us how serious you regard the pensions issue as far as hospital consultants and GPs are concerned?

Matt Hancock: I regard the issue as very serious. There is a significant problem that is an unintended consequence of a different tax change and its interaction with the NHS pension scheme. The problems for GPs and for consultants are quite different in policy terms. The interactions between the pensions tax regime and the NHS pension are very complicated, but I am absolutely determined to solve the problem.

Q356 **Andrew Selous:** Could you tell us about the level of engagement you are getting from the Treasury on this issue?

Matt Hancock: You will have seen yesterday that the Chief Secretary took the UQ on this—

Q357 **Andrew Selous:** Which I placed.

Matt Hancock: She made constructive comments in terms of making progress. I have spoken to the Chief Secretary since, so this is an urgent priority that we are taking forward.

Q358 **Andrew Selous:** When you say urgent, can you give us an indication of the rough timescale for doing something about it? From what I have seen, it is building up and the last thing we want is for it to come to a head over the summer as we go into the winter.

Matt Hancock: This has to be solved with a consultation first. I want to get the consultation paper out as soon as possible. We are putting the final touches on that consultation, and I met the BMA yesterday to discuss it. That was a constructive discussion. As you can see, the Treasury is engaged. After all, at its core this is a tax policy rather than a Health Department policy, but of course the biggest impact is in my area.



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We are committed to resolving it by the new financial year. I would strongly recommend that people who are affected by the lifetime allowance take no precipitate action on early retirement, because we are going to fix this problem. For people who are affected by the annual allowance, I understand the problem, but we still need to make sure that we find solutions urgently so that people can do the work they want to do and that the NHS needs them to do.

Q359 Andrew Selous: Can you give us an assurance that the consultation will be wider than just the 50:50 accrual proposal, which I understand the BMA do not think is sufficient to address the breadth of the problem?

Matt Hancock: The 50:50 proposal would go some way to solving some of the problems. The BMA makes a case that it does not solve all of the problems. I have heard that case. The consultation will include open questions as to how best to solve the problem. Everybody will be able to respond to the details that we put out, explaining how they think it best to solve the problem. We are just working on the final details of that, following a meeting with the BMA yesterday.

Q360 Andrew Selous: What would you say to the GP who is doing fewer sessions per week at the moment because of fear of breaching the annual allowance?

Matt Hancock: I would say that we are trying to fix the problem and we understand the interactions. We are going to try to fix it as soon as possible.

Q361 Chair: Some of this is not the Treasury. Some of it arises from difficulties that GPs have in actually finding out where they are with their pensions. One of my constituents was told that they would have to wait for three months to get a response. At the end of that period, when they chased it up, they were told that their pension records had not been updated by Primary Care Support England for three years and that they would have to wait a further three months once their records were updated. Isn't there something you also need to do to sort out the speed with which people can get up-to-date information about where they are with their pensions?

Matt Hancock: If you write to me with that case, I will absolutely look into it. That is the first I have heard of that particular problem. I have heard lots of problems in this area, but I am very happy to look into that one.

Q362 Chair: I will get permission to forward the email to you. I have met a number of GPs over the last couple of weeks, and that seemed to strike a chord—the delays in finding out whether they have a liability at all in the future. Many young doctors simply do not want to take on extra hours because they do not know where that is going to wind them up.

Matt Hancock: In many, many cases, people raise concerns that are not fully founded. I have looked into a number of cases where the problem



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for an individual is not nearly as big as they worry. It is one of the reasons why I want to solve this as quickly as possible. I think we can give reassurance to quite a lot of people.

For instance, I have seen cases where people said that they have been faced with a very large up-front total tax bill, but we have already changed the rules to ensure that people do not have to pay cash tax bills up front and instead can ensure that that is swallowed within a rising pension pot. There are a number of areas where people are understandably concerned because they have heard rumours, and the rumours are much worse than the reality.

I will fix the substance, but I also want to provide people with the reassurance that in many cases doing extra work increases their total remuneration, and the problem is not nearly as big as is feared. I want to get the facts out there, both so that we can reassure people and so that people get up-to-date information as fast as possible about what the actual impact on their total pay is. That is only fair.

Q363 Andrew Selous: Secretary of State, what lessons have you learned from the failure of the 2016 GP forward view to get 5,000 extra GPs in primary care by 2020? We need to understand where we went wrong on that in order to arrive at a long-term plan.

Matt Hancock: Yes. Great question.

Andrew Selous: What have we learned from that to make sure that we do not fall into the same pitfalls?

Matt Hancock: The good news is that on the latest figures the number of GPs is rising, albeit only by 300. We have a long way further to go, but at least we are moving in the right direction.

Looking back to the GP forward view and what happened afterwards, the No. 1 thing is that the focus was understandably on hiring new GPs, and that has been successful. There is a record number of GPs in training; it is three thousand four hundred and—

Sir Chris Wormald: Seventy-three.

Matt Hancock: Thank you. I do big picture and the permanent secretary does detail; it is a good team effort.

There was a successful focus on new GPs. I think there was not enough focus on retention, both in people doing a full week's work, full time, and in keeping people in general practice in the NHS. The NHS people plan focuses on training new staff, including new GPs, on recruiting from overseas and on retention. Hence why I reacted the way I did to the initial questions about the people plan; the retention piece is about far more than just the numbers coming through. It is about the overall culture and what it is like to work in the NHS, dealing with some of the pressures that many people feel under.



Q364 **Andrew Selous:** What do we need to do to encourage GPs to work more sessions? I think the average is about three and a half days a week. If it went to four and a half, it would make a massive difference up and down the country.

Matt Hancock: Yes.

Q365 **Andrew Selous:** Secondly, many GPs are retiring in their mid-50s when, ideally, we should be getting another 10 years or so work from them. What are we doing in those two areas?

Matt Hancock: Tackling early retirement is partly about financial incentives, and sorting out the lifetime allowance pension issue, for instance. It is partly about workload. It is the same answer for people who go from full time to part time. There is the annual allowance incentive problem and workload. If you are working and your list is longer than it has ever been, it is hard. I get that. It is hard.

One of the solutions is not only getting more GPs—there is a virtuous circle if we can get that going more strongly—and getting them to the right places, but changing primary care so that GPs have more support. I was really struck a year ago to the day, when I became Health Secretary, by the fact that in primary care there is on average one nurse for every two GPs. In secondary care, there are two nurses for every doctor. They cannot both be right.

My instinct, strongly shared by Simon Stevens, is that far more support from other health professionals around GPs also makes it better to be a GP. I do not want to put words into the mouth of the royal college, but Helen Stokes-Lampard is a wonderful woman and I think she probably broadly shares that view.

There are examples around the world where the ratio is far higher than 2:1 other health professionals to a GP, where in a primary care system the GPs do the difficult cases where a lot of judgment is needed, and the full weight of their training can be brought to bear on a case, and nurse practitioners and other health professionals and nurses in GP practices can do an awful lot of the broader work. We are in the middle of a move to that structure. There is a long way still to go.

Q366 **Andrew Selous:** Do we have a target for the number of overseas GPs we are trying to recruit in the meantime to get the numbers up?

Matt Hancock: No, we do not have a target for the share between recruitment overseas and domestic training. We have an overall goal of 5,000 more than the 2015 baseline.

Q367 **Andrew Selous:** But we have not put a date on when we achieve that in the long-term plan, have we, unlike the GP 2016 forward view? Maybe you feel you have been burned by that experience, but it leaves me a little bit nervous that there is no date.



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Matt Hancock: Why don't I look to see if we can put a date on it in the final people plan that comes out? It will be dependent on the HEE budget. It is also dependent on how quickly we can fix the problems that are driving retention issues.

Q368 **Andrew Selous:** Personally, I feel it would be helpful from a motivational point of view within the Department if everyone knew that we were trying to get to a certain number by a certain time.

Matt Hancock: Yes. If I can explain where I came from on that, I arrived to find that we were missing the target. Indeed, we were going backwards. We were clearly not going to hit 5,000 by the original target date. I was very clear that we needed to keep the target, and we needed to do work on what date it was realistic to hit it by. I will take that away and look at putting it in the final people plan.

Andrew Selous: That is excellent; fantastic, thank you.

Sir Chris Wormald: I think you said that the five year forward view for GPs was a failure on the basis of the 5,000.

Q369 **Andrew Selous:** I didn't say that today. I just said that you have not achieved the 5,000 target.

Sir Chris Wormald: There was an awful lot more in the five year forward view for GPs than just the figure, although of course that was very important. An awful lot of that thinking is there in the long-term plan and is going ahead. We are investing more in primary care and all those sorts of things. I would not want to leave the impression that that plan was entirely about the numbers. A lot of the thinking continues, as you have seen.

Matt Hancock: Before we leave primary care, I have some news that I can give you. As you know, we are forming GP services into primary care networks. I can report that there are now 1,259 primary care networks that include 99.7% of all GP practices. We will be getting that to 100% in the coming days and weeks.

