OFFICIAL – SENSITIVE

SECRETARY OF STATE FIRST DAY PACK – TWO PAGE NOTES FROM DIRECTOR GENERALS

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A. Communications and media handling

Director: Rachel Carr

About us

1. The Communications Division provides a full range of integrated communications services, including internal and corporate communications support, digital and stakeholder engagement expertise and a 24/7 media relations function.

2. We work with our Arm's Length Bodies (ALBs) to assure spend on public health and information campaigns such as the recently launched NHS recruitment campaign and Be Clear on Cancer. We also have a highly respected insight function using traditional social research and digital analytics to help understand audience and stakeholder sentiment in real time.

3. The team is ready to work with you and your Special Advisers to advise and develop a comprehensive communications strategy to support your priorities. We can share our suggestions for how we start to develop a long term communications plan to support your ambitions in a separate paper.

Background

4. Your appointment comes shortly after the 70th anniversary of the NHS which the Government marked by announcing a new funding settlement. The announcement attracted significant media interest and was broadly welcomed by the public with polling showing an uptick in those who felt the NHS would improve over the next few years. In the main, media are also supportive, though some carry the caveat that taxes must not rise to pay for the investment. Stakeholder reaction was more split (24% positive and 40% neutral/mixed, 36% negative) between those who feel the money is not sufficient and will not come from the Brexit dividend and those who claim the funding settlement is unaffordable and that not enough has been done to tackle perceived NHS profligacy.

5. We have emphasised to media that the funding settlement is not the end of the matter. In return the NHS must now produce a long-term plan for the health service. This is due to be published in the autumn when we will also release our Green Paper on social care – in recognition of the fact that neither issue can be solved in isolation. The Permanent Secretary and DG Finance notes cover this in more detail.

6. As a result there is now a friction between the immediate need for Government to demonstrate what this significant funding package will deliver for the public and the need for the detailed plans for the NHS and for social care to be worked up. We are working up a communications plan which aims to use targeted interventions by you to highlight key areas where this money can transform outcomes (such as cancer and mental health) ahead of the publication of the plan. As well as this we propose a regular drumbeat of stories on reducing waste to illustrate work going on by the Government to make sure the NHS spends its budget as efficiently as possible.

7. Other issues that may attract significant media and stakeholder attention over the coming months include:

- the impact of Brexit and negotiations (on workforce and regulatory environment and access to drugs);
- the ongoing public health risks following the Novichok attack in Salisbury;
- (from October/November) a focus on winter performance (the recently announced funding boost will not cover this winter); and
- our proposals to tackle childhood obesity.

8. Despite this, the media appetite for positive stories on health is very strong and there will be plenty of opportunities to deliver proactive as well as reactive communications on your policy priorities. We would like to understand your overall approach to media and press, and stand ready to offer any support you may need.

Your early media announcements

9. We would like to establish a plan of proactive media announcements for the next three months so that we can start building integrated communications plans around them. The Permanent Secretary has highlighted a number of potential priority areas your predecessor had been focused on which you and your Ministerial team may want to pick up. We have potential announcements in train on many of these and it would be good to know which you would like to go ahead with.

10. Mental health: Following the NHS funding settlement, mental health is one area where you could proactively demonstrate how a boost in funding could benefit the public in the long term. This could include some early work on committing the NHS to **minimum level waiting times for mental health conditions**. The **Children & Young People's Mental Health Green Paper** is currently at write-round and could also be an excellent platform to set out your personal vision in your first few weeks. Your predecessor had committed to the UK hosting the first **Mental Health Global Summit** this autumn with ministerial representation from more than 30 countries. As you know, there is a great deal of interest in the role **social media companies** can play in better protecting children on line and protecting their mental health. In your former role, you worked with the previous Health Secretary to challenge social media companies to do more on this issue. We are still waiting to hear back and this could provide you with an early opportunity to push them again publicly – the Daily Telegraph is currently running a campaign on this issue.

11. Social care: Adult social care continues to be a difficult and unresolved policy issue, which has significant repercussions for the NHS. The next steps will be addressed in a **Green Paper**, due in the autumn. A major challenge to engaging the public in a debate around social care is that around half the public do not know social care isn't free, most people don't see it as being relevant to them and people do not understand what social care is. We could form a coalition with stakeholders to launch a low cost social and consumer media **education campaign** (we know 43 stakeholders are interested in doing this) to get the public in a better place to take part in a consultation later this year. We are also developing a major **adult social care workforce campaign** to increase the number of applications to jobs in the sector and to raise the profile of the sector as a good place to work using money from the HMT EU Exit fund.

12. Technology, innovation and research: Technology has the potential to **transform outcomes for patients** through new treatments and innovation. But also to revolutionise the way staff in the NHS work, improving patient experience and making the NHS more efficient and effective. We suggest you build on the momentum of the PMs recent announcement in May combining new technology (AI) and cancer outcomes, by announcing new **genomic medicine commitments** to revolutionise the way we treat disease – including by 2019 all seriously ill children will get genomic analysis as part of their treatment and by 2023, five million people will have had genomic analysis to diagnose and treat disease. Towards recess we need to announce £450m in funding for the NHS to use **technology to become more digitised and efficient**. Sustainability and transformation partnerships (STPs) will be able to bid for the money setting out how they will use technology to tackle pressures – such as mobile technologies to support care delivery near homes.

13. NHS workforce: Despite the recent NHS Agenda for Change pay deal, **workforce pressures** continue to be a challenge for the NHS, with c.100,000 vacancies across various specialities. A particular pressure is on nursing, and the Department has recently launched a joint recruitment campaign with NHS England to promote the NHS. As part of the long term plan, we will publish in the autumn a 10 year **workforce strategy** outlining how the NHS will change the shape of its workforce to meet the needs of an ageing population as well as the priorities set out in the long term plan around improving cancer care and mental health services. You could launch an ambition to make the NHS one of **the world's best employers**, including action on bullying and harassment, ambitions on increasing representation of women and people from BAME backgrounds within the NHS.

14. Public health and prevention: Last month we announced our updated **Childhood Obesity Plan** which received widespread support from campaigners and media alike. In the coming weeks we need to publish consultations on the banning of energy drinks for sale to children and price promotions in supermarkets. We have consulted on changing the **organ donation** process to an opt-out system. We are now due to publish our response to the consultation which will signal our intention to bring forward primary legislation.

15. Patient safety: Improving safety cultures within the NHS was a major priority for your predecessor and remains a key reputational risk in the wake of the scandals of sub-standard care at Mid-Staffs, Morecambe Bay and Winterbourne View. The **Gosport report,** which looked at hundreds of deaths at Gosport War Memorial hospital and highlighted a number of safety failures, was recently published and the Government is due to respond to this in autumn. Following Gosport, patient safety remains high on the agenda, and as such we recommend you remain on the front foot in promoting the safety improvement agenda. We have developed proposals for a programme of engagement over the summer/early autumn on patient safety ahead of the publication of the NHS' long term plan. This would include a series of roundtables, visits, forums, and speeches at key safety events to discuss next steps for improving patient safety.

B: Finance and Group Operations

Director General: David Williams

1. Finance and Group Operations - around 500 people - provides direct support to you and your Ministers; oversight, challenge and support across the health system to help you ensure that the NHS has robust, funded plans aligned to your priorities and is getting on with delivering them; and the full range of corporate services for the Department itself. Four of my teams cover issues that range across the whole health system landscape...

