

Public Accounts Committee

Oral evidence: NHS Specialised Services, HC 916

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Members present: Meg Hillier (Chair), Deidre Brock, Chris Evans, Mr Stewart Jackson, Nigel Mills, Karin Smyth

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, and Robert White, Director, National Audit Office, and Richard Brown, Treasury Officer of Accounts, HM Treasury, were in attendance.

Witnesses: David Williams, Director General, Finance, Commercial and NHS, Department of Health, Simon Stevens, Chief Executive, NHS England, and Dr Jonathan Fielden, National Director of Specialised Commissioning, NHS England, gave evidence.

Q1 Chair: Welcome to the Public Accounts Committee on Monday 9 May 2016. The sun is shining and we have a Labour Mayor of London, but I won't rub that in—that will be my only political comment from this chair. I am pleased today that we are looking at the commissioning of specialised services in the NHS, on the back of a National Audit Office Report into this very important area, which accounts for 14% of NHS England's budget, so it is a significant Report.

Since NHS England took over responsibility for commissioning specialised services in April 2013, spending on the services has increased at a faster rate than in other parts of the NHS. We want to look today at why that is and what is being done to ensure that this large chunk of your budget, Mr Stevens, is going to be manageable in future.

We have as our witnesses today Dr Jonathan Fielden, the director of specialised commissioning for NHS England; Simon Stevens, the chief executive of NHS England, who is one of our frequent flyers—if we did frequent flyer points, you would be flying off somewhere very exotic—and David Williams, the director general of finance, commercial and NHS at the Department of Health. The hashtag for anyone following us today is #specialised.

We are keen to find out what is happening with this budget. Given that you have just done two and a half hours with the Department of Health, I am sure that that will inspire you to give short, crisp answers. We will be equally short and crisp in our questions, because we also are keen to

deal with this with dispatch. This raises important issues, but not ones that we do not think we can deal with in an hour and a half, if we are disciplined. If we can aim for that, I am sure our audience will be pleased.

One of the first questions I have for you, Simon Stevens, and I guess for Jonathan Fielden as well, is this: how do you know whether you are achieving your objectives for specialised services? Once again, this Report highlights a lack of data and information about the outcomes.

Simon Stevens: As the Report makes clear, the cards were thrown up in the air, in terms of how specialised services were commissioned, on the back of the 2012 changes in the national health service. Rather than more of them being done locally by primary care trusts, a higher proportion of services—approaching £15 billion-worth in 2016-17—were defined as to be nationally commissioned.

My predecessors, in conversation with the National Audit Office, described how the principal task facing NHS England in its first year of operation—2013-14—was to make sure that the CCGs, which control two thirds of the NHS budget, were up and running and that there was a seamless transition. While that was successfully achieved, I think it is fair to say that there was an opportunity cost in terms of the effort and attention that was able to go into specialised commissioning in the early days

One consequence of that was that in 2014-15 and 2015-16—in other words, the last two years—there has been great importance in getting financial control systems into specialised commissioning. We have successfully done that, with the result that the overspend has progressively come down year by year, and in fact we will have ended the last year in a balanced financial position for specialised services.

Now the task is to focus on driving improvement and value from the £15 billion-worth of public spending that is going into specialised services, recognising that there are intrinsically more pressures in this part of what the health service does than in many other aspects of what we do, by virtue of new technology, research, NICE appraisals and all the other good stuff that no doubt we will come on to.

Q2 Chair: I do not doubt all those challenges. One of the problems in reading this Report is that I was not quite clear about the strategy for specialised services. Can you lay out in simple terms what your objectives are and then pick up on this point about the information, the quality of data and how you will know whether you are meeting the objectives?

Simon Stevens: As the Report makes clear, specialised services, as currently defined, are quite a diverse range of diagnosis, treatment and care services. There are 146 different things that are defined as specialist.

Chair: If anyone is interested, it is in appendix 1.

Simon Stevens: Some of them are for rare conditions, where we pay for the whole treatment. Others are for part of the care that somebody is getting, but most of it is local. On cancer services, for example, if you are a cancer patient and you need surgery, that will be funded by your local clinical commissioning group, but if you need chemotherapy or radiotherapy, that might be funded as part of the national specialist commissioning service. In other words, for some services it

is the whole package, and for other services we are part-funding elements of the treatment. That is the first differentiation. The second is that some services are provided across a wide range of hospitals and clinics, and others are provided in just a very small number in the country.

To go to your question directly, we are trying: first, to ensure that patients get high-quality care and that we use this national oversight to level up standards and quality across the country; secondly, to ensure that we get the maximum bangs for our buck out of the enormous sums that are going into this part of the national health service's expenditure; and thirdly, where appropriate, to link up the specialist part of services with the local part of services so it appears, and indeed is, seamless from the point of view of the patient involved.

Q3 Chair: Those are the objectives but, as you say, there is quite a range of different types of treatment. What are you doing to make sure the data is in better shape? It is collected differently, which is one of the reasons for the muddle—that is perhaps a polite way of putting it—or the problems of controlling the budget. You haven't got data to prove what is going on. Or if you have, what was going on before? When it was in local areas, how did they know what was going on?