Chair: We have not left general practice, as Paul has another question.

Q370 **Dr Williams:** Secretary of State, I would like to ask you a question about patients' experience of general practice. An increasing proportion of patients say that their experience of booking an appointment is not satisfactory. People report to me that they make sometimes hundreds of telephone calls at 8.30 in the morning. When they eventually get through, they are told, "We're sorry, you are going to have to call back and repeat the exercise tomorrow." Sometimes, people say that they cannot get a GP appointment for six weeks.

Three out of 10 people report a poor experience. Seven out of 10 people report a good or satisfactory experience. Clearly, it works in some places and does not work in others. What are you going to do to help the people for whom it is not working?



Matt Hancock: Clearly, part of the solution is expanding the service that is available, as we have just discussed—both GP numbers and wider personnel in primary care. I also think there is a technological solution. The standard phone system that is used is unsatisfactory. Even without going to the full use of technology and Skype for a GP appointment, which works very well for some people and which we are rolling out, the ability to book, whether by phone or online, could be much better.

The very long waits to see a GP are nearly always to see a named GP. There are very few areas where the urgent need to see a GP has the same degree of problem. I too hear stories of people who have to phone over and over again. There are examples of new technology that allow for most people to go online and pick a GP appointment. You could take a bit longer and pick a named GP appointment with your named GP, or you could go for a sooner one with a GP or healthcare professional in that practice.

Getting people culturally used to the idea that more often than not, when you go to the doctor, you do not see a doctor but a nurse or other health professional is a big culture change that we need to go through as a country. That frees up resources for the receptionists at the doctors to use the same system, but by answering the phone to people who cannot go online.

Q371 **Dr Williams:** I know all these things and you know all these things, and practices in which it is working know all these things as well, but what are you going to do to make sure that patients who happen to be registered with a practice that has decided not to take up those technologies are not disadvantaged?

Matt Hancock: This is where primary care networks can help. It is one of the examples of why we have gone to primary care networks. In an individual small GP practice, especially one under pressure, they often do not have the bandwidth to make that sort of improvement. You need quite a lot of communication with your patients and you need to improve the system and get the technology. You need to go through, essentially, what we could regard as a change management process.

A primary care network gives us two advantages. First, there are only 1,259 of them. There will be a few more than that once we have finally completed it, but it is a tractable number, as opposed to the tens of thousands of GP practices.

Secondly, a primary care network can go through the individual practices putting in place the new system with the support for people—both patients and staff—that is needed to get on to the new technology. I have seen this happen in some GP practices where there has been a massive problem in the past. They moved on to the new system. The patients were concerned, and the GPs did not want everybody complaining. Nearly always, within a short space of time, everybody is much happier with the



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new system driven by technology, but it takes sensitive handling to get from A to B.

Q372 **Dr Williams:** What is your ambition for this? When will you be satisfied and—

Matt Hancock: Never.

Q373 **Dr Williams:** What is the ambition? How will you know that you have been successful in helping to improve GP services?

Matt Hancock: If, in a year's time, the proportion of people saying that there is a problem of access, and the means of access falls from around three in 10 to, say, half that figure, that would be a reasonable target. That may be a goal that you as a Committee might want to set me.

Q374 **Chair:** Looking at things like extended access and Sunday opening, what I am hearing from GPs is that that is taking away from the availability of an overstretched workforce to cover out-of-hours shifts and that quite often Sunday extended opening hours are not well filled. Do you think it is time to review the evidence about Sunday GP opening and some of the extended hours aspects? Net, have they actually been a good idea? Should we review it?

Matt Hancock: We have only just completed the roll-out, which happened ahead of time. I think we need to give it a little bit of time to bed in, but there will be a moment when we assess whether it has worked. It is part of the culture change, isn't it?

Q375 **Chair:** But Sunday opening has been going on for a while. I am hearing that the take-up has not been high, but the real challenge is finding people to fill the out-of-hours shifts. In other words, GPs are doing shifts where there is low demand, whereas out of hours is struggling to fill shifts.

Matt Hancock: Chris is going to come in. My overall approach is that you have to follow the user need and what the patients want. This was done as a Government decision to ensure that it was available.

Q376 **Chair:** Don't you think it is political though? It was a political decision to say, "We have seven-day opening." It was not something that was needed but it had unintended consequences, so we should look at that.

Matt Hancock: We should look at how people actually use their GP services, and whether they concentrate just on their iPads, for instance. We need to make sure that we deliver care in the place that people want it at the times when people want it.

Q377 **Chair:** People need it to be available out of hours.

Matt Hancock: Absolutely.

Q378 **Chair:** But you cannot fill your out-of-hours shifts because you have an overstretched workforce.



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Matt Hancock: I do not think it is necessarily automatic that there is a link from one to the other. I want to go away and think about that.

Sir Chris Wormald: I was going to say exactly that. NHS England looks at this quite carefully and has been discussing with local areas what is appropriate in different places. I have not had a conversation with them about it for a while; we said we needed to go away and get an update, but, from memory, it is quite different in different parts of the country as to whether or not the local population wants Sunday opening. I will go away and check, but I think they have been taking a reasonably flexible approach about the balance between weekends, evenings and Sundays depending on what local areas want. As I said, I have not had an update for a while, so I will go away and check, and we will come back to you on that.

Matt Hancock: There is an interaction with technology. First, people may choose to access GP or primary care services through technology at different times of the day and week than they would by shipping up at the surgery. One of the things we have found from the expansion of telemedicine availability in primary care is that the times when doctors want to work change. More people are willing to do evening work by telemedicine because they can do it from their own home.

Chair: We are going to come on to social care.

Q379 **Mr Bradshaw:** Secretary of State, in the 2017 general election, your party promised a Green Paper on long-term social care by the summer of 2017. Where is it?

Matt Hancock: It will not be published before the new Prime Minister is in place.

Q380 **Mr Bradshaw:** Why has it not been published in the last two years?

Matt Hancock: Because we have not been able to find a way through that would get the sort of cross-party support that is hugely helpful for projects like this. That has not been helped by the nature of the wider political debates that have been going on.

Q381 **Mr Bradshaw:** Hold on. You are blaming other parties. You are in Government. You have a majority on paper with the DUP. You had a manifesto commitment. What evidence do you have that it is other parties' fault that you have not published the Green Paper?

Matt Hancock: For instance, we all lived through the 2017 experience of landing a social care policy in the middle of an election campaign. I thought the major parties had taken from that experience that we should try to resolve this in a way that was more collaborative. I think the work of your Committee and the Communities Committee, as I have said many times before, was an exemplar of how cross-party working can proceed.

I observe that at the start of May my colleague, Damien Green, who was responsible for this area of policy when he was in Government, came



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forward with a proposal that was remarkably similar to your proposal, and it was attacked on the day by the shadow Chancellor as a tax on old people. It has proved difficult, and I regret that it has proved difficult, to build cross-party consensus more broadly than Select Committees.

Q382 **Chair:** It was broader than that.

Matt Hancock: I had hoped it was too.

Q383 **Mr Bradshaw:** You mentioned our report. The Lords have come out with a report. Two reports have been drafted following extensive consultation and evidence-gathering with MPs across the political spectrum. You are a Government of one party plus the DUP, yet you have not been able to agree to put a Green Paper out.

A Green Paper is only a discussion document. Why don't you just put it out so that we can talk about it? If Labour attacks it, you will have a field day because you will be able to say that the Labour party is being irresponsible. Why not just put it out there?

Matt Hancock: The Lords report is a case in point. The Lords report is also a cross-party report and it comes to a different conclusion from you.

Q384 **Mr Bradshaw:** But you are in Government. It is your job. You are the Minister. You are the Secretary of State and it is your job to come up with policy for everybody to consult on. Why don't you just do it?

Matt Hancock: As I say, we are going to have to await the next Prime Minister before we can make progress on this. I wish we had been able to put something out. As with pensions and other similar very long-term issues, it is far better if it is done on a cross-party basis.

Q385 **Dr Williams:** On 28 March 2018, a letter to the Prime Minister from the Chair, signed by more than 90 MPs from across the parties, offered to work collaboratively on this issue. That offer was not taken up. Secretary of State, how can you say that it has been blocked because there has not been cross-party collaboration when a large group of cross-party MPs have offered the chance to work on it?

Matt Hancock: I have taken this up and had discussions with my opposite numbers and various people, and the Committee. I wish that we had been able to find cross-party agreement, but I have not been able to do that yet.

Q386 **Mr Bradshaw:** The *Daily Express* said last month that 77 people over 65 have died every day waiting for a social care package since you first announced it more than two years ago. In total, 64,000 people have died. Is that a statistic that you recognise?

Matt Hancock: I have not seen that statistic, but what I would say is that the long-term solutions to this are by their nature long term. We also need short-term solutions, which we have provided. The total budget available to spend on social care has gone up by 11% over the last three to four years. We have put in an extra £650 million this financial year,



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and £240 million in the last financial year, since I became Secretary of State a year ago.