- The **Ministers, Accountability and Strategy** directorate (Kathy Hall) leads on overall strategy and planning for the health and care system, including the legislative framework and sponsorship of and appointments to our Arm's-Length Bodies – we can provide you with a full list of upcoming appointments if desired. Our Strategy & Implementation Units support you by providing a flexible resource to track progress and drive delivery on your key priorities through data analysis and frontline intelligence and by undertaking cross-cutting, longer term policy development work. The Implementation Unit supported the previous Secretary of State's priority meetings and if you would like to continue with a similar set up, they can work with your Private Office to support you on the agenda, briefing and management of those. The Spending Review team leads on long term NHS planning issues and the follow up to the Prime Minister's recent announcement on funding. Kathy's Directorate also includes the Ministerial Private Offices, led by your Principal Private Secretary, who provide you with direct day-to-day support and the Parliamentary team to assist you with your duties in the House.

- The **Communications** directorate (Rachel Carr) provides a full range of integrated communications services, including internal and corporate communications support, digital, social media and stakeholder engagement expertise and a 24/7 media relations function - see separate brief on early comms priorities.

- The **Finance** directorate (Chris Young) leads on financial management for the health system, covering planning and resource allocation to key Ministerial priorities and to our Arms-Length Bodies, in-year financial management and driving delivery of key efficiency programmes, production of the annual report and accounts and support to Ministers and the Accounting Officer in their financial responsibilities to Parliament. Chris also oversees capital planning (£5.8Bn including R&D), the Department's management of its own running costs (£190m) and directly sponsored programmes (£3Bn) and our anti-fraud work.

... and two are focused on how we organise and run ourselves in DHSC:

- The **Workplace and Transformation** directorate (Dom Brankin) leads on accommodation, technology and security issues across the Department and our Arm's-Length Bodies. This team managed the successful move to our new offices in 39 Victoria Street last Autumn. NHS technology issues are led separately, from Jonathan Marron's area.

- The **Human Resources** directorate (Anna Jenkins) leads on the development and implementation of the DH's own people strategy, focusing on strategic workforce planning, capability building and talent management, reward and organisational and cultural change. NHS workforce issues are led separately, from Lee McDonough's area.

Key issues on which to make early progress

2. NHS finances – and what is delivered for the money - will be a dominant theme. There are three elements: publishing our Annual Report and Accounts for 2017/18; living with our budget settlement for this year, which is at risk; and agreeing the NHS plan for the long term funding settlement announced by the Prime Minister last month.

3. Our **Annual Report and Accounts** are due for publication on Thursday this week but could be delayed until Thursday 19th July. They will show that the NHS has (just about - £25m out) delivered financial balance in 2017/18 and that DHSC has managed within all its Parliamentary controls. Under the 2006 NHS Act, the Secretary of State is required to publish an annual assessment of NHS performance and for convenience we use the Annual Report and Accounts as the vehicle for doing this. The current text was agreed by your predecessor last week. We can either publish as currently planned on Thursday making it clear this is your predecessor's assessment, delay until 19 July to give you time to review this and the wider accounts before publication, or remove the Secretary of State performance assessment and publish this separately later in the year. With apologies, we need a decision **today** – separate advice is with you.

4. The **NHS RDEL budget for 2018/19** is £114.6Bn. This includes an additional £1.6Bn allocated to the NHS in Budget 2017, £540M of transfers from the Department's non-NHS budgets and £800M of new money for the Agenda for Change pay award. Following difficult discussions with Simon Stevens and colleagues, a high level agreement was reached with NHS England and Improvement to eliminate the provider deficit, recover A&E

performance and deliver the biggest volume increase in elective activity since 2009-10. The detail of the financial and operational plans that underpins this agreement is still being worked through by NHS England and Improvement but is not yet settled and achieving the high level agreement is proving very difficult in practice. There remains in plans a provider deficit of £516m (against an expectation of financial balance) and options to close this will be presented to you by the end of the month. This will not be straightforward as further savings measures are likely to impact performance levels: we will need to balance priorities between winter capacity, financial management and elective activity. You can also expect advice this month on how to ensure the new money announced for the NHS from 2019/20 does not lead to a loss of financial discipline this year.

5. **Long term plan and multi-year funding settlement.** You have an immediate opportunity to shape how the follow up work to the Prime Minister's announcement on long term funding for the NHS is conducted, both on content, process and how you want personally to engage. For example, we, No10 and the Treasury have all been keen to push the NHS to go further and faster on efficiency, productivity, tackling waste and exploiting new technologies, data and digital. Similarly, your predecessor was focused on shifting to a more outcome-focused system with emphasis on improving cancer survival, mental health and infant mortality, compared to the best in Europe. You will want an early discussion on the current programme plan, in particular inter-relationships with the forthcoming Social Care Green Paper, the Department's approach to negotiations with the leadership of NHSE and NHS Improvement over performance commitments, workforce strategy and the engagement strategy.

6. To recap, in June the Prime Minister announced that the NHS will receive an increase of £20.5 billion a year in real terms by 2023-24 (3.4% per year growth on average over the next five years). The PM also announced that the Government would be willing to look at proposal for legislation developed by the NHS to support the delivery of the long term plan. Your private office has a copy of the Long-Term Plan agreement with the NHS. Whilst the funding does not represent the full amount many independent think tanks said the service needed to improve, it was welcomed by NHS leadership and sufficient to secure a commitment to key reforms including productivity and efficiency. This funding is conditional on the NHS developing a long term plan that meets a set of tests set out by Government. To be able to agree the NHS long-term plan in advance of Budget 2018, we have agreed four checkpoints with the NHS to review content over the coming months:

- End July – to agree the scope for the long-term plan, including Government's expectations for priorities.
- Mid Sept – to agree overarching outcome goals for the plan (with a view to selecting announcements for Party Conference), as well as more immediate operational priorities for 2019/20.
- Mid-late Oct – to agree the core policy content of the plan in the individual chapters.
- Mid Nov – to sign off the final plan for publication.

7. The NHS financial settlement covers a majority of the total budget for which DHSC is responsible – however, there will remain a large number of important budgets to be agreed at the Spending Review. These include budgets for adult social care, public health, and others which will be essential to the NHS long-term plan (e.g. capital and workforce training budgets); as well as central DHSC budgets.

8. And finally…when Carillion collapsed in January, **two PF2 hospitals were left mid-construction** without a building contractor. The Royal Liverpool site is most advanced and we continue to explore with lenders and the in situ PFI company how they can restructure the deal to deliver the project without concessions from the Department which would bring the deal on balance sheet. The Midland Metropolitan in Sandwell is less advanced and the previous PFI deal has been terminated. We want to bring a decision on whether to progress with a new PFI deal (the Chancellor's clear preference) or conventional procurement (judged by DHSC to be the most viable option) to Ministers - the Chancellor, David Lidington and you - before the summer break if at all possible.

Key Areas for Early Discussion

- NHS plans for 18/19 and how to secure the capacity needed for winter while delivering NHS financial balance.
- How you want to approach and engage in the NHS long term plan.
- How you want to work with our Arm's-Length Bodies – particularly NHS England and NHS Improvement – and hold them to account. Your predecessor held weekly meetings with the NHS leadership on priority issues. It would be helpful to agree your approach and know how you wish to manage this relationship.
- Key areas for your Strategy and Implementation units to focus on, which will also allow us to confirm that Departmental resources are aligned to your priorities.
- Steers from you on comms and media priorities – see separate comms brief on page 2.