Simon Stevens: The budget and the data are related, but they're not quite the same thing. Part of the issue with the way the money flows is that about 40% of the £15 billion of spending is reimbursed through the national tariff system, about a third is locally negotiated and about a quarter is a direct pass-through that nationally we pay a hospital when it prescribes a high-cost drug or uses an expensive medical device. Those three different payment routes have their own information flows associated with them. What we are now doing is ensuring that we get much greater aggregation of data, so that for the kidney services programme or the cancer services programme we can look in the round at the variation that exists across the country. We can then use the commissioning levers to drive improvement.

Q4 Chair: I want to come on to the variation, in both cost and quality, in a moment. Jonathan Fielden, do you want to add anything to that? Once again—we often see, and not just when we look at health, that there is an issue about data—you have a cost and an outcome, and the data on that is not very clear. What would you add?

Simon Stevens: Can I just introduce Jonathan for those who do not know him? I am sure the Committee does.

Chair: Perhaps we should call him Dr Fielden.

Simon Stevens: Dr Fielden is the national director for specialised services. He is well experienced. He is one of the most senior medical directors in the country. He was previously the medical director of University College hospital and before that the Royal Berkshire hospital, and he has been a practicing clinician, so he brings strong clinical expertise to this role.

Q5 Chair: That is always welcome, as long as clinicians don't spend more money than they need to.

Dr Jonathan Fielden: Thank you for the welcome. One of the reasons why it's important to have clinicians here is to get that balance. I think clinicians get that balance. It's very important to

get the balance between quality and the resources available, and Simon has articulated how we are doing that. Getting close to standardisation across the country has been a focus of improvement as we have come from the separation that we had prior to the Act through to the greater consistency that we have got for that. We are driving uptake of more standardised formats for that and better uptake of the quality and completeness of that data through validation and otherwise.

We have centralised storage of the information so we can analyse it in better ways. We are also improving the front-end visualisation so that it can be used by us centrally and, importantly, as we get better quality data, by our teams closer to the frontline, with the appropriate safeguards, so they can do that level of comparison. We are particularly focusing on the areas where we need to get, to use Simon's phrase, the biggest bangs for our buck—devices and high-cost drugs—so we can really focus on getting the best value for patients out of the tax money that we have.

Q6 Chair: We will go on to some of this in more detail later. NICE approves many of the treatments that come through the specialised services route—not all, but many of them. Do you know what percentage, roughly?

Dr Jonathan Fielden: About three quarters of the NICE technology appraisals apply to specialised, and a significant amount of our high-cost drugs spend is related to that pipeline. A substantial proportion, if not most of the uplift in this current year, is related to the pressure on drugs coming through from that. So how we work with NICE and with our Department of Health colleagues is critical in this area to make sure we get the best value spend as well as the quality.

Q7 Chair: Absolutely. So NICE will agree a treatment on its cost-effectiveness. Its worry is not affordability, but once it has agreed it, it is then something that has to be delivered.

Dr Jonathan Fielden: If it comes out with a direct edict like that, yes, we legally have to provide it. Importantly—as we have seen with hepatitis C, for example—expressions have come through with an ability for us to be able to deliver it for patients in an effective way, but within the resources we have available.

Q8 Chair: So NICE is agreeing to things without having to worry about whether they are affordable, and NHS England has to fund whatever NICE agrees to. Doesn't that explain, Mr Stevens, why the budget is so out of kilter?

Simon Stevens: As always, Chair, you have put your finger on it. Yes, there is an issue about the interactions between different elements of medicines pricing and budget management that currently exists. We have the voluntary pharmaceutical price regulation scheme, the NICE technology appraisals and the funding decisions that NHS England needs to make for about three quarters of the pipeline. Frankly, I do not think that those three mechanisms are interacting optimally at the moment.

However, as Dr Fielden says, in the case of hepatitis C, NICE has shown a thoughtfulness about enabling a phased approach to those investments, but there is an issue about the way the cost-effectiveness hurdle interacts with the pricing negotiations and with the affordability considerations, and the danger is that things that have come through the NICE pipeline then pre-empt other potential investments that might have offered higher value for patients in the round.

Q9 Chair: That brings me to figure 15 on page 41 in part three of the Report. This could throw up lots of issues, but I want to ask what you think about the level of compliance with national specifications by the commissioning hubs. The list has the North West at 74% compliant and East Midlands topping the league at 96% compliant—Mr Mills is no doubt happy about that. Does that mean that if you live in Mr Mills’s constituency, you get better treatment than if you live in Manchester or Liverpool or somewhere? On these derogations that exist for either commissioners or providers, does that mean they are doing the same job, but cheaper or differently or better, or do you take very seriously this compliance with the national service specifications? Perhaps I can ask Dr Fielden.

Dr Jonathan Fielden: The national service specifications have been set with a strong clinical input into them. They have been set over a period of time and it is probably correct to say that they have been set with a view more towards the quality or excellence of outcome, rather than necessarily to all the affordability aspects within those. The environment within which we operate does change, as we are all well aware. Within those, the idea is to get as much consistency across the country, and that is what we are aiming to do. So there are aspects of how well the data is completed in this variation in results. There are aspects of how close the providers have got and which of those derogations providers—

Q10 Chair: Sorry, to pick up on that first point, some of this may be down to the way it is recorded.