Of course, like so many people, I want to see a long-term solution, both so that we have a sustainably funded social care system into the future and so that we can remove some of the injustices in the system, like the fact that unlike any other area of Government policy people have to sell their home in order to pay for it. There are injustices in the rights that you have for Government support according to your condition, whether you have dementia or cancer, for instance. There is a whole series of injustices in this area that I would dearly love to see addressed, and there is the short-term funding problem. We have done better on the short-term funding problem with the provision of funding, albeit one year to the next—I stress that is a short-term solution—than we have with being able to bring forward proposals for the long term.

Q387 Mr Bradshaw: You talked about dementia. The Alzheimer's Society said today that over the period we have been waiting patients have spent £15 billion of their own money on care. Is that a figure you recognise, and is it acceptable?

Matt Hancock: I saw that on the front page of the newspapers. In fact, one of the reasons I was a couple of minutes late was that I was with the Alzheimer's Society at their presentation downstairs.

Q388 Mr Bradshaw: Purely coincidentally I am sure, the man you are backing to be the next Prime Minister has promised as his priority a tax cut for the richest 8% of the population, amounting to £8 billion annually. That is exactly the same figure that the Lords Committee, and indeed we, believe needs to go into social care to plug the gap. Which would be your priority?

Matt Hancock: He has also proposed solving the social care problem and made it clear that that will be a high priority for his Administration. We do not know for sure that Boris Johnson is going to win. I think he will, and I hope that he does. He has made the commitment to tackle social care as a very significant issue.

Q389 Mr Bradshaw: But government, as you know, is about priorities. Would your priority be to give £8 billion to the richest 8% of the population or to solve the social care crisis, as Health Secretary? That is your responsibility as Health Secretary.

Matt Hancock: I am absolutely clear that we need to reduce taxes when we can afford that, and I am delighted that Boris has made the clear pledge to tackle the problems in social care.

Q390 Mr Bradshaw: How is he going to do it?

Matt Hancock: He has put forward high-level proposals and I look forward to working—

Q391 Mr Bradshaw: How is he going to pay for it?



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Matt Hancock: He has made a series of proposals during the campaign, as has Jeremy Hunt. As we know, there is fiscal firepower in the Treasury currently because the economy is growing strongly and employment is very high. A year ago, when I came in, one of the questions in my first evidence session was, "How are you going to pay for the £20 billion extra for the NHS?" The answer is that we have not had to put up taxes to pay for that because there are more people in work paying taxes rather than people paying more tax. The best way to fund strong public services is with a strong economy.

Q392 **Chair:** Can I add one section on the issue of sleep-in shifts, particularly for disabled adults who require overnight care? The issue has not been resolved. As you know, the advice is still being given that providers should continue to pay sleep-ins at the national minimum wage, but there has been no earmarked extra funding for that. A great deal of anxiety about payments is being caused to people who are in control of their own personal budgets. It is causing a huge amount of stress for severely disabled adults, and is putting providers at significant risk of collapse.

The issue has not been resolved. We are waiting for the Supreme Court judgment in 2020, but providers are still being advised to continue paying without having any money earmarked. It is particularly an issue for young disabled adults.

Matt Hancock: The Court of Appeal judgment that was reached just under a year ago is that employers are not required to pay the national minimum wage for sleep-in shifts.

Q393 **Chair:** But they are being advised to continue to do so, so that they do not have a huge backlog liability if the Supreme Court judgment goes the other way.

Matt Hancock: As far as I understand it, there has been updated public guidance following the ruling. Of course, I have to be careful in what I say because this area is, as you mentioned, being appealed to the Supreme Court, who are set to hear the arguments on 12 and 13 February next year. That is the situation.

Q394 **Chair:** Can I clarify something? Learning Disability Voices wrote to me about this on 7 June. They say that they understand the Government's position to be that providers should still continue to pay sleep-in shifts at the national minimum wage. Are you saying that is not the case?

Matt Hancock: We put out updated public guidance, and I will write to you with the full details of that guidance. I am being careful in what I say because the area is under judicial consideration.

Q395 **Chair:** It would be helpful if you could clarify it because, as I said, there is a great deal of concern that the issue has not been resolved. We have been backwards and forwards in correspondence on it, but if you could write to me again that would be very helpful.



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Matt Hancock: I will write to you before the end of next week.

Q396 **Chair:** Thank you; that would be helpful. We come now to the issue of prevention. It is extraordinary that the prevention Green Paper was apparently on the grid for publication this week for No. 10 and it has been pulled at the last minute.

Matt Hancock: I wouldn't believe everything you read in the newspapers.

Q397 **Chair:** Well, I think I believe that.

Matt Hancock: You may well believe it but—

Q398 **Chair:** It was from a very good source. Was it on the No. 10 grid for publication this week? Presumably, you would have known that.

Matt Hancock: Not as far as I know, no. Obviously, I have been doing a lot of work on it, but as far as I know it did not have a grid slot.

Q399 **Chair:** The publication has not actually been delayed. Is that what you are saying to me?

Matt Hancock: I was not aware of a set date for it to be published. In a way, that is process rather than substance.

Chair: I think there is a great deal of substance to discuss on this.

Q400 **Dr Williams:** I would like to ask about the soft drinks industry levy. As you rightly said in January, it has taken 90 million kg of sugar from drinks since it was introduced because companies reformulated their drinks to avoid the levy. You hailed it in January, but last week you backed a review into the soft drinks industry levy. Are you no longer convinced that the evidence shows that it is effective?

Matt Hancock: I am strongly supportive of following the evidence. In fact, last month I asked the CMO to conduct a review of the evidence around this, and I look forward to hearing what she has to say.

Q401 **Dr Williams:** What is the expert advice that you are currently getting about the impact of the soft drinks industry levy?

Matt Hancock: The facts on the ground have not changed. However, it is always best to base your judgments on the best available evidence. That is what I have always sought to do as a Minister, and I think evidence-based reviews are very valuable in formulating future Government policy. Hence, I had already asked the CMO to conduct such an evidence-based review.

Q402 **Dr Williams:** What was the remit of the review? Is it a review into the policy that has already been implemented, or is it a review looking at potential extension of the levy?

Matt Hancock: It is to gather evidence around the area covering both.



Q403 **Dr Williams:** The levy itself is up for review.

Matt Hancock: The question is whether we should gather evidence about the impact of the policy and any future policies associated with it. I think all policies like this should be based on the evidence. I am delighted that the CMO, who is one of the finest scientists of her generation, will be conducting that evidence-based review.

Q404 **Dr Williams:** The evidence is that it has taken a large amount of sugar out of people's diets. There is not yet any evidence that that is being translated into a reduction of childhood obesity, but there is certainly less sugar being consumed. Do you see the case for extending it, given that less sugar is being consumed, perhaps to milk drinks?

Matt Hancock: The case for an extension was always due to be considered by the Government in 2020. When the so-called sugar tax was first introduced, we always said that we would look at it again in 2020. I commissioned the evidence base from the CMO in anticipation of that consideration being given next year.

Q405 **Dr Williams:** Would you like to see it extended?

Matt Hancock: I would like to see the evidence.

Q406 **Dr Williams:** If the evidence shows that it is reducing consumption, do you think that is a good thing?

Matt Hancock: Let's see what the evidence says.

Q407 **Dr Williams:** What if the evidence showed that it is reducing consumption?

Matt Hancock: I do not want to prejudge what the evidence says. I want to look at the evidence.

Q408 **Dr Williams:** But we already have evidence that shows that. You are looking for the evidence review; that is reviewing existing evidence. There is already evidence in the public domain that shows it is reducing consumption. Do you think that is a good thing?

Mr Bradshaw: You highlighted a speech.

Matt Hancock: Yes, but having asked Sally to do this work, I do not want to prejudge it. I want to ensure that she can come to a full scientific basis.

Q409 **Dr Williams:** I am not asking you to prejudge it; I am asking—

Matt Hancock: But you are, because you are asking a conditional question—if this is the outcome.

Q410 **Dr Williams:** You are asking for an evidence review.

Matt Hancock: Yes.

Q411 **Dr Williams:** The evidence that is being reviewed is there. You have



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hailed it, and there are papers that have been written in *The Lancet* and the *British Medical Journal* that have looked at it. I am sure that you are getting expert advice on it.

Matt Hancock: I am.

Q412 **Dr Williams:** Do you think it is a good thing that consumption of sugar is reducing as a result of the soft drinks levy?

Matt Hancock: I am a massive fan of tackling obesity. I think that is incredibly important.

Q413 **Dr Williams:** That was not the question I asked. Is it a good thing that consumption—

Matt Hancock: You keep asking about the evidence. As I said, I asked Sally Davies to do an evidence-based review, and that is what I will be looking to.

Q414 **Dr Williams:** If the evidence-based review shows that it works, would you politically—this is a political question—support extending it, perhaps to other products, or perhaps increasing the level at which taxation applies so that we are taking more sugar out of people's diets?