C. Community and Social Care

Director General: Jonathan Marron

1. Community and Social Care Group has 315 staff and is focused on out of hospital care and how to keep people living better for longer in the community. This includes through the provision of primary and community care services to proactively manage health and avoid unnecessary hospitalisation; self-help, support and access to NHS services for people with mental health conditions; and the adult social care system, which aims to meet people's care needs and prevent them from escalating. All of this – and other parts of the health and care sector – is underpinned by the use of technology, data and digital services and protection against cyber threats and cost-effective medicines, also my Group's responsibility.

2. To give a sense of scale, in 2016/17 (latest consistently comparable figures) we spent around £13.5bn on primary (including optical and dental care), £10bn on community services, £11bn on mental health, together with £16.8bn on social care, mainly through local authority spending, in part funded by council tax. Our medicines spend was £15.5bn, with £7bn through hospitals and £8.5bn through community pharmacies.

3. This note briefly introduces the work of the group and the Directors in charge of each section.

Care and Transformation (Juliet Chua and Lyn Romeo the Chief Social Worker)

4. Responsible for NHS transformation and new models of health care (ACSs, ACOs, STPs), oversight and funding of the adult social care system, delivery of community health services, and commissioning policy and sponsorship of NHS England. The key issues include:

On the NHS:

- **Accountability arrangements for NHS England** including the appointment of a new Chair, your annual assessment of their performance and how you wish to hold them to account
- The delivery structures they have put in place including **Sustainability and Transformation Partnerships** (STPs), their evolution to **Integrated Care Systems** (ICSs) and the development of **Accountable Care Organisations** as part of a move to a more collaborative and integrated approach to the NHS

On Social Care:

- The proposed **Green paper** to address the funding of social care, the introduction of any cap to tackle perceived unfairness, options to raise revenue to fund any cap, and a range of measures to improve performance, outcomes and integration of health and care.
- The **Aging Grand Challenge** and the opportunity to harness health data and economic opportunities from aging to promote products that support healthier aging and better care.
- **Sleep Ins**. We will present proposals to tackle the liabilities created as a result of changing the guidance on payment of the minimum wage, a significant challenge for some providers.
- **The state of the social care market**. There are significant challenges in relation to funding, potential provider failure and securing the necessary workforce.

Mental Health, Dementia & Disabilities (Antonia Williams)

5. Responsible for delivery of mental health policy and service transformation, coordination of offender health policy, dementia and disability policy. Key issues include:

- Implementing the joint DHSC/DfE **Children and Young People's Mental Health Green Paper**, which sets out a programme to transform MH provision for children through dedicated MH leads in schools, schools based Mental Health Support Teams and piloting a four week wait for specialist services. Currently with HA for clearance and scheduled for publication before recess.
- Supporting Professor Sir Simon Wessely's review of the **Mental Health Act,** looking at both the legislation and practice surrounding the Act, with a particular focus on the disproportionate impact on BME groups,
- Ensuring delivering the **Five Year Forward View for Mental Health** (published in July 2016) which seeks to provide care to 1 million additional people, backed by £1bn additional spend.

- Organising **Global Ministerial MH Summit** in October this year bringing together Ministers, Experts and people with lived experience from all around the world to demonstrate political leadership. We need your confirmation that you want to press ahead as soon as possible in order to secure decent attendance.

Digital, Data and Primary Care (Katie Farrington) and (Tim Donohoe, Chief Technology Adviser)

6. Responsible for cross system policy for technology and information in health and social care and digital strategy and sponsorship of NHS Digital; and for primary care, including general practice, dentistry and the voluntary sector. Key issues include:

On Technology and Data

- We have oversight of a 5 year, £4.2bn **digital transformation programme** covering a set of transformation programmes and the running of a series of core IT services for the NHS. The programme covers provider digitisation, the creation of integrated health and care records, and making these available to patients (via an App) and for research and commercial purposes.
- We are investing in **Cyber security** following the WannaCry attack in 2017 and the ongoing concerns in this area
- We have launched a successful "Opt Out" programme to help address concerns over **data sharing**
- We are working closely with BEIS and DCMS colleagues on the **AI grand challenge**

On Primary Care

- As of December 2017 there were around 41.8k GPs (Headcount) recorded as working in General Practice, this represents 33.9k Full Time Equivalents (FTE). As of December 2017, there were around 92k non-GP General Practice staff (FTE) including around 15.8k nurse FTEs – the equivalent headcount was 133k, including 22.9k nurses.
- Reforming the GP contract focusing on increasing the scale of GP operations (through networks) increasing multi-disciplinary working (rather than the GP doing everything) and increasing integration with other services.
- Improving GP recruitment. We have a target of increasing GP numbers by 5000. To date we have seen overall reductions in numbers of GPs and we are not yet confident that NHS England's plans will deliver the Government's commitment with risks on international recruitment and retention.
- Improving access to GP care. We are making encouraging progress towards meeting the Government's commitment that 100% of the population should have access to weekend and evening appointments by 2019.

Medicines and pharmacy (Liz Woodeson)

7. Responsible for the health and care system's approach to the funding and provision of medicines and community pharmacy services and sponsorship of Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health and Care Excellence (NICE). Liz works closely with Steve Oldfield the Department's Chief Commercial Officer. Key issues include:

- **Community Pharmacy Contractual Framework**. You will need to agree the approach to funding Community Pharmacy for 2018/19 and beyond. We reduced the funding in 16/17 and successfully fought a judicial review of this decision (currently awaiting appeal judgement). The decision needed is on whether further reductions should be made, and the level of those reductions.
- **Medicines regulation, Brexit and the Medicines and Healthcare products Regulation Authority (MHRA):** We need to determine the future arrangements for the regulation of medicines after the UK leaves the European Union. This is a key issue for the pharmaceutical industry and getting it right will help retain a flourishing life sciences sector in the UK.
- **Medicines supply and Brexit**. We are preparing for possible disruption to the supply of medicines in a no deal scenario. You will see in further advice that our preferred option of asking suppliers to stockpile an additional four weeks' supply of medicines is expected to cost the Government c£250m.

D. Acute Care and Workforce

Director General: Lee McDonough

1. The Acute Care and Workforce group consists of around 230 people and brings together the DHSC teams responsible for supporting the NHS to deliver high quality, safe and sustainable hospital care and securing the right health and social care workforce now and in the future. This includes assuring the quality, safety and effectiveness of NHS hospitals and supporting service improvement in acute care, including cancer care; improving hospital access and flow and delivery of NHS performance and standards. We are also the DHSC sponsor for the following Arms-Length Bodies: NHS Improvement (NHSI), Care Quality Commission (CQC), Health Education England (HEE) and NHS Resolution (NHSR).