Dr Jonathan Fielden: There may be an element about the quality of the information, and we are improving that, as we have alluded to. We are improving that, particularly this year, by using an online mechanism that allows us to get the data in a better way and to look into it in more detail. There are also aspects where the provider derogations say that they cannot meet the specifications. Commissioner derogations are those where you might need to move some services or look at the flow of services in particular areas, which are, as you can imagine, sometimes quite complex to change for those areas. We have a mix of both of those. So I do not think that this reflects a radical difference in the quality of care for patients. Those elements are looking towards ensuring that we have consistency, both in the information and in what our providers and commissioners believe they are getting for the money available.

Q11 Chair: If it does not affect the quality of care for patients, why do you have the national compliance figures? There is a big difference between 96% compliance and 74% compliance.

Dr Jonathan Fielden: I think it is very important that we have national specifications, so that there can be an understanding of—

Q12 Chair: I am not doubting that it is important to have that. But then you have a point of variation. So you are saying that patients are not losing out because of that variation.

Dr Jonathan Fielden: We are moving to a place where we know that either the services that are provided are at the specification or there is a path towards meeting the specification or, where they cannot get to that, for whatever reason, that we are working, as commissioners and with our

NHSI colleagues, to make sure that those services are either moved, or moved to somewhere where there is a better quality of provision.

Simon Stevens: To add to what Dr Fielden has rightly said, prior to 2013 there was no national visibility to the differences that existed in the way that specialised services had been provided across the country, so the first thing is that you draw back the veil, you see the variation in all its glory and you say, “What are we going to do about it?” The core level of standards—the minimum level of standards that is required—is what the Care Quality Commission obviously inspects all these providers against, and they determine if the care is safe and of an acceptable standard. These service specifications, to a significant degree, are the gold standard. They are what people should be aspiring to, over and above what the CQC and others say is necessary.

If you have a group of clinical experts meeting to say, “In an ideal world it would look like this,” some of those gold standards might, in the real world, be difficult to bring about, in that they might involve trade-offs between, say, whether children’s services and adults’ services are on the same site, or whether cancer services are next to other related disciplines. Where you see some of the so-called commissioner derogations, they are just because of the basic structure of services. You would have to start with a blank sheet of paper, at very considerable cost, to move to the gold standard. So what Dr Fielden and colleagues are doing now is working through which of these gaps realistically can be improved upon and which of them we just have to accept are, in the real world, trade-offs that we should make, for example between access, geographical convenience and concentration.

Q13 Chair: Transparency on that would certainly be helpful, but I am going to bring in the Comptroller and Auditor General, Sir Amyas Morse.

Sir Amyas Morse: I would like to make two points. The first is just a comment that to describe them as gold standards when quite a lot of areas in the country are managing a very high level of compliance is a bit difficult to accommodate, I think. In other words, to say that—

Simon Stevens: It just shows how golden parts of the NHS are, Sir Amyas.

Sir Amyas Morse: Thank you, that is very oratorical. Secondly, regarding those parts of the country that have derogations, I believe they are supposed to be temporary, but some parts of the country have had them in place for a long period of time. I think I am right in saying that.

Dr Jonathan Fielden: You are correct in saying that, but as Simon has articulated, some of these derogations, particularly on the commissioner side, are very difficult to deliver in the change, because of the nature of the change and the linkage of services to other services.

Sir Amyas Morse: They are difficult because of the nature of the change.

Simon Stevens: Particularly around co-location. Should you spend tens of millions of pounds moving a service so it is co-located with something else, but as a result the population in, say, Liverpool would have to go to Manchester or vice versa? It is those kinds of trade-off.

Sir Amyas Morse: So examining what I call alternative solutions—you are going to work your way through and look at the alternative solutions, which may be going to another nearby centre and

say, “Look, that works. It’s perfectly good. We’ll change the standard to cover that.” Is that what you are going to be doing?

Dr Jonathan Fielden: We will be looking through, getting as many of the services as possible to the service specifications, but quite a lot of the service specifications are about process rather than outcome. We will be focusing on “What are those that deliver the best outcomes for patients and the experience that goes with them?” rather than necessarily on just the process.

Q14 Karin Smyth: Within that though, some of the variation might be a good thing to have. How do you know what is required in the North West as opposed to what is required in the South West?

Dr Jonathan Fielden: The providers and the commissioners will grade their compliance with the standard. That standard is then checked.

Q15 Karin Smyth: That is about compliance with the standards, though, not about looking at what is required in those geographical regions. Who is doing the needs assessment about what should be commissioned in each of those areas?

Dr Jonathan Fielden: The standards are brought together by clinicians and managers who know the field. There are the providers and commissioners saying—

Q16 Chair: Is that clinicians and managers in each local area, or are you talking about the national level?

Dr Jonathan Fielden: That goes through the national clinical reference groups, to get that national consistency. Providers and commissioners grade against that, which is then checked by a quality effectiveness team centrally, and then, with the regional teams, they work out whether that is fine, whether they need to go and have a closer look, whether they need to have a peer review of that service to make sure that it is close to the needs of that area, or whether there is significant derogation that needs effort between ourselves and others to resolve.

Simon Stevens: I would make the distinction this way. You might have a specification for what a high-class cardiac surgery unit should look like, but the decision as to how many cardiac operations are likely to be required in a particular part of the country will obviously depend on its needs, its age structure, the morbidity of the population and so on, so you can—

Q17 Karin Smyth: Who is doing that work?