Matt Hancock: That is another of those conditional questions.

Q415 **Dr Williams:** It is a political question. These are political choices about—

Matt Hancock: No, it is a conditional question.

Q416 **Dr Williams:** These are choices about public health policy.

Matt Hancock: I look forward to looking at the evidence.

Q417 **Andrew Selous:** I want to broaden it to the obesity debate, if I may. A recent report by St Thomas' Hospital's charitable arm told us that only 5% of children in Paris are obese, but the figure for London is 22%. We are a bit of a European outlier. When you look across the channel, what lessons do you draw from what Europe does better in this area that you think we could usefully copy here for the UK?

Matt Hancock: This is really tricky territory. There is a whole series of cultural questions, in particular in terms of diet and the prevalence of home cooking. There are differences between different countries, essentially, in how people eat and the nutrition that we have.

Q418 **Andrew Selous:** Is there any intrinsic reason why the UK could not move towards a more European attitude to food? If you look at the prices of some foods, fresh food seems to be cheaper in Europe according to the recent Food Foundation report, whereas often in the UK processed food seems to be cheaper. There seems to be something odd going on with the pricing mechanism. I wondered whether anyone in the Department of Health was looking at that.

We have seen success in Amsterdam in some areas. They are actually



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building on the reductions in childhood obesity there and looking at what some supermarkets are doing. They are trying to sell less unhealthy food to children. It seems to me that, if we want to be world-leading, we have to look at what other countries are doing well to learn from them.

Matt Hancock: I totally agree with you. There is such a lot of work to do. The recent evidence on the price impact of going for fresh and non-wrapped food compared with pre-prepared food I thought was incredibly striking. I think it was from Hugh Fearnley-Whittingstall, who has done some good work in the area. There are international comparisons, but the thing is that we have to start from where we are. We are so far behind some other countries that we have to do a whole lot of work even to catch up.

Sir Chris Wormald: We have some national examples. I am sure you have seen the case of Leeds, which had some success.

Q420 **Andrew Selous:** I have looked at some of the Leeds data.

Sir Chris Wormald: On your general point that we should look at what works, yes, of course we should. We look internationally at best practice from around the world. There is always a translation question, and quite frequently what works here already is better.

The public health position internationally is quite mixed. We do very well by European standards on smoking—

Andrew Selous: I will stick to obesity for the moment, if I may.

Chair: I think there is a political question as well for the Secretary of State.

Q421 **Andrew Selous:** Can I come back to the actions proposed in chapter two of the childhood obesity plan? I am picking up a little bit of concern from the Obesity Health Alliance and others about the length of time of some of the consultations. Could you give us an update on when those consultations will be concluded and we can expect to see action on things like the 9 pm watershed, the multi-buy promotions and other areas like that?

Matt Hancock: I do not have an exact list in front of me, but I can come back to you.

Q422 **Andrew Selous:** That would be helpful.

Matt Hancock: Some of those are currently open, and some are closed but have only just closed and we are considering the responses. We need to take action in this space. We have set out a whole load of actions in chapter two, and we are taking that work forward.

Q423 **Andrew Selous:** While you are Secretary of State, you will ensure that there is no delay on sticking to the chapter two timetable on consultation and action following that.



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Matt Hancock: Yes, there has been a huge amount of work.

Q424 **Andrew Selous:** The last area I would like to ask you about is calorie labelling. I will ask you the same question I asked Simon Stevens a week ago. Do you know how many calories you have eaten in the last 24 hours? Ballpark, are you able to tell us?

Matt Hancock: No.

Q425 **Andrew Selous:** Does that worry you, Secretary of State? As men, we are supposed to eat less than 2,500 a day and for women it is 2,000. It is almost impossible to find out if we are doing that, yet it is Public Health England guidance to us all. How are we supposed to stay within it if the labelling is so poor?

Matt Hancock: Part of the reason that I have not is that it is not just about labelling. It is also about how we live our lives. I try to eat in a way that keeps me reasonably healthy. It is a challenge that all of us face.

Q426 **Andrew Selous:** What is behind my question is that I am frustrated by the calorie labelling on what we buy when we go out.

Matt Hancock: Yes, absolutely.

Q427 **Andrew Selous:** It is one of the actions in the childhood obesity plan that out of home there will be calorie labelling. We are bringing it in for one part of the landscape, so I am really asking about when we go to supermarkets. Don't you think there is a role for better information in GP surgeries, for example, as to how many calories are in the typical meals we Brits eat? Wouldn't that be a help in terms of public education?

Matt Hancock: Yes. An important thing to consider is how that information is imparted. Sometimes it is there, but it is in tiny print on the back and you can hardly see it. There are other ways of imparting that sort of information that are better.

Q428 **Mr Bradshaw:** You rather dismissed the Chair's questions about process, Secretary of State, but process is quite important. As Cancer UK pointed out this week, obesity is now the main cause of cancer. If the Green Paper is not delayed, when can we expect it?

Matt Hancock: Shortly. The question of what is on the Downing Street—

Q429 **Mr Bradshaw:** You said shortly about the social care Green Paper two years ago, or your predecessors did.

Matt Hancock: I do not think I did.

Q430 **Mr Bradshaw:** You are constantly saying shortly about Green Papers that then never appear. A lot of them just vanish, don't they?

Matt Hancock: No.

Q431 **Mr Bradshaw:** What do you mean by shortly? Let's be a bit more specific. We have had shortly before and it never happens.



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Matt Hancock: I cannot be more specific because the date has not been agreed.

Q432 **Mr Bradshaw:** The outgoing public health Minister who resigned in March tells me that he did the write-around several weeks ago, before he left, so what is going on?

Matt Hancock: I am not going to get into internal processes. I do not know whether that is true or not.

Q433 **Mr Bradshaw:** He also told me that the write-around draft contained plans to extend the sugar tax to sugary milk drinks; to ban the sale of energy drinks to the under-16s; and a slew of other policies aimed at improving public health. It would be very disappointing if those did not emerge in the eventual Green Paper, wouldn't it, because of what is going on with the current Tory leadership contest?

Matt Hancock: No. The public health Minister has been doing a brilliant job. She has been in post for a long time and she has been responsible for the final drafting of this Green Paper, not her predecessor.

Q434 **Mr Bradshaw:** Caroline Dinenage?

Matt Hancock: Seema Kennedy.

Q435 **Mr Bradshaw:** Do you think that the sugary drinks tax is regressive?

Matt Hancock: I have not seen analysis on that, and it is always worth looking at the evidence.

Q436 **Mr Bradshaw:** I beg your pardon? You are Health Secretary, but you have not looked at the evidence that caused your Government to introduce it in the first place, and that showed it was not regressive and that actually the people who most benefit from it are the least well-off.

Matt Hancock: It is a tax policy that has been in place for some time. I was not the Health Secretary when it was brought in. I have just asked for a review of the evidence.

Q437 **Mr Bradshaw:** But, given that there is a major public health crisis, you have not yourself studied the evidence that showed that the policy is not at all regressive.

Matt Hancock: The thing is, Mr Bradshaw, when I want to see the evidence, I get the very best people to assemble it, and then I do not prejudge the outcomes of that evidence.

Q438 **Mr Bradshaw:** Is it not rather strange that you have only asked for the evidence since your favourite contender for the Tory leadership made a boo-boo over this? You never asked for it before.

Matt Hancock: No, I did ask for it before, so that is nonsense.

Q439 **Mr Bradshaw:** Has Caroline Dinenage been reprimanded for calling what Boris Johnson said "Bollocks"?



Matt Hancock: No.

Q440 **Johnny Mercer:** Secretary of State, there are obviously two different lines of thought in politics around the sugar tax at the moment. For those who do not have the deep whirl of ideology and are just pragmatists and want to see childhood obesity decreasing and have been to places like Amsterdam to see where this has happened—I am genuinely asking you because I want to be able to say this to people—what would you say is the line in your mind between state intervention and a smaller state actually intervening on behalf of the most vulnerable people, who are at times exploited by very clever agents?

Matt Hancock: What I would say is that all taxes have behavioural consequences. Those of us on the centre right who think about the dynamic impact of taxes really understand that. For instance, some people make the argument that, as we reduced corporation tax, we increased corporation tax receipts because it led to an increase in economic activity. That is a classic centre right argument about the impact of taxes.

It also works in other areas. There is evidence, for instance, that the anticipated static expectation of receipts from the sugar tax were £600 million, but the actual receipts were £253 million, which demonstrates a dynamic impact. The question you have as a policy maker is where do you want your dynamic impact to fall? Hence, it is so important to review the evidence and base your analysis on the evidence.

Q441 **Johnny Mercer:** Do we have any evidence from other cities that have a better record? You have heard that we are a bit of an outlier when it comes to childhood obesity.

Matt Hancock: There isn't anywhere else that has done a sugar tax in the same way. There are other cities that have been successful. Chris mentioned Leeds. You mentioned Amsterdam, but nowhere has really tackled the problem. The countries that do well on obesity are ones where there is a big cultural difference. Nowhere has yet turned around a problem that has gone too far, so to speak.