2. There are a number of immediate issues which will require a decision or a steer from you which are set out below. In addition, there are a range of significant policy questions on which you may wish to prioritise an early discussion particularly in relation to performance of the health and care system both in terms of the opportunity presented through the long term funding settlement, but also current year plans and preparation for this coming winter, the most challenging time of year for the Acute Sector. Workforce is also a key area on which you will wish to take a view. The NHS employs c1.4m people (1.045m FTE) and at £48bn, workforce expenditure represents 42% of overall hospital spend with a further £5bn spent on education and training. The social care workforce is made up of c.1.5m (1.1m FTE) people across 20k employers. The workforce plan , the first in 25 years, that will be published at the same time as, and in support of the long term NHS plan will be vital to ensure we have the right workforce for the future and to address significant workforce gaps including in nursing, general practice, mental health and diagnostics and social care. There is a discussion to be had about whether to combine an NHS workforce plan with a social care workforce plan, or to handle this separately alongside the social care green paper. Workforce budgets are not part of the long term settlement and will need to be settled along with other wider DHSC budgets including social care, and public health at the Spending Review – this will need careful handling. On delivery structures, NHS England and NHS Improvement are undertaking a significant programme of integration, with a particular focus on ensuring a stronger oversight of the system at regional level and strong integration of financial control and operational oversight of Winter and emergency care. There are significant challenges ahead to achieve this, and the Department will need to take a lead role in shaping the new approach to system management and the structures and relationships to deliver which you will wish to steer.

3. Key issues on which we would welcome an early discussion with you include:

- **The Doctors and Dentists Pay Review Body (DDRB**) has recently reported with some recommendations substantially higher than we can afford in the current year and no additional resources available from Treasury. We have been considering delaying and reducing the award this year to manage costs, but offering the possibility of a multi-year deal in subsequent years to manage frustration from doctors. We will need to engage with NHS England to get their view - we need a proposal that balances affordability, reform and industrial relations risks. **The central departments are seeking your views this week to enable a public sector wide announcement on pay prior to recess and we will provide you with advice urgently on this issue.**

- **NHS Performance**. The NHS is below the standards for all headline metrics except for four of the eight cancer waiting times targets. NHS England and NHS Improvement have been implementing an ambitious joint plan to recover performance during 2018/19, although delivery of this will be challenging, in particular addressing A+E performance against the 4 hour standard, currently 90.4% against 95% target, and the number of patients waiting less than 18 weeks for hospital treatment which is at 87.5% against a target of 92%, with an overall waiting list of 4.01 million.

- **Winter preparations.** 17/18 was a challenging winter with a long period of cold weather and high levels of flu. However the NHS was regarded as being well prepared and having better grip than in previous years. Despite growth in activity levels the NHS has recovered its performance to a slightly higher level in May 2018/19 at 90.4% against the 4 hour standard compared to 89.7% at the same time in 2017/18. We need to build on the lessons learnt from 17/18 by maintaining focus on effective and efficient patient flow across the breadth of the health system, but with an additional emphasis on increasing capacity in hospitals both by reducing long-stay patients who no longer need treatment in an acute bed. We are working with NHSE/I and with Cabinet office and No 10 on the range of interventions, but you will wish to be assured robust plans are in place well in advance of winter season..

- **Patient safety:** The DHSC policy team are responsible for a number of Departmentally–led national policy projects to improve quality and safety, this was a key priority for your predecessor and an areas where the NHS has made great progress in recent years. **We would welcome an early discussion with you on this agenda to get an understanding of your priorities.** A review into a number of women's health issues sodium valproate, primodos and surgical mesh is being led by Baroness Cumberlege, and she has made an initial finding recommending a pause in the use of surgical mesh in the treatment of stress urinary incontinence that is being made public on 10th July. NHS England will lead the clinical response. **It will be important to have an early meeting with Baroness Cumberlege who is leading the review of these issues.**

- **NHSE and NHSI integration.** Both the Chair (Baroness Dido Harding) and the Chief Executive (Ian Dalton) of NHS Improvement were appointed in the last year. They are working with the leadership of NHS England to implement an ambitious plan which brings together a number of their functions particularly, in the first instance, focused on their senior leadership team including their 7 regional directors, finance director and clinical and operational leadership. Delivery of the new regional structure is particularly important in the context of operational control during winter, and you will want to be assured they are on track to deliver this part of the change programme specifically.

- **GP Indemnity**: NHS Resolution provides indemnity cover for NHS Trusts. In contrast indemnity in primary care is provided by three independent Medical Defence Organisations. Your predecessor publicly committed in October 2017 to offer a broadly comparable state-backed indemnity scheme for General Practice, with a target introduction date of April 2019. This programme of work has strong interdependencies with policy on General Practice provision and with the current GP contract negotiations. **We would welcome the opportunity to brief you on GP indemnity given there are a number of significant decisions, which will shortly need to be agreed with HMT Ministers, including overall scheme design, funding, and managing any 'winners and losers'.**

- **Clinical Negligence and Cost reduction:** one of the impacts of clinical error and safety lapses, avoidable or otherwise, is on the NHS litigation bill, and addressing the rising cost of settling clinical negligence claims against the NHS (from c £0.4m in 2006 to £1.8bn in 2016/17) is a key strategic priority. We, along with MoJ and HMT, have committed to publishing a cross-government strategy this Autumn aimed at setting out our approach to address this inflationary trend in both damages paid to patients and associated legal costs. We will want to brief you on the work so far to ensure your steers are fed into the next stage of strategy development.

- Last December, following a commission from SofS, Health Education England (HEE) published for consultation a draft **health and care workforce strategy** on behalf of the Department and our ALBs. The draft strategy discusses the key challenges facing the workforce such as training sufficient numbers of clinical staff, vacancy rates, changing expectations about work and the impact of technology, morale and retention, and increasing demand for services, and poses a number of questions for consultation. The current intention is the HEE, working with the department and other ALBs, will write a final **workforce plan to** support the long term service plan in November. The quality of this plan will be key to the success of the NHS plan. We would welcome a discussion on overall approach, given there are some tensions between the different ALBs which you will wish to be aware of, as well as your views on whether to combine an NHS workforce plan with a social care workforce plan, or to handle this separately alongside the social care green paper.

- **Workforce Supply**: There are significant and immediate supply challenges already in play on nurses, GPs and some other medical specialities, and we are taking action on international recruitment, retention, participation and agency working to seek to mitigate these in the short term. In the medium to longer term, we are taking steps to increase domestic supply but long training times mean that we are likely to have a significant reliance on immigration for some years before we are in a more balanced position for both nurses and doctors. You are due to attend **the Ministerial Immigration Implementation Task Force** at the end of the month to set out our plans to minimise reliance on overseas workers in both health and social care and we will provide you with full briefing shortly.

E. Global and Public Health

Director General: Clara Swinson

1. The Global and Public Health group is concerned with keeping people healthy, and thereby contributing to economic prosperity and a sustainable health and welfare system. It aims to keep the UK safe from existing or potential threats, which individuals cannot mitigate themselves, and to keep people living healthier for longer and therefore not to need, or to minimise, NHS care.

2. Factors influencing our health include early years, education, housing, employment, our families and communities. The NHS, central and local government and individual behaviours are strong influencers of our health. We are also concerned with international systems, since threats such as infectious disease do not stop at borders.

3. DHSC leads the **national public health system** to achieve these aims, together with:

- Our public health executive agency, **Public Health England** (Chief Executive – Duncan Selbie), which provides services and support to the NHS and local government and expert advice to government;
- Local government, which has legal duties to provide services such as sexual health and substance misuse, funded by a grant of £3.3bn pa, and runs other services that affect health, such as housing;
- The health service, which delivers services to prevent disease (e.g. immunisation and screening) and treat disease (e.g. cardiovascular health) in primary and community care as well as hospitals;
- Sponsoring three Arms-Length Bodies which provide and regulate services in England and some other parts of the UK: NHS Blood and Transplant, the Human Fertilisation and Embryology Authority and the Human Tissue Authority;
- The Food Standards Agency, a non-ministerial Department accountable to Parliament through DHSC Ministers;
- The Devolved Administrations, when DHSC acts internationally on behalf of the UK.