Simon Stevens: Our specialist commissioning teams as well. The service specification and the needs assessment are two sides of the same coin, but they are not the same thing.

Q18 Karin Smyth: You have 146 across each geographical patch and you have specialist teams with knowledge of those 146 in each patch that you are confident understand the needs that

are required to be met and commission accordingly under a national framework with national standards. I think it would be helpful to talk us through that, so that people in Bristol and in Amber Valley, for example, might know that they have the same access to those sorts of services.

Chair: Talk us through how that fits together, Dr Fielden.

Dr Jonathan Fielden: I think you are talking about the standards of service rather than access to service. The standards of service that we are talking about—

Q19 Karin Smyth: I want it to be clear for the people of Bristol and the people of Amber Valley or elsewhere that if they need treatment x, they can be assured that the correct needs assessment and commissioning support team are therefore commissioning that service in that geographical patch, and I cannot see how that happens.

Simon Stevens: It will not necessarily be in that geographical patch, because some of the needs of people in Bristol will be so specialised and rare that it might be a question of going to Southampton, Oxford or some other centre or, indeed, vice versa—somebody from Oxford might have to travel to University Hospitals Bristol.

Q20 Karin Smyth: So how can someone in Bristol know and be assured that taxpayers' money is being spent wisely in making sure they have access to that service? Where do I as an MP or Mr Mills as an MP go to be assured that that is being done, and who is doing it?

Simon Stevens: In terms of who is doing it, NHS England is doing it if it is one of these 146 prescribed, specialised services, but our view, my point of view, has been that we want to try to reconnect the decisions that are being made nationally with the sorts of decisions that are being taken locally, so as we have set out the funding envelope for the people of Bristol over the next five years, we have included in it the line for the specialised services that would be being procured on their behalf, and we have said to the local CCGs, "Join with us to make some of these decisions." That way we can bring together the whole view as to how money is being used. I am talking about the £2,000 per person on average that the NHS will be offering for your constituents.

Q21 Karin Smyth: One of the figures in the Report talks about the barriers that CCGs have identified to doing some of that work. Do you want to talk us through that? Remind me what figure it is.

Chair: Figure 12 on page 31.

Simon Stevens: A year and a half ago, we consulted on the idea that one way of trying to give local CCGs more involvement in this would be to change the list of the 146 so that some of the things that were being done nationally at the moment they would instead be able to do themselves, but that gave rise to two sets of concerns. First, individual CCGs were worried that they either lacked the bandwidth or would be managing financial risk that they were not certain about. Secondly, some of the patient advocates were unkeen on the idea of redistributing some of these services to 209 CCGs; they liked the fact that they can come to Dr Fielden and hold NHS England to account for the national consistency.

That was the debate of about 18 months ago. To try to square that circle, as I have said, we have created a place-based budget for Bristol and we have exemplified the element of that which is specialised commissioning, for which we are responsible to the Department and to Parliament; nevertheless, people in Bristol can see how that is being done, and it provides the basis for a dialogue with the CCGs locally. In Greater Manchester, as part of the Greater Manchester devolution process, we have created the ability for the Greater Manchester arrangement to do its own specialised commissioning, subject to the national standards that will be in place. So part of the budget that we are putting into that pot for 2.8 million people in Greater Manchester will include specialised commissioning services.

Q22 Karin Smyth: So some of the STPs will pick up that across the piece, but where they are not big enough, how do you see that playing out in terms of some of these barriers?

Simon Stevens: My personal view is that we have ended up, for reasons I think we all understand, in an overly bifurcated world between locally commissioned versus specialised commissioned. Actually, the notion that you can have a sort of regional approach that is somewhere between the two is at the right population level for a lot of these decisions. But I think we can create that virtually, without having to throw all the cards up in the air again in some new reorganisation.

Q23 Chair: So virtual regional health authorities.

Simon Stevens: You are tempting me.

Chair: I will make it a question: are we talking about virtual regional health authorities?

Simon Stevens: We have 10 commissioning hubs—

Chair: Commissioning hubs—I was wondering what the latest phrase is for this new virtual structure.

Q24 Karin Smyth: Taking us back to where we started, that variation within what something might be is not necessarily a bad thing, in terms of the derogations. People might disagree about that. I know we are looking at different things—compliance with the contract, the cost, gold standards and the needs—that suggests that there is an assurance behind the process in terms of what is happening in each regional area. Do you think that is fair?

Dr Jonathan Fielden: I think what patients have been looking for is consistency in the outcome and the experience wherever they are, but the exact detail in how it is then delivered and commissioned will to some extent have a regional and more local variation. Simon has described how we will have that spectrum of how we commission, from the more devolved way of the Manchester set-up, through a set-up with perhaps less than that around delegation, to others that do not have quite the capacity, capability or even desire in this area just being involved in the decision to others that are what we would describe as being “at the table”—they understand what is going on, but do not have the capacity, the capability or the desire to be really involved.

There is significant variation across the country in CCGs’ ability, but as we work with our STP colleagues for that in particular—we have mentioned Manchester, but we will be working with

South East London and looking for one other sustainability and transformation plan area to work with—it will be how we work through the spectrum in a way that gives that consistent outcome and experience for patients, but allows the degree of delivery variation locally, so it can match the desire for what our local commissioners want.