Q442 **Johnny Mercer:** I know that people have gone pretty hard on you over this, but the reality is that both contenders to be the next Prime Minister have said that they will follow the evidence.

Matt Hancock: And care deeply about solving the problems of obesity. I think it is always worth waiting for the evidence.

Q443 **Chair:** You mentioned the dynamic impact of the tax. It has gone from £600 million to collecting £253 million.

Matt Hancock: They are the correct figures, yes.

Q444 **Chair:** Isn't that the perfect tax? It drives reformulation and that is why you are collecting less. It has had the impact of making producers reformulate. Surely, that is very good evidence that it has had an effect.



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It depends what your end point is.

Are you going to assess whether it is effective by whether or not it has in itself been the magic bullet in preventing childhood obesity, or are you are going to be saying that it is successful because it has reduced sugar consumption, which is the point my colleague Paul was trying to get at? If you are going to say, "We will scrap it because childhood obesity hasn't changed," surely that would be appalling, Secretary of State. It is not just about obesity; it is about things like the fact that the biggest cause of admission to hospital for children is to remove their rotten teeth. We are interested to hear from you what looks like success. What do you mean by evidence? What will be your end point?

Matt Hancock: I look forward to coming back and giving you a full assessment after we have seen the full scientific evidence from the CMO.

Q445 **Chair:** Is the end point for you going to be whether it reduces sugar? Is that a good end point, or is the end point going to be whether it has had an impact on obesity? What are you judging as success? Is it a proxy marker? What is your marker for success?

Matt Hancock: There is a problem that the biggest cause of admission to hospital among children is because of dental problems.

Q446 **Chair:** Removing rotten teeth.

Matt Hancock: Largely tooth decay. There is also a problem of obesity. Both of these need to be tackled. To say is it one or the other—

Q447 **Chair:** I am not saying one or the other.

Matt Hancock: Obviously it is both.

Q448 **Chair:** But if you are judging the end point and if you are going to say to us, "Well, we'll scrap the sugary drinks levy if there hasn't been a reduction in obesity," that would be appalling.

Matt Hancock: No, I am proposing to follow the evidence.

Q449 **Chair:** That is what we are trying to ask you about. What evidence are you most interested in? Are you most interested in reduction of sugar or in some—

Matt Hancock: As I say, I am interested in both and I look forward to Sally's report. We are going to look at all these things in the round. There is another point as well. For both the goals you mentioned, there are also other policies that can be brought to bear.

Q450 **Chair:** Yes, you have to do both. But the worrying thing is that, if there is a change in philosophy that says childhood obesity is all about making children run around a bit more and that we do not want to do anything that upsets industry, I am afraid we are in real difficulties. What people want to be clear on from you, Secretary of State, is where you feel all of this fits in.



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I want to quote to you for a minute from your vision for prevention, which was published in November, to great fanfare. You said: "There is a role for government to create the environment that makes healthy choices as easy as possible, and to address the conditions that lead to poor health. This could be through laws, regulations and incentives." Are you still committed to the fact that sometimes laws, regulations and incentives have a place?

Matt Hancock: I am committed to that. I am committed to every word of that paper. Absolutely.

Q451 **Chair:** That is what I wanted to hear. We are not going to be saying that all of this is nanny state nonsense and it has all got to be swept out of the way because one of your colleagues does not like anything that looks like intervention.

Matt Hancock: We are going to be following the evidence, Sarah.

Q452 **Chair:** Well, that is very good. We shall be bringing you back to discuss that if you are still in your post.

Matt Hancock: Did I mention that we should follow the evidence?

Chair: Yes, I know, but we want to be clear about what you are going to be measuring. There is a philosophy that we are hearing from some of your colleagues that we do not have to care about things like this if they involve things that industry does not like.

Q453 **Mr Bradshaw:** You keep saying "follow the evidence," but you have only started saying it since Boris Johnson made his remarks.

Matt Hancock: No, that is just not true.

Q454 **Mr Bradshaw:** You have been a Minister for longer than that. Was your evidence not evidence-based before the leadership campaign?

Matt Hancock: Dearie me. You cannot base your questions on things that are not true, Mr Bradshaw. I asked the CMO last month to undertake this review, and I am delighted that she is undertaking it. I keep being invited to prejudge the outcome of a review of one of the most brilliant scientists of our age, and I would rather let the evidence speak for itself.

Q455 **Chair:** If the CMO says, "Extend it because the evidence supports it," will you be recommending that to your colleagues?

Matt Hancock: I will be waiting to see what she says.

Chair: I think we have gone as far as we can there. Paul, do you want to talk about the first 1,000 days?

Dr Williams: I do not have a specific question.

Chair: We will move on to Brexit.

Q456 **Mr Bradshaw:** Do you still agree with yourself on this, Secretary of State?



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Matt Hancock: Yes.

Q457 **Mr Bradshaw:** Good, because on 2 June, you said in your interview with *The Times*—I think it was while you were still in the leadership race; I cannot remember—“No deal is not a policy option available to the next Prime Minister, whether they like it or not.” Do you still agree with your statement?

Matt Hancock: Since then, if you follow the evidence, you will see that there have been votes in the House of Commons.

Q458 **Mr Bradshaw:** For goodness’ sake, what a joke.

Matt Hancock: Since then, there has been a vote in the House of Commons, which I, frankly, expected the Government to lose, but which the Government won by 11 votes. You have to follow the evidence.

Q459 **Mr Bradshaw:** You now think that a no-deal Brexit is desirable, do you?

Matt Hancock: No, and I have never said that, but I think we need to prepare for it and always have.

Q460 **Mr Bradshaw:** You said it was not a policy option available to the next Prime Minister.

Matt Hancock: That was my judgment at the time. At that point, there was a vote in the Commons, which I think a lot of people expected the Government to lose, to make time available in the parliamentary timetable for legislative action to rule out no deal. The Government won that vote by 11 votes, so there you go.

Q461 **Mr Bradshaw:** You are talking about one vote, but there had been previous votes where MPs voted 400 to 160 against no deal, and there will be other opportunities to vote. You are basing your judgment now on a single vote in the Commons in the middle of the Conservative leadership campaign rather than what your best assessment of the judgment was when you were running to be leader of this country, in your interview with *The Times* on 2 June.

Matt Hancock: When the evidence changes, I consider that evidence, yes.

Q462 **Mr Bradshaw:** So it might change back again if Parliament votes to stop no deal. You might have to change your mind again.

Matt Hancock: I have always maintained the view that we need to prepare for no deal. I prepared the Department for no deal on 29 March, and I am preparing the Department and the overall health system for a no-deal exit on 31 October.

Q463 **Mr Bradshaw:** In spite of the fact that the British Medical Association believes that a no deal would have catastrophic consequences for the health and social care sector. Thanks to an FOI, because the NHS would not volunteer this information, trusts also talk about a catastrophic



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consequence or impact of a no-deal Brexit on the health and social care system.

Matt Hancock: I do not recognise that. I think that the plans we have put in place have allowed us to make the necessary preparations. You know our caveats around guarantees and how we rely on others to make preparations as well. For instance, the pharmaceutical industry did a great job in the run-up to 29 March. We are ramping up no-deal preparations again now, ahead of 31 October, and I am confident that the Department is doing everything appropriate for a no-deal exit then, should that happen. That is not my preferred outcome. It never has been, but it has always been something I think it is necessary to prepare for.

Q464 **Mr Bradshaw:** If you are still in this job as Health Secretary in October under a Prime Minister heading for no deal, you would be comfortable with that, would you?

Matt Hancock: I have always been clear that we need to prepare for a no-deal exit.

Q465 **Mr Bradshaw:** I am not talking about preparing. I am saying if it is about to happen, rather than having a referendum or—

Matt Hancock: It is not my preference, but, as in the run-up to 29 March, I am fully prepared to make the necessary preparations in advance and then do my duty to ensure that people get the medicines they need.

Q466 **Mr Bradshaw:** How are those preparations going, particularly when it comes to freight and shipping? They were not going too well previously, were they?

Matt Hancock: Preparations were in place ahead of 29 March and we have renewed those preparations for the new date.

Q467 **Mr Bradshaw:** What about the ferries? They did not exist, did they?

Matt Hancock: We got the ferry contracts that we needed to and the capacity that was necessary. As you might have seen, because it was published 10 days ago, we have made further preparations for 31 October.

Q468 **Mr Bradshaw:** And the warehousing and all your fridges.

Matt Hancock: We have renewed the contracts with refrigeration capacity to make sure that we have the plans in place. We learned a lot from doing that in the run-up to 29 March. We have renewed the contracts as appropriate.

Q469 **Dr Williams:** I want to ask about post-Brexit trade deals. Donald Trump has said that the NHS is freeloading from the United States because our drug prices are too low. Do you think that the NHS is freeloading off the United States?