4. The UK is well respected internationally and plays an important role in **global health**:

- DHSC is the lead government department for the World Health Organisation (WHO), working closely with Department for International Development, Public Health England and the Foreign Office. The WHO is the UN agency responsible for health, for example on response to health emergencies such as Ebola or Zika;
- The European Union currently regulates some public health issues and provides a system of surveillance and response to health threats and disease outbreaks. We are planning to incorporate these areas into UK law. A separate brief is provided on EU exit;
- We also work with other countries bilaterally or in groups, e.g. the G7 and G20 on common issues.

5. The main work areas in the group are:

- **Emergency Preparedness and Health Protection** (Director – Emma Reed): This directorate prepares for and responds to emergencies, including COBRA, and works on the government's Prevent strategy. It practices for terrorist or other threats such as pandemic flu or Ebola. It ensures the delivery of a national immunisation and screening programmes. It also runs a global health security programme, supporting middle and low income countries, as part of the 0.7% of GDP spent on development.

- **Population Health** (Director – Mark Davies): This directorate covers policy on behaviours which affect health such as tobacco, alcohol, and obesity. It analyses and advises on work to reduce the injustice that health outcomes are poorer for those in lower socio-economic groups and works with other departments on issues such as drugs policy and child sexual abuse. It delivers the Healthy Start vitamin and food programme, and provision of abortions for women from Northern Ireland.. It also covers health ethics, such as advances in embryology and surrogacy law.

- **EU, International and Public Health System** (Director – Paul Macnaught): This directorate coordinates the DHSC position on EU exit. It covers our current relationship with the EU; working with the World Health Organization to make it more effective; and regular health ministerials in the G7, G20 and Commonwealth. It leads on reciprocal healthcare arrangements with the EU (and others). It is also responsible for the legislative, policy and financial frameworks for the public health system in England and sponsors our Executive Agency, Public Health England.

- **Work and Health** (Director – Tabitha Jay): This joint unit with the Department of Work and Pensions aims to improve the employment and health outcomes for disabled people and those with long term conditions, particularly mental health and musculo-skeletal conditions which account for the largest amount of sickness absence. It works with the NHS, Job Centres, and employers to trial better ways to help people stay in work when their health deteriorates, and to get unemployed people with disabilities / long-term conditions back into work.

Strategic issues

6. England is largely a healthy country and average life expectancy has been improving, but many years are spent in poor health and high variation persists between the wealthiest and poorest communities. Current trends, for example on obesity or diabetes rates, will harm health, and health in the UK is also at risk from global threats.

7. There are a range of strategic issues to consider, including:

- **Prevention**: How to best incentivise and support action from government, public services, and individuals to keep healthy, will have a particular focus over the next few months in preparing for the NHS long term plan and Spending Review. It will be helpful to discuss particular areas of focus, for example obesity, or tackling the injustice of different health outcomes for different groups. An independent review of the recent breast screening incident will report in October 2018.

- **Economic productivity**: A Green Paper in 2017 set out the approach to meeting the manifesto commitment to get one million more people with disabilities into employment by 2027. We are developing options on incentives and obligations for employers, occupational health, and building the evidence base to deliver scalable interventions. The PM has asked for a note from you and the Secretary of State for the Department of Work and Pensions in July.

- **Anti-microbial resistance (AMR)**: The UK and our Chief Medical Officer are leading the world to tackle the growing problem of AMR, which arises from bacteria becoming resistant to life-saving antibiotics. We will want to discuss our domestic and international approach and plans to make the refreshed UK Strategy as impactful as possible.

- **International health**: We are working on how to leverage UK financial contributions to improve the capability of the WHO to respond to emergencies. There are also opportunities with the G7, G20 and Commonwealth to influence the global agenda on health, fitting with your manifesto commitment to reaffirm the UK's role as a global nation. Dates for international meetings are set well in advance and we advise which ones to prioritise.

- **Reform of the public health system**: The last Spending Review reduced the ring-fenced public health grant given to Local Authorities by 23% in real terms. A decision on whether to end the grant and move public health services into extended retained business rates from April 2020 will need be taken in early 2019. We will need to consider any changes for the public health system in the light of the NHS long term plan and the independent review of breast screening later this year.

Immediate issues

8. We are currently responding to the **poisoning in Amesbury** and will brief you for any Ministerial COBR meetings. The risk to wider public health is currently considered low and health officials are embedded in the national and local response teams. I advise an early introduction to our **emergency response arrangements**, which will cover how DHSC works with the rest of government, the NHS and PHE in the event of an emergency or mass casualty event.

9. On **EU exit** on public health, we will brief you on negotiated and non-negotiated scenarios for maintaining health protection surveillance systems, for the approach to reciprocal health care for UK and EU citizens, and for maintaining high standards of food safety. Further Ministerial decisions on the detail will be needed throughout the negotiations. We will also be preparing for a potential 'no deal' scenario to cover urgent 'Day 1' public health issues such as supply of blood products and cooperation on health security in the event of a disease outbreak.

10. **Pandemic flu** is the government's highest risk (on the Cabinet Office's national risk register). In any given year we estimate the likelihood of a pandemic to be 3%, based on 3 pandemics in the 20th century, and the impact of a 'reasonable worst case scenario' to be 750k deaths. We have contingency plans and a work programme to keep this up to date and supplement it. We can brief you further on the current threat and our work in response.

11. There are also a number of **time-critical issues** on which we would welcome early steers, including:

- Organ donation, where a Government response to the recent consultation on moving to an 'opt-out' system is due before recess so the Government can continue to support Geoffrey Robinson's Private Member's Bill, which could go into committee in September;
- Responding to the Joint Committee on Vaccination and Immunisation recommendations on changes to the immunisation programme including HPV for boys, which will be published by 18 July;
- Consultations on the range of policy announcements included in Childhood Obesity Chapter 2;
- Options for securing the best clinical outcome from adult flu vaccines for 2019/20 onwards;
- The appointment of a new Chair for Public Health England, for which interviews will be completed shortly;
- The appointment or reappointment of the Chair of the Food Standards Agency.

F. Commercial

Chief Commercial Officer: Steve Oldfield

1. The Commercial Group is the newest addition to the DHSC ExCo structure: previously part of the Finance & Operations Group under David Williams, my arrival in October 2017 (from the private sector, this is my first role in a government department) coincided with the decision to create a separate commercial unit. The purpose of the Commercial Group is to unlock value across the healthcare system so that we can continue to invest in front line services for better patient care, by reducing costs and generating receipts through improved commercial behaviours.

2. The breadth of commercial work in the healthcare system is vast. With a spending budget of around £125bn, it has a complex and devolved commercial operating model of over 700 delivery partners, many of which are at arm's length from the Department, as well as being a unique internal market of public and independent providers.

3. To that end, the primary roles of the Commercial Group are to:
    - act as senior advisors to you as Secretary of State, on all key commercial, procurement and market issues relevant to the Department and the wider healthcare system;
    - take a system-wide view of commercial policies and delivery across the DHSC family and ALBs (including NHSE / I, NHS Digital etc), as well as driving performance and building commercial capabilities and capacity across the health system;
    - own the Department's commercial Blueprint and strategy, overseeing its development and implementation;
    - lead and oversee the Department's direct commercial activity, including implementation of the NHS Supply Chain Transformation Programme, shareholder responsibilities for DHSC's companies and ventures, private / corporate finance transactions, and DHSC-led procurement activity.