Q25 Karin Smyth: Will the accountability for that rest with you?

Dr Jonathan Fielden: The accountabilities for that are clearly set legally, and unless you get right through to the devolved area then the accountability rests with NHS England to get that national consistency. It would only be where we can ensure the national consistency that we take the further step.

Q26 Chair: I want to bring in David Williams on the Department's role in making sure that the objectives that Simon Stevens set out for you, minutes ago now, for commissioning specialised services are adhered to. How are you assuring yourselves in the Department of that?

David Williams: The progress against those objectives forms part of the overarching accountability relationship between Health Ministers, the Department and NHS England. For example, the way ahead and progress in this area has been the subject of conversation and debate in two of the formal Secretary of State accountability sessions over the past 12 months. It contributes to the headline requirements set out for NHS England in the formal mandate, and of course it is supplemented through routine exec engagement and through our engagement with the board of NHS England.

Q27 Chair: What happens if they don't meet objectives or if there is a problem? I don't know how much detail you have on regional variations yet—that is for NHS England to deliver. What do you do if a flag arises that something is not getting there? We have seen an increase in resources for this—it is a huge chunk of the budget and a challenging part of the budget. How do you make sure you are really on top of something before it could go horribly wrong and be expensive?

David Williams: If I break this down in two parts: on the financial performance specifically, this would be part of very routine and regular monthly engagement between myself and my team in DH and finance teams in NHS England under Paul Baumann. Clearly, we are interested in variations against individual components of the NHS England budget, but we are also looking at how that is then balanced within decisions by NHSE, the board, within the overall financial envelope that we have set.

Looking more broadly, I expect these issues would flag firstly in the routine exec engagement. As senior departmental sponsor for NHS England, we would have routine engagement every six to eight weeks around issues of interest, supplemented then and feeding through to those formal ministerial accountability meetings.

Q28 Chair: What I suppose I am driving at is that this a big chunk of the budget. Resources went up significantly in 2015-16. Is this something you just nod through? Obviously, NHS England has

a degree of autonomy, but you have to assure yourself that that is a sensible decision and there is not another bit of the budget that it will affect somewhere down the line.

David Williams: Again, let me come to this in two ways. In terms of NHSE's performance specifically here, this is part of a rich and continuous conversation about departmental expectations and how NHSE is delivering against its mandate. There is also a role for the Department in that sort of system stewardship, holding the rein, looking at how we are working, for instance, picking up on earlier conversations with NICE in their assessment work. To the extent that some of the costs in this area relate to drug spend and some of those—we are trying to discover what they are—are managed and let by the Department, although that is an issue of constructive engagement between us at the moment.

Q29 Chair: You mentioned drugs there, and we might as well deal with that. We do not want to repeat the discussion about the cancer drugs fund, but there are issues around the cost of drugs. NHS England deals with this on a day-to-day basis, but the Department has a strategic role in trying to make sure that the British taxpayer and patient is getting a good deal. When would you step in on something that is quite strategic, such as trying to negotiate with pharmaceutical companies about drug pricing, and when would that be NHS England's sole remit?

David Williams: The overall framework set through the voluntary PPRS is something for which the Department has responsibility. We are beginning to think through what any follow-on arrangement might look like when the current scheme comes to an end in a couple of years' time. Obviously, we are looking to see precisely where accelerated access review recommendations may come out this summer and how they may be relevant to the way ahead.

Beneath that high—more strategic—level there are routine engagements around the frameworks for drug purchasing that are currently managed and led by the Department of Health's commercial medicines unit. One recommendation that we are exploring is that from a departmental perspective we can set a framework, but the volume of demand is really an NHS England responsibility, and getting the best commercial deal, if you are having a conversation about volume, is an area where we can do better.

Q30 Chair: So are you saying that the Department could do better, that NHS England could do better, or that as a whole you could do better?

David Williams: Actually, because of the way in which we work jointly and if you are able to give suppliers greater confidence in the level of demand, you ought to be able to get a better price.

Q31 Chair: Which brings us back to Karin Smyth. I am sure she will come back to that.

Can I go back to resourcing issues, Simon Stevens? As I said, resources have increased quite a lot in the last year. You have gone for a 7% cost increase and, as you acknowledge, that is at the low end of your estimates—the lower end of the range. Are you sure you have got that right, and can patients see the benefit at this point?

Simon Stevens: There are trade-offs. As we all know, this is occurring at a time of historically constrained NHS funding growth, so a pound spent in one area is a pound not spent on primary care, mental health services and so forth.

Chair: Absolutely. You don't have to tell us that. We appreciate that.

Simon Stevens: We recognise that at the moment some of the spending drivers are outside our control. If, as Dr Fielden says, three quarters of NICE technology appraisals are directed at his budget and he is legally required to fund them within 90 days, as the situation currently stands that is factored in, but over and above that we think there are areas of specialised commissioning expenditure where some not insignificant savings could be obtained.

Q32 Chair: Can you give an example?

David Williams: Yes—reimbursement of high-cost devices. We have just had to compensate individual hospitals for the prices they individually pay and as a result there is a very large spread in the prices that the same manufacturer charges different hospitals and that the same hospital obtains from different manufacturers. Just over a year ago we proposed that we would do a gainshare with hospitals on savings, but they were not keen on that, given the potential financial risks, so our approach from April this year is to use a national procurement approach for those devices that will bring transparency and enable us to harness the purchasing power of the national health service as a whole. That is one example of where there is a lot of price variation that I think we can drive out.