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Matt Hancock: No, I think we get a good deal for our drugs. As the largest single payer system in the world, we are able to negotiate well with global drugs companies. I am very proud of the drugs deals that we do because, while we always look to get drugs cheaper, and particularly for generics there is further work that we need to do, we strike a good deal.

Q470 **Dr Williams:** I agree with you. Your equivalent in the United States Administration, Alex Azar, said that the United States would “pressure” other countries through trade negotiations, “so that we”—the United States—“pay less, they pay more.”

Matt Hancock: That is the nature of trade negotiations.

Q471 **Dr Williams:** That is what Trump wants because apparently we are freeloaders. Won't any trade deal with Trump mean our health service paying more?

Matt Hancock: No, because we will negotiate well. For instance, you might have noticed that Donald Trump first said that the NHS needed to be “on the table” in a trade deal, and then, after pressure from the Government, within 24 hours, reversed that position. Of course, we shall be robust.

Q472 **Dr Williams:** When we are talking about health services being on the table, it is pricing of drugs that is likely to be on the table. Can you absolutely guarantee here today that the NHS will not be paying more or will not be worse off as a result of a post-Brexit trade deal with Trump's USA?

Matt Hancock: For a start, under existing terms there are zero tariffs on pharmaceuticals. That is one of the tenets of the WTO terms. While we welcome the supply of US pharmaceuticals to the UK because they save many lives, we do that on the basis of direct agreements with US companies. We have done a five-year deal that any trade deal would not have direct impact over.

Q473 **Dr Williams:** Their ambition is that they pay less and we pay more.

Matt Hancock: I do not understand why that would happen. The NHS buys drugs from US pharmaceuticals, from European pharmaceutical companies and from pharmaceutical companies right around the world. We do that by buying directly from those companies.

Q474 **Dr Williams:** What they are trying to do is to put the price we are paying—they are very explicit about this—into their trade negotiations, so that, as a price of getting better access to US markets, we pay more for drugs. But you are guaranteeing that you will not let that happen.

Matt Hancock: There is absolutely no need for that to happen.

Q475 **Dr Williams:** Do you guarantee that? Is that a red line for you?

Matt Hancock: I am not doing the trade negotiation, but it is just not—



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Q476 **Dr Williams:** Is it a red line for the Government?

Matt Hancock: It is not an issue in the trade negotiation because there is already a zero tariff regime, and we already very successfully buy drugs.

Q477 **Dr Williams:** They are not talking about tariffs; they are talking about the price we pay for the drugs.

Matt Hancock: But trade negotiations do not have an impact on the market prices between a buyer and a seller, the seller being a US pharmaceutical company and the buyer being the NHS. We will keep doing those negotiations in exactly the same way.

Q478 **Dr Williams:** They won't achieve their objective.

Matt Hancock: I do not think they will achieve that objective, no. I cannot see how they could do so.

Q479 **Chair:** To follow up Ben's point, Secretary of State, there is a big difference between a no-deal Brexit happening at the end of March and one that happens at the end of October. We are coming into the flu season and areas of peak demand. You will need to think about how you are going to store flu vaccines, for example. Have you made an assessment of how much extra you might need to stockpile at that time of year, coming into peak demand?

Matt Hancock: We have made an assessment. Overall, we think that the requirement for storage will be slightly lower, rather than higher. The reason for that is that following the 29 March work there are now more routes for bringing in pharmaceuticals that do not go through the narrow straits. Therefore, we think our flow assumptions have changed and that overall the requirement is lower but broadly the same. We have made those assessments. I do not know whether Chris wants to go into more detail.

Sir Chris Wormald: It is in hand.

Q480 **Chair:** There is a greater requirement for things like vaccines and so forth.

Matt Hancock: You have to take the net though.

Sir Chris Wormald: Your base point is absolutely right. We import more drugs at that time of year than we do in March. Our updated plans take account of those changes. As the Secretary of State says, essentially, how this works is that some things about 31 October get easier than 29 March and some, as you say, get more difficult. We have assessed both of those.

Q481 **Chair:** You have built that in.

Sir Chris Wormald: Yes.



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Q482 **Chair:** The other concern has been that it is coming to the Christmas time of year, so warehousing and storage space is at a premium. I have been hearing reports that storage capacity is already fully booked out.

Matt Hancock: We have re-procured ours, yes.

Q483 **Chair:** You have re-procured it.

Matt Hancock: Absolutely. Yes.

Q484 **Chair:** You have no concern about the ability to cope with medicine supplies.

Matt Hancock: Correct. We have re-procured it and we are going for re-procurement on options for transport capacity as well.

Q485 **Chair:** When Simon Stevens came to this Committee, he felt you needed to have sign-off on the ferry contracts and—

Matt Hancock: That's right, and we published it the next day.

Q486 **Chair:** That included the ferry contracts, so you are all set on that.

Matt Hancock: Yes. It included the structure through which we will buy the ferry contracts. We are doing the ferry contracts slightly differently from last time. Last time, we bought capacity on ferries. This time, we are buying options for capacity on ferries, so that if we use it we will pay for it and if we don't we won't.

Q487 **Chair:** Further to Paul's point, do you think that Vertex is an example already happening of there being pressure not to negotiate on prices? As we know, Vertex are an extreme outlier.

Matt Hancock: Vertex are an extreme outlier in terms of their willingness to engage and go through the proper processes.

Q488 **Chair:** In a good way or a bad way?

Matt Hancock: In a bad way, and in their willingness to get life-saving drugs into the UK. That has absolutely nothing to do with Brexit or trade deals or anything. It is just poor—

Q489 **Chair:** You do not think there is pressure being put on them by the Trump Administration not to negotiate on prices. As I say, they are an extreme outlier.

Matt Hancock: No. I think it is just poor practice from a company that ought to know better.

Q490 **Chair:** Poor practice indeed. It is not just poor; for example, they are not complying properly with NICE. Having said to us that they were co-operating, NICE have said that they are not. Given that it is so poor, what happens next? Are you going to be looking at possibilities around a buyers' club for the generic equivalent sourced from Argentina, or perhaps looking at the possibility of pilots being conducted and using



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that?

Matt Hancock: Yes.

Q491 **Chair:** What is happening next, Secretary of State?

Matt Hancock: We are looking at all options. I met the global CEO of Vertex earlier in the year. He gave me commitments to engage further in the process. There has been some better engagement, but we want to see much more. In particular, it is not just about the licensing and procurement of Orkambi. It is also about the triple, the name of the next therapy, which is earlier in terms of where it is up to in clinical trials, and making sure that that treatment is necessary. We want to make progress, and we are looking at all options to see what more we can now do to put pressure on.

Q492 **Chair:** You are looking at all options. What is your preferred route?

Matt Hancock: My preferred route is that Vertex take the deal on the table, which is good for them and good for people who have cystic fibrosis.

Q493 **Chair:** Of course, that would be everybody's preferred route, but we are not making progress.

Matt Hancock: Well, unfortunately it is not Vertex's preferred route, despite the fact that it is profitable for them.

Q494 **Chair:** Given that it is not their preferred route, we now need to move away from wishful thinking. What is the next step, Secretary of State?

Matt Hancock: We are currently assessing all the different options, including the ones you mentioned. The Crown licence has been raised with us. It has some significant downsides, not least with the rest of the pharmaceutical industry who behave in a spirit of partnership with the NHS, as opposed to the spirit of confrontation we get from Vertex.

There are other potential routes through, some of which you mentioned. We have to be very careful about how we do that. Also, there are ongoing discussions between Vertex and NHS England. I want to make sure that I do not say anything that gets in the way of those discussions, but Vertex should consider the latest offer from NHS England again.

Q495 **Dr Williams:** We were particularly disappointed to learn that Vertex had actually destroyed stock of a drug that they had made and not been able to sell to the NHS. For the families concerned, is there a date or a deadline that you will put on this, by which time it needs to be resolved?

Matt Hancock: I will consider that. It is just awful. I know CF sufferers, and I have raised money for the CF Trust in the past, before I was in politics. I have met some of the sufferers, as you might have seen. It is just awful because this drug is available. The deal on the table is profitable for the drug company and they can do the deal and save lives. It is deeply frustrating.



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Q496 **Chair:** We all agree with that, but what we would like to know is whether there is a deadline date.

Matt Hancock: I will look at doing that, but the question is, a deadline for what? If you are thinking of a deadline, the question you have to ask is, "And what is the consequence of passing the deadline?"

Q497 **Mr Bradshaw:** Do you feel any responsibility at all for raising the hopes of the children and families who would like to get access to medicinal cannabis?

Matt Hancock: I feel responsibility for having played my part in decriminalising medicinal cannabis, although that was a Home Office lead, and then for making sure that we get the system working. It has not been straightforward, partly because of the actions of organisations that are independent, but we now have a process in place so that people whose clinicians judge it is appropriate for them—where their clinician is on the specialist register—can get that treatment. It is available, but there is still a constant stream of casework from people for whom it is not working. I spend a significant amount of time trying to make sure that the process works.