4. The Commercial Group in DHSC is organised into two Directorates comprised of six areas: Commercial Policy, Procurement, Contract Management, Companies & Ventures, Scan4Safety and Supply Chain. Along with these areas which we manage directly, we provide commercial support and assurance to the wider Department and its ALBs, and in particular, working with Medicines and Pharmacy Directorate (led by Liz Woodeson in Jonathan Marron's group), I am also accountable for delivering the next voluntary agreement with Industry for branded medicines pricing (successor of PPRS): this is covered further below.

5. Work in my group is currently split into two directorates:

- **The Commercial Directorate (led by Melinda Johnson)** provides expert commercial advice and services to DHSC, ALBs and the wider health service, as well as managing the shareholder interest in 5 out of the 6 DHSC owned/part owned companies. The directorate is made up of six professional disciplines.
    - The Procurement team delivers and supports procurements for DHSC core, some executive agencies and ALBs by providing procurement policy, guidance and documentation (including for NHS trusts).
    - The Contract Management (CM) team provide advice and expertise, conduct supplier relationship management, support high risk contract issues as required and implement and embed technology to support the CM process.
    - The Company Management team manages and completes the sale of SofS retained estate, and manage the SofS interests in DHSC owned/part owned companies, including taking a Shareholder Director role, oversight of company creation, ongoing operations, and divestments.
    - The Commercial Capability and Policy Advice team builds commercial awareness, capability and expertise in policy teams across the health family, so that policies which are developed include a full assessment of the commercial opportunities and risks from the start.
    - The Supply Chain Resilience team are focussed on enhancing the supply resilience of medical devices and clinical consumables essential for the delivery of life saving care in the NHS. The team works closely with Medicines and Pharmacy Directorate and ALBs to identify and mitigate broader supply chain risks across the NHS associated with EU Exit.
    - Scan4Safety is a programme, which delivers improvements in patient safety, clinical productivity and supply chain efficiency using barcode technology. Six demonstrator sites have been completed which demonstrated a 4:1 ROI for trusts and the programme is currently looking to secure funding for wider roll out in the NHS.

- **The Procurement Transformation Programme ("PTP", led by Jin Sahota)** is a time limited programme aiming to transform how NHS trusts procure non-medical supplies (i.e. everything except medicines). The NHS is one of the biggest purchasers of certain types of goods and services in the country, however the full value of our buying

power is not yet being adequately realised under the current model of procurement. This programme aims to increase centralised procurement of non-medical supplies from 40% of all spend (current) to 80% under the new Future Operating Model. The programme is currently on target to realise £230million worth of cash-releasing savings by the end of the current financial year. Key to the success of this project will be the creation of an independent buying "agency", and the engagement of all NHS Trusts and entities.

6. There are a number of specific issues on which we would welcome an early discussion with you:

- **Medicines cost and pricing**: Spend on branded medicines is controlled through a voluntary agreement with the pharmaceutical industry: the Pharmaceutical Price Regulation Scheme (PPRS). The current PPRS – which expires at the end of 2018 – requires companies to pay a proportion (currently 7.8%) of their NHS sales back to the Department. For companies that choose not to join PPRS, a statutory scheme applies which imposes the same level of payment but with fewer flexibilities.

  We are currently at the latter stages of negotiations with the pharmaceutical industry on a new voluntary scheme from 2019. These negotiations will determine the overall affordability and productivity of branded medicines expenditure for the next five years, and will need to address the affordability problem posed by a rapidly-increasing number of high-cost medicines while recognising the importance of the pharmaceutical sector to the wider UK economy. We aim to secure a 'heads of agreement' on the scheme by the end of July, and will be coming to you for early sign off on any agreement reached.

- **Interaction with wider industry discussions:** There is a strong interrelationship between our work on medicines cost and work, led by the Office for Life Sciences, on progressing the life sciences industrial strategy and a series of life sciences sector deals. In addition, the Office for Life Sciences will be taking forward the work programme arising from the Accelerated Access Review, which aims to get the most innovative medicines and medical devices to patients more quickly but at lower cost. Alongside this, NHS England and NICE have implemented changes to their approach to medicines appraisals, which provide a trigger for a commercial discussion if the annual cost of any drug is over £20m, having successfully defended the proposals against a judicial review claim by the lead pharmaceutical trade body (the Association of the British Pharmaceutical Industry). In our negotiations on a new voluntary scheme, and on wider discussions with the pharmaceutical industry, it is important that we proceed with both the drugs bill and economic contribution in mind.

- **Price increases in generic medicines:** Last year saw an additional burden placed on NHS finances due to some extraordinary increases in the price of certain generic (off-patent) medicines, although overall spend on generics medicines was 4% less in 2017/18 than 2016/17. The Department took action to address the situation, such that the cost pressure on the NHS has substantially reduced. A Public Accounts Committee report following its hearing on the National Audit Office's report on this topic is expected after the summer recess.

- **DHSC-owned Companies:** As outlined above, you are whole- or majority-shareholder in a number of DHSC-owned companies, a peculiarity of the Department which is not so common in others. The activities, performance, challenges and future options for these companies differ widely, and in addition there are some key executive and non-executive appointments which need to be made in the coming months. We therefore recommend an early briefing in order to gauge your interest in such activities, and your steer on whether you see this as a core activity of the Department moving forward.

G. Science, Research and Life Sciences

Chief Scientific Adviser: Prof. Chris Whitty

1. The Chief Scientific Adviser (CSA) has responsibility for science advice including for healthcare and in emergencies, research, supporting analysis and supporting life sciences. This includes the following broad areas of work:

Science, Research & Evidence Directorate (SRE) Director: Louise Wood

- Leading the National Institute for Health Research (NIHR), the UK's largest funder of health research, concentrating on translational, clinical and applied research for patient and public benefit in England. This aims to keep the UK at the forefront of medical research.
- Leading the NIHR policy research programme, to provide research to answer specific questions of relevance to the policies of Ministers, the NHS, public health and social care.
- Issues of science policy, such as genomics or data, relevant to science, and ensuring health features in the science of other Whitehall departments and DHSC science serves wider Government priorities.

Office for Life Sciences (OLS) Director: Kristen McLeod

- The Office for Life Sciences, which is a joint unit with the Department for Business, Energy and Industrial Strategy (BEIS), aims to maximise the opportunities from the life sciences industry in the UK, supporting their contribution to improved health and outcomes in the NHS and ensuring the UK is a competitive location for life sciences investment. OLS lead on the Life Sciences contribution to the Government's wider Industrial Strategy and also coordinate Brexit preparation work in relation to Life Sciences.

Chief Scientific Adviser's (CSA) office

- Independent scientific advice on areas of importance to Ministers and the Department, and clinical and public health advice in support of the Chief Medical Officer. The CSA acts as First Deputy Chief Medical Officer when needed. The current CSA, Chris Whitty is also professor of public health (London School of Hygiene & Tropical Medicine), and a practicing consultant physician in acute medicine and infectious diseases at University College London Hospitals.