Q33 Chair: So capital kit, basically. I will bring in the Comptroller and Auditor General, but before I do, what percentage of the budget for specialised services is spent on that sort of kit?

Simon Stevens: High-cost pass-through drugs are in the zone of £3 billion and devices would be north of half a billion on top of that. It is not insignificant.

Sir Amyas Morse: Taking all your remarks just now, it sounds like it is quite possible that you will have an out-turn of more than 7% on specialised services this year, despite all your efforts. I am not critical of any of your efforts, but you sound like you don't have the control that would allow you to hold that at a particular level currently. I think you were telling us that. When I look at your budget plans for next year, it is indicative of 4%, so let's imagine that the out-turn this year—I am being very modest— is north of 8%. So now we are saying that we can halve that. You told us that the majority of that is drugs. Forgive me; I'm not saying you shouldn't go for that, but is that actually real practical politics in the world you are inhabiting?

Simon Stevens: As you rightly say, there is a risk. It is a risk that, on balance, we believe is right to put in that part of the portfolio, as against piling more risk on to, say, primary care funding or local CCG hospital funding, given the hospital deficits and so forth. But it will require some things to come right, and it will also require some tough decisions on some controversial reimbursement topics during the course of the year. Inevitably, this is an area where the asks are always greater than the ability to instantly fund them. We just have to accept that, given the constraints under which we are operating, some very difficult decisions will inevitably have to be taken.

Sir Amyas Morse: And next year?

Simon Stevens: As for next year, I think that in the allocations paper for December we assumed a 4.8% uplift, compared with 7% this year. Part of the particular lift in 2016-17 is that there has been a big increase in hepatitis C funding. Perhaps unknown to many, this will have turned out to have been the national health service's single biggest treatment investment during the last year, on the back of some effective, and indeed cost-effective, new medicines. However, with a large patient population we are having to take a phased approach to how we implement that, in line with the NICE appraisal recommendations.

Q34 Chair: From what you are saying, it sounds as though you really can't budget because of the constraints, as you put it, that you are under.

Simon Stevens: We are budgeting—

Chair: You are budgeting, but each year you are making in-year tough choices. Perhaps I am paraphrasing but that is quite tough, both for providers and potentially for patients, because you have to make difficult decisions. On one level I can see why you are doing that but, because of the uncertainty that is built in right from the beginning, you actually have no real certainty over the budget. Dare I say that it's a bit finger in the wind—I don't like to say that in front of auditors because they don't like it?

Simon Stevens: Providers are seeing very specialised services' incomes continue to rise, and patients will see the NHS continue to offer a wider array of treatments this year than we did last year. It is really just about the pace at which we can expand the number of good new things that we are able to reimburse.

Sir Amyas Morse: I am sorry but, to try to understand, may I ask something very pedestrian? If you find that it is going up faster than you thought this year, are you in a position to influence the tough choices that people actually make, or will you just be exhorting them without really being able to stop them spending the money? I am sorry to be so blunt, but I think we really need an answer to that.

Simon Stevens: There are two ways in which we are seeking to provide some kind of mitigation to those circumstances. The first is that this summer we will be ranking the new investments through the CPAG progress—

Q35 Chair: Could you just spell out what CPAG stands for?

Simon Stevens: CPAG is the clinical priorities advisory group. The group will be looking at the long list of possible new things that we might look to buy through specialised commissioning, over and above those that have been mandated by NICE or other sources. So we will obviously have to set out where we can go down that list, based on how much money is available.

Q36 Chair: This funding is about a quarter of your total spend, isn't it? Because you said that three quarters was through NICE.

Simon Stevens: There will be a very small amount left for the new CPAG list, but there is a whole range of things on there: wonderful treatments for cystic fibrosis, microprocessor-controlled

limbs, and a range of new drugs that have not come through a NICE appraisal. We are going to have to cut our cloth accordingly on that.

The second risk mitigation is that we have established a shared incentive fund with providers of hepatitis C treatment. This means that in the event of an overspend there, some of that incentive funding will fund that overage in the first instance. To the extent that there isn't an overspend, that funding would be available to purchase other specialised services or local funded opportunities in those providers themselves. So a combo of CPAG plus the specialised services incentives scheme, the CQUIN, for hepatitis C is what will give us some comfort.

Q37 Chair: What does CPAG take into account? One example given to us by Muscular Dystrophy UK was that of a cough assist machine that can help keep people out of hospital. That costs £5,000, whereas a week-long stay in intensive care can cost more than £13,000. That is what they say, but you can correct me. I am sure that Dr Fielden will know the precise figure. Clearly, if a cough assist machine keeps someone out of hospital, even for a week or half a week, it has paid for itself. Is that cost-benefit analysis something that CPAG would do, or something that you would look at, Dr Fielden? Perhaps you could answer first.

Dr Jonathan Fielden: CPAG takes clinical information on the clinical benefit of a case and looks at that. Then it looks at the cost side of it. That will then give a range of what is highly clinically beneficial and what is at low-cost additional cost. Many of those will actually move through quite promptly. Those that are lower cost and of clinical benefit move even quicker. Those that are high cost and high benefit are the ones that then go to the relative prioritisation process that CPAG does, and that will be done in June for that. That will allow us to relatively see which are the highest within that process and which are less beneficial for the costs that they deliver.