Q498 **Mr Bradshaw:** It is not a constant stream of people for whom it is not working; it is not working.

Matt Hancock: That is not true.

Q499 **Mr Bradshaw:** Patients are not getting it. In fact, the number of patients getting it has gone down since the law changed.

Matt Hancock: Again, I am afraid that is not true.

Q500 **Mr Bradshaw:** Give us some figures.

Matt Hancock: Let me look for the figures. It is slightly frustrating. The data is reported in arrears. There have been eight unlicensed cannabis-based medicines prescribed in the four months to March. I can write to you with the full figures.

Q501 **Mr Bradshaw:** That would be helpful. Have you had the chance to read our recent report on this subject yet?

Matt Hancock: Yes.

Q502 **Mr Bradshaw:** What did you think of it?

Matt Hancock: I am going to respond formally in due course because it has only just come out. My overall goal is to make medicinal cannabis available to people whose doctors think that it is appropriate. We have to get to a point where it is a normal licensed drug, where the evidence has gone through the normal robust procedures. We have had the interim report. We need a final report and a report from NICE to make sure that it is licensable through MHRA and then delivered on a cost-effective basis



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to the NHS, approved by NICE. Then the clinicians and consultants will be able to prescribe medicinal cannabis.

With the Home Secretary, I made the drug available in this country and I want the system to work. It is unlicensed as yet because the evidence has not fully been assessed, so it has been a struggle, and one that I have been engaged in, sometimes to get the individual drug to an individual patient, to make sure people can get it.

Q503 Mr Bradshaw: When can we expect randomised control trials, which are necessary for it to be licensed, to begin?

Matt Hancock: The licensing process is already under way and we can expect a decision in the autumn.

Q504 Mr Bradshaw: But when can we expect the trials to begin, because we need to have the trials, don't we?

Matt Hancock: No, because the licensing process takes into account the global evidence. You do not have to have trials in this country. What I have done is put in place a process review to make sure that the process of getting the drug to the people who need it goes as well as possible.

Q505 Mr Bradshaw: That is really great. You are saying that you are hoping to license medicinal cannabis without going through the lengthy and convoluted process of randomised control trials in this country.

Matt Hancock: It is not my decision to do that. It has to be independent, as you understand, but they can take global evidence into account, yes.

Q506 Mr Bradshaw: We did not hear that from the experts. That is very encouraging. Will you also ensure that families do not have their medicinal cannabis confiscated, as many of them currently do, when they have to import it from abroad?

Matt Hancock: I hope that we do not have to have it imported from abroad.

Q507 Mr Bradshaw: But at the moment we do.

Matt Hancock: When they have the appropriate signed-off paperwork with them, it should go through. We now have a process in place so that that can happen.

There are a number of complications with some of the cases, because they are in devolved areas and that makes it even more complicated. If there is not a specialist clinician on the register who has expertise in the area in that jurisdiction, the payment comes from the devolved NHS but the authority comes from somebody in England. Some of the cases have been particularly difficult because they have been in devolved areas. That is not blaming the parents of the kids who desperately want this treatment. I understand that. Again, I have met a series of them and I



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understand why they want and need these drugs so much, but it has made the process more difficult in a number of cases.

Q508 Mr Bradshaw: There is another thing that families say they would really like, and they will be very encouraged by what you have just said here today before this Committee—that they might get the drug licensed without having to go through lengthy randomised control trials. They are very keen to have observational trials running quickly alongside any randomised trials. Is that something you could help facilitate where necessary?

Matt Hancock: I have looked into that and I am open-minded towards it, but I am not sure it will get the quality of evidence base that will enhance the evidence already available.

What we have done in response to that request is that NIHR, the research body, has put out a call for research to make sure that the evidence that exists can be brought to bear. It is very important that that research call is answered. We have had some who have responded to that call. Because medicinal cannabis is not a drug that is normally run and developed by the big pharmaceutical companies, that process needed some support and personal intervention to make sure that it worked. As far as I understand it, it is in hand and I will give you an update when I write back to you with the numbers who are getting prescriptions.

Q509 Mr Bradshaw: Lovely. Thank you, I would be grateful.

Matt Hancock: The other thing that we should do in this whole area is always separate the two different types of medicinal cannabis, because it is going better for one than for the other.

Q510 Chair: Could you clarify when the process review is due to report?

Matt Hancock: Very soon. I will write to you when I publish it.

Chair: We come now to overseas visitor charging.

Q511 Dr Williams: The evidence I have heard from Doctors of the World on overseas visitors is that most of the people they are helping have been in this country for quite a long time. They say that the average person has been in the country for six years, and has often been through the asylum process or has been trafficked here and then released, or may have been in a relationship with a British national and their status here was dependent on that relationship which has broken down. It is worth making clear that, even though they are called overseas visitors, we are not talking about people who have come here for the purpose of obtaining NHS treatment.

We have taken some compelling evidence from doctors in a BMA review and from charities like Doctors of the World and Maternity Action. They have told us that changes to the regulations introduced in 2015, and then again in 2017, have meant that there are vulnerable people living in our communities—perhaps people who clean offices at night or work in bars



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or restaurants—who are being denied the crucial care they need. As we have been given that evidence, will your Department undertake a review of the impact of the regulations?

Matt Hancock: I am very happy to look at that evidence in individual cases. It is important that we have an overseas visitor charging scheme. This is the national health service, not the international health service, and we have recovered £1.3 billion that can be invested in frontline services. I am a robust defender of having an overseas visitor charging system in place.

We have to make sure that it works properly. That includes exercising the exemptions. There are exemptions for refugees, asylum seekers, some categories of failed asylum seekers and victims of modern slavery, among others. Making sure that the exemptions are correctly followed is important as well, because the system needs to be fair and proportionate. The fairness is making sure both that people who ought to, pay for care that they receive on the NHS, and that those who do not have to pay for the NHS get it for free.

Q512 **Dr Williams:** Nobody could disagree with that. The problem, Secretary of State, is that there are not enough exemptions. There are too many people for whom the rules are being correctly applied but they are either being asked to pay up front for care when they do not have the means to pay for it, or they are getting emergency care and then getting a bill that comes with lots of complications.

It is not individual cases. We have been told that these charities have encountered more than 1,000 cases. There is a real problem. Will you review the exemptions and the impact on vulnerable people?

Matt Hancock: I would like you to send me that evidence, and then we can take it from there. When I looked through the exemption list before raising the overseas charge, I was comfortable with the exemptions as they are. You cannot have exemptions too wide, otherwise it undermines the principle of the whole thing. Let me look at the evidence of the individual cases, which are hard cases, because getting the boundaries right is always the most sensitive and difficult thing in any of these sorts of regimes, both in terms of what people get for free—there are things like emergency care and primary care that everybody gets for free—and in terms of who gets everything for free. There are two sets of boundaries. I am content with them as they are on the evidence that I personally have seen, but I am always happy and willing to look at more evidence if that is necessary.

Q513 **Johnny Mercer:** I think this has been covered, but how are we doing generally? Is it working?

Matt Hancock: There is an issue about some hospitals applying the scheme fairly.

Q514 **Johnny Mercer:** It just seems to be disparate in different parts of the



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country.

Matt Hancock: Yes. There are some trusts that simply do not apply the regime as they ought to. Making sure that we get fair application of the scheme is important.

Q515 **Chair:** Secretary of State, could I come to the issue of IT in the NHS? You came into your role and wanted to make digital IT and those kinds of things part of your USP for the role. Where are we at the moment with having NHS records that are properly joined up, so that you can access your records at any GP within a primary care network, for example, or see them shared between hospitals, GPs, pharmacists and social care? Where are we with having a properly interoperable and integrated IT system? Where are we with that project?

Matt Hancock: We have made significant progress, but it is different in different parts of the country. The decision was rightly taken, before I arrived, to make sure that it was driven forward first in the areas of the country that were best placed to make it work, to show that it could be done. The so-called global digital exemplar programme took 27 different types of trust to a cutting-edge level of technology. Those 27 trusts now all have what I would regard as 21st-century, and in some cases world-leading, technology.

There are a further 27 trusts that are so-called fast followers. Each of the lead trusts was paired with another trust that wanted to get going. The fast followers have now largely got to decent modern levels of technology. That gives us over 50 trusts of the just over 200 where we are in really good shape. Those trusts are increasingly building interoperability with their local health ecology—with primary care, social care, hospices, the community trust, mental health trusts and the ambulances. They are the primary as well as the acute. That is working brilliantly in some places such as the Birmingham university hospitals trust, Southampton, Leeds and the West Suffolk hospital.

Those are at the absolute cutting edge, but that leaves a whole load to go. We instituted NHSX to lead the drive within the NHS to get to the next segment, the next 100, from having done a quarter to having done three quarters. Then we will need a slightly different programme of work for the quarter that are the least digitised. They need a huge amount of support, which is not just about tech. It is about leadership and capability to bring them up to speed.