Chief Economist's Directorate. Director: Chris Mullin

- The Director of Analysis/Chief Economist's role is to ensure Ministers and the Department are served by rigorous analysis and robust use of evidence and that analytical insights are central to all decision-making.
- Oversight of the Department's analytical professions (economics, statistics, social research and operational research) and leadership of its analytical community (150 analysts, mainly within eight teams spread across the Department).
- Small central analytical team with professional responsibilities, a cross-cutting analytical perspective and oversight of impact assessment process, international comparisons, horizon scanning and data science projects.

Key Areas

The National Institute for Health Research (NIHR)

2. The UK has one of the most effective medical research sectors in the world (arguably the most effective). This includes basic, translational and applied sciences. The NIHR, the largest national research funder in Europe, has an annual budget of just over £1bn used to support five broad streams of work which underpin the future of the NHS and public health:

- Funding of high quality research for the NHS, public health and social care to improve patient health, the health of the public and the efficiency, productivity and cost-effectiveness of health and care services;
- Training and support for health researchers to ensure the UK remains at the leading edge internationally;
- Providing world class research facilities;
- Working with the life sciences industry and charities to benefit all; and,
- Involving patients and the public at every step of the research process.

Additionally, from this spending round NIHR allocates Official Development Assistance (ODA) money to support UK strengths in global health research and to strengthen research capacity in low and middle income countries.

Life Sciences (OLS) – Steve Oldfield and Jonathan Marron's roles in Life Science are referenced on pages 12 and 6 respectively.

3. 'Life sciences' refers to the application of biology and technology to health improvement, including biopharmaceuticals, medical technology, genomics, diagnostics and digital health. As a sector in the UK, it is truly world-leading.

4. The UK has one of the strongest and most productive life sciences industries in the world, generating turnover of over £70 billion per annum and ranking top in major European economies for health life sciences foreign investment with a focus on R&D and innovation. The "Golden Triangle" between Cambridge, Oxford and London is a recognised global hub for life sciences with four of the top ten global biomedical research universities.

5. The aim of the Office for Life Sciences is to improve the health and wealth of the nation. Our core objectives are to:

- **Generate inward investment in to the UK** (working closely with the Department for International Trade);
- **Protect and support the very significant life sciences investment we already have** in the UK;
- **Help innovative UK life sciences companies to grow** and make their home in the UK or to help ensure that the UK benefits in some way from this home-grown innovation;
- **Help to get innovative treatments to NHS patients faster**, at a price the NHS can afford.

6. In light of these objectives, our key areas of work are:

- **Implementing the Life Sciences Industrial Strategy (LSIS) and Sector Deal:** Professor Sir John Bell (the Government's life sciences champion) led the development of a new industry-led strategy to realise the vision of the UK as a top tier global hub for medical research and innovation. The LSIS (launched on 30 August 2017) capitalises on our strong science base, and sets out what industry thinks Government needs to do to guarantee the long-term success of UK life sciences. The Government has agreed to work in partnership with industry to make fast progress on implementing the LSIS. This laid the groundwork for a Sector Deal for Life Sciences, launched on 6 December, in which Government announced policy progress on the LSIS and industry announced large scale investments in UK life sciences. Strong progress has been made on implementation since the Deal's launch and we are now working with Professor Sir John Bell and the industry, through the newly established Life Sciences Council, to agree the priority areas to focus on in the next phase of implementation.

- **Improving access and uptake of cost-effective and innovative technologies**, to bring life-changing treatments to patients more quickly. This means implementing the response to the Accelerated Access Review which we published in November 2017, including delivering an £86m funding package. Key elements of implementation will include: a new Accelerated Access Pathway and Collaborative chaired by Lord Ara Darzi and bringing together partners from across the system to fast-track ~5 breakthrough treatments to patients each year; a digital health technology catalyst to stimulate digital health innovation; an SME scheme to support smaller industry players to develop the real-world evidence they need to get the NHS to adopt their innovations; increased capacity for the 15 regional Academic Health and Science Networks to establish them as a key part of the delivery architecture for innovation, supporting adoption and diffusion of new technologies locally and nationally, and a new Pathway Transformation Fund to support the necessary changes to clinical pathways to enable uptake of innovation.

- **Brexit preparations.** The importance of the life sciences industry to the UK economy means we are working very closely with industry to prepare for Brexit, both to mitigate risks and be ready to seize opportunities. The future arrangements for the regulation, trade and supply of medicines, med tech and other health products are critical for the success of the sector in the UK. We are continuing to provide advice to Ministers with colleagues across DHSC and BEIS on the different negotiating positions we may wish to take. Further information can be found in Paul Macnaught's note, which starts on page 17.

H: Role of the Chief Medical Officer

Chief Medical Officer: Professor Dame Sally C Davies

Background to the Role

1. The Chief Medical Officer (CMO) is the most senior medical adviser to Her Majesty's Government (HMG), and a Permanent Secretary at the Department of Health. This is a statutory role and has been occupied since 1865. The CMO supports Ministers across HMG to ensure that government policy benefits the health of the people and has science and evidence at its heart.

2. Professor Dame Sally C Davies was appointed CMO in 2011. A haematologist by background, she previously created and ran the National Institute of Health Research (NIHR) which distributes over £1bn of funding each year. She is the first woman to be CMO and the first CMO to be both a Fellow of the Royal Society and American National Academy of Medicine.

3. The CMO is supported by a private office and two Deputies, Professor Jonathan Van Tam and Professor Gina Radford. They lead on health protection (e.g. flu) and health promotion (e.g. smoking) issues respectively. She also supervises the Department's Director-General-level Chief Scientific Adviser, Professor Chris Whitty. Professor Whitty runs the Science, Research, and Evidence (SRE) Directorate (which includes the NIHR), the Chief Economist's Directorate and the Office for Life Sciences.

4. The CMO for England works in tandem with the CMOs of the Devolved Administrations. She leads for the UK as a whole in all international health matters. The relationships between the CMOs are important for ensuring the UK has unified and well-aligned health systems that come together effectively on key public health protection (e.g. infectious diseases) and improvement (e.g. physical activity and obesity) issues. This is particularly important during health emergencies.

Current Priority Areas

5. The CMO provides senior advice to Ministers and Government on a wide variety of health issues and Ministerial priorities, emergencies (Ebola, pandemics, flu, chemical poisoning) especially global and public health (linking with Clara Swinson's note in this pack). Current high-priority areas include:

- **Novichok and Salisbury/ Amesbury**: Currently provide advice to Ministers, including COBR, and Public.
- **Medicinal Cannabis:** CMO report sent to Home Secretary
- **Antimicrobial Resistance (AMR):** The CMO has led the global effort to tackle antimicrobial resistance; that is, the rise of drug resistant infections that threaten the foundations of modern medicine. This has included: conceiving of and championing the independent Lord O'Neill AMR Review; leading the UKs domestic and international action; leading a global awareness campaign; and driving for a United Nations General Assembly high-level meeting and side-event (September 2016). She is now the United Nations Convenor for the Interagency Coordination Group (IACG) which resulted from the General Assembly Declaration in 2016.
- **WHO Reform & Global Health Protection:** The CMO represents the UK at the World Health Organization (WHO). In this role she champions UK interests in global health and ensures that WHO is held to account. The CMO leads the cross-HMG effort to ensure strong reform of the WHO following the Ebola crisis. International health protection emergencies (such as Zika and Ebola) are also led for the UK domestically by CMO.
- **Public Health Campaigns:** The CMO speaks directly to the public on key public health issues, acting as HMG's independent trusted clinical voice in print, radio and TV media. This includes significant HMG policy announcements, such as the Childhood Obesity Plan and routine public health communication such as 'Stoptober' or the flu vaccination campaign. Perhaps most prominently, the CMO provides advice and reassurance to the public during public health crises such as Ebola.
- **CMO Annual Reports:** The CMO has a statutory duty to produce annual reports on the state of the nation's health. These independent reports focus on issues to make recommendations to HMG on how health can be improved. Previous reports have covered topics including; women's health, mental health, infectious disease, genomic medicine and pollution.
- **Genomics:** The CMO sits on the board of Genomics England Ltd (GEL), which is leading the HMG priority effort to collect and sequence 100,000 Human Genomes. Funded by NIHR, the project aims to transform the NHS and clinical understanding, while driving investment in the life sciences sector.