Q38 Chair: You are looking at the specialised services budget? Do you look at the knock-on costs to other bits of the NHS? If you do not—Simon Stevens is nodding his head—which bit of the system is doing that kind of analysis? That is something that we look at very often in this Committee and it is not always picked up.

Dr Jonathan Fielden: Where it is possible to do that, we do.

Q39 Chair: How do you do that? What is the mechanism for doing it?

Simon Stevens: If you are being uber-pedantic about it, there is a nine-box grid that ranks, as Dr Fielden says, degrees of patient benefit against degrees of cost and savings, so the group that reviews these looks at the kind of case that your example has just raised, and assesses the likely accuracy of that in the real world, and then ranks it against alternative incremental spending. The reality is that many cases are said to be cost saving but, when put through the mill, sometimes it is a little more complicated than that. I do think there is genuinely an opportunity for the NHS sometimes to be a faster adopter of, in particular, new technologies and devices that have that potential. One of the things that the accelerated access review is supposed to be proposing for us is exactly what such a pathway might look like, so that, say, for the top 10 or more innovations each year, over and above the normal course of business we would have a quick route to getting coverage

and diffusion across the NHS, where we can be confident that there really is a genuine benefit from doing so.

Q40 Chair: Presumably there is a cost benefit if you get it right about bulk purchase. The NHS is going to be a big purchaser of some of these bits of equipment. Is that something you look at as well—if you roll it out at greater speed you get lower unit cost?

Simon Stevens: Exactly. As it happens, some of our greatest hits in that area are necessarily confidential because part of the basis on which manufacturers are often willing to give us substantial discounts is that we do not tell anybody, so that it does not impede their negotiating position in other countries. We have had examples both on devices and, indeed, on some of these high-cost drugs, where by being a constructive but hard-nosed negotiator with the relevant pharmaceutical company we have secured very substantial discounts.

Q41 Chair: Can you give us an example without naming names, either of you? What percentage cost?

Simon Stevens: In the rarer conditions field we have had some success, but in order to succeed you need to be able—unfortunately this is just the economic reality—to say, “Look, if we don’t get this the NHS just isn’t going to be able to afford it, at least this time round.” Then in those circumstances people often think carefully about whether the rack rate—the retail price they were seeking to charge the NHS—is in fact what they wish to continue to try and charge the NHS.

Q42 Chair: So you are contending that the NHS gets a better deal than some other countries’ health systems—or you presume; you don’t know, I suppose.

Simon Stevens: Yes, the evidence on that is quite clear, although there is a real pressure on pricing for new chemical entities, particularly in the oncology field, in all countries. The new biologics are an issue, and this is going to put huge pressure on the NHS as it is on other countries. Our job is to try to winnow through the hype from the reality and, for those new medicines that really are effective—genuinely innovative—where manufacturers are willing to price reasonably, to make sure that we get those into the system quickly.

Q43 Chair: I am going to bring Karin Smyth in, but before I do I want to touch on governance issues, because we have talked about these different bodies, and governance arrangements have changed twice in the last three years. Are you content, now that you have settled on a good governance structure, that it is fit for purpose and that it will actually deal with these complex issues that you have been describing?

Simon Stevens: I hope so. I think so. The reason I say “I hope” and “I think” is because we are at a different stage of the journey. Back in 2013-14 the principal task facing NHS England and my predecessors was to get CCGs up and going. That was done. In light of that, it was an adjustment to ensuring that specialised commissioning budgets were properly managed. Through the taskforce arrangements over the last 18 months, that has been secured. Now it is to drive strategic change,

under Dr Fielden's leadership. I am hopeful—almost veering towards confident—that Jonathan will be able to do that.

Q44 Chair: Well, Dr Fielden, you have been set a target now. Do you think the Government's arrangements are now fit for purpose?

Dr Jonathan Fielden: Yes.

Chair: They are not going to be fiddled with again?

Dr Jonathan Fielden: I think they are fit for purpose. In particular, having the increased clinical aspect to that will add to our ability to deliver what patients need within the resources available.

Q45 Chair: We have just heard from Simon Stevens on a bit that he maintains cannot be transparent because of commercial confidentiality. We can have an argument—we argue about that quite a bit here, but we won't do that today. A lot of the evidence that we have had from the various interested bodies in this field has said that they feel that there is a great lack of transparency about how decisions are made. You have given a reasonably good explanation about how the decisions made through the CPAG—sorry, I have just used the phrase and now I cannot remember what it stands for.

Dr Jonathan Fielden: Clinical prioritisation advisory group—we have been fully transparent with that process and that is currently out for consultation, which closes on 11 May.

Q46 Chair: What will change, if that consultation gives the green light to the proposals?

Dr Jonathan Fielden: I would not want to prejudge a consultation. We are hoping, as Simon has just described, that our process of getting to and then using the nine-box grid of prioritisation will be acceptable. That will then allow our CPAG process to be even better this year. Interestingly, in this area we have looked internationally for comparisons of anyone who is able to do this and putting the clinical and cost-benefit together, we are leading on that. There are other people interested in how we are doing this. On the evidence available, it does seem to be robust.