In some parts of the country, you could now be picked up by an ambulance and what you tell the paramedic is already in the hospital before you get there. They can download your GP record and it flows through seamlessly. Then they can do the really clever stuff with the AI and data analysis overall in what they do in the hospital. That now happens in some parts of the country. It shows that it can be done. The clinicians absolutely love it when it all goes right because suddenly they can log in quickly and they do not waste enormous amounts of time



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repeating things. Patient satisfaction is higher, but there is an awful lot more to do.

Q516 **Chair:** I understand why you would want to start in places that are ready to go, but there is that other quarter that is in a very dire state and you are going to do them last.

Matt Hancock: No. What I was trying to explain is that we need two different approaches. The approach we have taken so far, essentially, we think, will work, co-ordinated on a regional basis, for the middle 100. Then we are going to have to have a more intense programme.

Sir Chris Wormald: To be clear, because I was there at the time, this was an attempt to learn the lessons of previous IT contracts.

Q517 **Chair:** Yes, we all remember that. We had a major cyber-attack with the WannaCry virus. How vulnerable is the NHS, particularly the quarter that are the least further on, to another major attack like that?

Matt Hancock: The vulnerability still exists but is significantly lower than it was two and a bit years ago when the WannaCry attack happened. First, there has been a direct investment in cyber-security, whose profile has been raised within the management of individual trusts.

Secondly, ironically, people sometimes think that more digitisation leads to higher cyber-risk. Actually, good digitisation lowers your cyber-risk as well. The approach we are taking is that, instead of the national programme for IT where they tried to impose a single system top down on the whole NHS, we are taking a standards-based approach. We now set standards of interoperability, of cyber-security and of privacy. Then trusts procure against those standards. The cyber-security standards have been raised. I have raised them since I arrived, because I was not happy that they were sufficiently rigorous. With the advent of GDPR, the privacy standards have also been raised, and we have introduced the interoperability standards.

Q518 **Chair:** I understand that you have two different approaches for the areas that need to catch up. How much is it going to cost in terms of the capital budget, bringing us back to where we started today?

Matt Hancock: We have a capital budget that is more than £4 billion over five years from 2016-17 onwards for this sort of development. There is a significant capital budget, but it is not just about capital because, increasingly, technology is a resource cost. For instance, if you move your storage to the cloud, it flips from being a capital cost to pay for servers to a resource cost.

Q519 **Chair:** To recap, did you say you had actually estimated what the capital cost was?

Matt Hancock: That is over four years, yes. The overall capital programme—



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Q520 **Chair:** Could you update us with where we are with the capital programme to bring all parts of the NHS up to the level of the front-runners, the quarter that are the furthest ahead?

Matt Hancock: Oh, I see. That will be a matter that will be settled in the spending review, when we get the full capital budgets. We have the capital budget for this year and there is some indicative for next year, but we have to settle that in the spending review.

Q521 **Chair:** That seems to me to be the point that is holding it up. You do not have the budgets to do it.

Matt Hancock: In year, on the tech side, there is capital available, but we have to settle the budgets for next year and onwards, yes.

Q522 **Chair:** In year, there is the money available for all parts of the NHS to bring them up.

Matt Hancock: No, for the programmes that we have running. It is £360 million, off the top of my head. I can write with the exact figure of the in-year capital.

Q523 **Chair:** I think people would be very interested to know. We have this huge variation across the NHS and it has always been an issue. We have some pockets of fantastic practice. In three quarters of the country it is not doing so well, and in a quarter it is doing badly. People will want to know when we are all going to be able to reach those standards. Perhaps you could write to the Committee with a bit more detail about what is needed to bring the entire NHS up to that standard.

Matt Hancock: I will. The other big change is NHSX, which combines the technology policy leadership from the Department and from NHS E and I all in one place, led by a brilliant official, Matthew Gould, who is driving it all through the system. I will absolutely write to you with the capital figure.

Q524 **Chair:** People want to know, because capital is going to be a major issue for the spending review.

Matt Hancock: It is one of my not yet settled budgets.

Q525 **Dr Williams:** I have a brief question around autism diagnosis waiting times. As you know, there is huge variation in the country around how long particularly children, but adults as well, have to wait from the first indicators that there may be a problem to the diagnosis beginning. The NICE guidance is that nobody should have to wait for more than three months before the process begins. Data collected by the National Autistic Society found that around a third of people are waiting at least three years. In my own constituency in Stockton, I found that most people were waiting for four years.

My local CCG, working together with Stockton Borough Council, invested in a new pathway that I visited a fortnight ago. They have managed to bring waiting times at the moment down to between five and seven



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months from four years, with a brilliant initiative. There is a good team working very hard and it is great to see.

I know that the Government have been collecting data on this because sometimes transparency of data can drive performance. By the end of March 2019, you would have collected a year's worth of data around diagnosis waiting times. When is that data going to be available so that we can all see it and use it to try to drive improvements in performance?

Matt Hancock: We have to make sure that the data is high quality. I would like to see it published as soon as possible. I totally agree with you that you can only manage these things effectively when you measure them properly.

I would love to know more about your individual example. In this area, of course budgets matter, but it is not all about budget. A lot of it is about how well managed the systems are and the complex interactions between health and social care.

Q526 Dr Williams: There was very good interaction with patients and families. There is complexity in commissioning because there is the local authority and the CCG, and then lots of different providers—community services and speech and language therapists. Schools are involved and, of course, the mental health trust and the acute trust. The fragmentation does not help, but political leadership and local CCG and local authority leadership have made the difference.

Matt Hancock: Absolutely, yes.

Q527 Andrew Selous: This is a slightly related issue, in a bizarre way, and relates to my study of foetal alcohol syndrome disorder. There has been a recent University of Bristol and University of Cardiff study in this area. It seems that quite a lot of foetal alcohol syndrome is misdiagnosed as being on the autistic spectrum. The Bristol and Cardiff study seems to show that about a third of British women are binge drinking during pregnancy. We are a bit of an outlier again.

Matt Hancock: A third?

Q528 Andrew Selous: Those were the figures from the study that the University of Bristol and the University of Cardiff produced. I have met the chief medical officer about this, and questioned her on it in the Science and Technology Committee. I am rather underwhelmed by the information on alcohol itself when you buy it. When you go into supermarkets, and in pubs and clubs and so on, there is such a range of very enjoyable non-alcoholic drinks that it is possible to buy now. We are talking about lifelong brain damage with foetal alcohol syndrome disorder.

If you talk to Members of this House who have adopted children who have FASD, it is quite harrowing. There is an all-party group that Dr Williams chairs, and a lady who had adopted some children told us some of the stories around this. In Canada, they believe that maybe up to half



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the prison population is affected by FASD. It seems to me that it is a bit of a sleeper going along.

Matt Hancock: Half the prison population?

Q529 **Andrew Selous:** In Canada, if you look at the academic research. I am glad that you are suitably shocked because I am rather amazed that the issue is not taken more seriously. The Member of Parliament for Sefton, Bill Esterson, leads the all-party group in this area and speaks out very bravely and very powerfully. *The Times* on the day of his Adjournment debate earlier this year called it a major health crisis, but it does not seem to have that level of profile with Public Health England. The labelling is useless. You are reviewing it in September. Supermarkets, pubs and clubs seem to do nothing to raise the issue.

I have rather sprung this on you; I do not think we told you that we were going to raise it.

Matt Hancock: No problem.

Q530 **Andrew Selous:** Could you commit to go back to the Department and ask questions of the chief medical officer and maybe rattle a few cages?

Matt Hancock: Yes. I am very happy to do that. I have put funds into support for children of alcoholics. I think this is incredibly important. I also think that the case for state intervention on behalf of the unborn child is very strong. I feel that very strongly with smoking in pregnancy as well. I am very happy to look at that.

Sir Chris Wormald: The chief medical officer is one of the most outspoken voices on this. I do not think she has underplayed the issue.

Q531 **Andrew Selous:** She may not have done, but if you look at what is coming out of Public Health England, if you look at labelling and if you go into supermarkets, pubs and clubs, I do not see the level of information we should expect if we are taking the issue seriously as a country. There is a lifelong cost to the taxpayer and hours of care from parents and carers for children whose lives are severely limited. I welcome your reassurance that it is on your radar.

Matt Hancock: Well, it is now, Andrew.

Q532 **Andrew Selous:** I know you have an awful lot to look at, but this is something that is avoidable and preventable. I hope you will take it with the seriousness it deserves.

Matt Hancock: Absolutely.

Andrew Selous: Thank you.

Q533 **Chair:** Secretary of State, our time is up. Before we finish, obviously there will be a reshuffle in the next couple of weeks. If you are no longer in your post in a couple of weeks' time, what would be your advice to your successor?



HOUSE OF COMMONS

Matt Hancock: That is another of those “if” questions that I try not to answer.

Chair: We love them on this Committee.

Matt Hancock: It is a great honour to be the Health Secretary and I look forward to doing the job.

Chair: Thank you.