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I. Making a success of Brexit

Director: Paul Macnaught

Introduction

1. The Department's view has been that the draft White Paper does what we need from a health perspective. We are finalising a separate note for you on the latest draft document.

2. The Civil Contingencies Secretariat (CCS) is gearing up to co-ordinate preparations for No Deal. You will be invited to a meeting of the National Security Committee on Monday 16 July. CCS envisage 11 workstreams including one on 'healthcare services'.

3. Close engagement of the life sciences industry and the convening by the NHS Confederation of a 'Brexit Health Alliance' of the main health and care interests have channelled stakeholder angst positively so far.

What health issues are raised by Brexit?

4. EU competence in health services is relatively limited, but there are a number of major issues which do affect the health and care system:

- Citizens' Rights issues, including workforce supply, reciprocal healthcare and NHS cost recovery.
- Future Security Partnership issues, specifically public health security.
- Future Economic Partnership issues, including medicines and devices trade regulation (and broadly the impact on the life sciences sector), research funding and collaboration, the impact of new customs and trading arrangements on the supply chain of the NHS, data, social and employment regulation, public health regulation more widely including food standards, and health cooperation between Northern Ireland and the Republic of Ireland.

Contingency planning for No Deal

5. Of the No Deal issues, the three big ones we need to get right over exit day are:

a. *Continuity of Supply of medical products to the health and care service*. While there are global markets, large proportions of NHS supplies are available only from or through EU countries. In anticipation of problems at the border in the event of No Deal, the EUXT(DPLD) cabinet committee recently agreed Jeremy Hunt's proposal to support the Pharma industry in stockpiling medicines ahead of exit day, and our own plans to create an 'air bridge' for centrally purchased equipment and perishable goods. We are preparing an announcement on this for early August (because of the lead times involved in stockpiling effectively), on which advice will come to you shortly (further information can be found in Jonathan's note [starts page 16]).

b. *Medicines regulation*. Irrespective of the longer-term model for UK regulation in the event of No Deal, the short-term fix for medicines regulation is simply to copy compliance decisions coming out of the EMA in the immediate aftermath of exit day. This approach has collective agreement and is also scheduled for announcement soon. Comms advice to follow (further information can be found in Jonathan's note [starts page 16]).

c. *Reciprocal healthcare*. As an absolute minimum we aim to provide ongoing support to the most vulnerable ex-pats in the event of No Deal, and have very effective comms around any changes in entitlements for expats and tourists. As explained below, our primary goal is to have reached bilateral deals with each individual Member State ahead of exit day that would maintain the status quo in the event of No Deal. We are finalising a short draft Bill to take powers to underpin this.

6. More generally, to enable the NHS frontline (and other service providers, including care homes) to plan effectively ahead of exit day, we plan to issue 'guidance' to the service in early August. This will set out what frontline organisation should do or not do over the coming months, with a promise of further guidance to follow after October. The guidance will need to strike the right tone and avoid an impression of scaremongering. A draft will be provided in due course.

7. We are coordinating the statutory instruments (SIs) required under the European Union (Withdrawal) Act. You are responsible to Parliament for Food Standards Agency SIs and Northern Ireland ones since they have no Ministers.

8. **Workforce supply.** There are 150,000 EU nationals working in the health and care system, including 90,000 European nationals working in lower-paid jobs in social care. We have been taking action to improve domestic supply of doctors and nurses through increasing medical student numbers and removing the cap on nurse training places, although there will be a lag before the full effects of this start to be felt. The future supply of lower-skilled workers in health and social care is more challenging.

9. The draft White Paper on the Future Relationship calls for a system of mutual recognition of professional qualifications which would replicate the benefits of the current arrangements. The plan for No Deal would be to unilaterally recognise EU qualifications at least in the short run.

10. **Medicines regulation.** Medicines regulation in the UK is overseen by the European Medicines Agency (EMA). The UK regulator, the Medicines and Healthcare products Regulatory Agency (MHRA), is a leader among the cross-EU network of national regulators. Generally the terms of the Implementation Period (IP) will involve the continuation of the status quo, but an important exception is the status of UK agencies, including the MHRA. The MHRA would no longer play the lead role in EU casework that it is used to. This could lead to a haemorrhaging of expertise and influence in the absence of a clear plan for the future, with detriment to patient safety and industry, not only in the UK but in Europe as well.

    The draft White Paper calls for continued cooperation with the EMA as now after the end of the IP, but without a vote for the MHRA. The European Medicines Agency itself is physically headquartered in London but – deal or no deal - will be relocated to Amsterdam when the UK leaves the EU.

11. **Reciprocal Healthcare and NHS Cost Recovery.** The Withdrawal Agreement maintains access to free UK-funded healthcare for the stock of UK-insured state pensioners resident in other EEA countries – particularly Ireland, Spain, France and Cyprus - after the end of the IP. There are currently 190,000 such UK-insured pensioners registered under the Reciprocal Healthcare scheme, and about 5,000 EU27-insured pensioners in the UK. The agreement does not provide for future cohorts to retire to the EU with healthcare rights, or for continuation of the European Health Insurance Card (EHIC) scheme.

    The draft White Paper calls for the current arrangements – for pensioners and EHIC - to be retained and applied to the 'future flow' of pensioners and tourists as well as the current 'stock'. The position on working age cohorts has been left flexible for now to take account of the cross-government position on immigration and labour mobility; in low alignment we could require EU nationals in the UK to pay the same surcharge as 3rd country nationals (raising upwards of £200m p.a. for the NHS).

12. **Public health security.** As a member of the EU, the UK is part of cross-European health security arrangements, including disease surveillance systems. The arguments in favour of ongoing collaboration are clear, although the politics on the EU side may yet trump this. The draft White Paper calls for a close partnership, but should ongoing cooperation not be negotiated we would fall back onto World Health Organisation (WHO) systems, bolster our domestic arrangements and make the best of it. We do not believe there would be a substantial loss of capability in practice but would prefer to avoid the risk.

13. **Future Economic Partnership.** Under the Single Market rules, medicines, medical devices, related clinical trials, tobacco products, alcohol, food labelling and substances of human origin are all regulated at EU level and DHSC is the lead Department.

14. **Health Research.** Opportunities include: a different UK position compared to some European countries on scientific areas such as genetically modified (GM) products; vaccines; data use for science; and some areas of EU regulation such as the Clinical Trials Directive. Challenges include: the large body of research funding for UK universities; access to internationally mobile talent; and potential issues around the single market in pharmaceutical products. The draft White Paper calls for close collaboration and says that the UK would make a financial contribution.

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