Q47 Chair: Do you fear any legal challenge? If something has gone through the nine-box grid and an organisation feels it is unfair, their expensive lawyers could take the NHS to court.

Dr Jonathan Fielden: I think one of the aspects of any process like this is that you can be subject to legal challenge—it is one of the joys of our legal system—but it is also very important that we ensure our processes are robust as possible so that we minimise that aspect.

Q48 Karin Smyth: Can we just try to be clear about where the money is? I think one of the things you said, Mr Stevens, was that the providers were having increased income from specialised commissioning.

Simon Stevens: Yes, it is one of the accounting identities in the national health service, that £1 of spending by us is £1 of income for somebody else.

Q49 Karin Smyth: Got it. The Report highlights some worries around provider sustainability, with regard to what is happening with increased costs—decreased next year. We will come back to the Department of Health around discussions on drugs and negotiations. But there is still a lot of cost in the system, isn't there? I am not sure where that is being squeezed through. Is that being pushed on to providers? My question is, how concerned are you about provider sustainability from this particular budget and its increasing demand?

Chair: There's a graph that shows that.

Simon Stevens: Yes, the providers with the highest profit levels in the national health service are providers of specialised trusts. If you look at the figures that NHS Improvement released in February this year, the Q3 figures—

Chair: Figure 13.

Karin Smyth: It is the NHS Improvement figures, I think.

Simon Stevens: The NHS Improvement—yes. You will see that the so-called EBITDA margin for specialised trusts is 3.5%, which compares with -0.1% for acute trusts in general. That is not in the Report—it is subsequent to the NAO Report.

Traditionally—the facts speak for themselves. Are there pressures in some providers? Absolutely, and that in turn will mean that there is a shared interest between Dr Fielden and the providers of specialised services in doing what we can jointly to take out shared cost, looking at the way in which services are being provided. You have got a long tail of providers who are doing very few specialised services. There are 300 providers, three quarters of whom are doing 10 or fewer of these 146 specialised services. The 30 largest providers account for half of the expenditure. Working out the right way of working with hospitals to help them with their costs—so that, together, we can expand access—is part of the rolling programme of service reviews in different areas, which Dr Fielden is leading.

Q50 Karin Smyth: You talked earlier about some difficult conversations. Is one of those difficult conversations with trusts about whether they should be doing some of those services in the longer term?

Dr Jonathan Fielden: That is part of the difficult conversations. Ensuring that we are getting the highest quality for our patients within the resources available means that the occasional practice is less likely to deliver that quality outcome, and therefore it is something that is less likely to continue. In some areas it is occasional because, actually, it is extraordinarily rare for a particular disease set so it remains in small numbers. Where there are significant volumes that can be moved into other areas, it is sensible to do that to get the quality.

Q51 Karin Smyth: Is this budget ring-fenced for those providers?

Simon Stevens: It is ring-fenced in the sense that we are paying for a certain set of services and we monitor whether we receive them. It is then a component of a provider's total revenue base, and how they move money around internally is at their discretion.

Q52 Karin Smyth: It is still at their discretion?

Simon Stevens: It is.

Q53 Karin Smyth: They all have 80% deficits, as the Committee has seen. If they start to move some of that money around to help with some of the deficit elsewhere, are you comfortable with that?

Simon Stevens: Our responsibility is to make sure that we are paying a fair reimbursement for the services that are being obtained. If they are able to provide those services more efficiently such that they get themselves some elbow room that they can use to help with other pressures, that is fine. At the moment, one of the things that the NAO Report rightly points out is that, for the third of specialised commissioning funding that is locally based on historical price differences, frankly there is a bit of dispersion in what those reimbursement levels look like, and that dispersion sometimes owes more to history than it does to what fair, efficient reimbursement would be.

Q54 Karin Smyth: How are they being resolved?

Simon Stevens: Until this year we have not been permitted to resolve them, in the sense that, for the locally negotiated prices, the rules set out by Monitor—as was—said that unless the provider agreed, you just had to pass on the uplift in inflation plus whatever that year's aggregate efficiency assumption was. The trouble with that is that it locked in these differential reimbursement levels for 35% of £15 billion, which is obviously of great importance. The change to the rules that took effect from this April is that the local price negotiations have to pay attention to the differences in benchmark prices for that provider versus others doing similar services. Again, this is going to be a difficult set of conversations but, over time, if we are to drive efficiency in the way that the NAO rightly recommends, it is what we are going to have to do.

Q55 Karin Smyth: And that will be happening in the hubs?

Simon Stevens: Yes.

Karin Smyth: On which you will still be able to keep a grip at national level?

Simon Stevens: Yes.

Karin Smyth: So are you concerned about that provider stability, or do you feel that you are going to have a grip of that over the next few years?

Simon Stevens: Well, we are concerned about provider stability in other parts of the forest because, obviously, we have earmarked £1.8 billion of this year's NHS budget, as you know, for the sustainability part of the sustainability and transformation fund to enable people to dig themselves

out of the deficit pressures that have been bubbling up in the system over several years. The challenge in specialised commissioning is to expose variation and then, in a collaborative fashion with providers, to seek to drive that down in order to create headroom to invest in the new treatments that we could otherwise be funding.

Q56 Karin Smyth: Behind part of that question is that it is about 14% of the spend. Do you see it staying at around 14%? Is 14% of the spend right?

Simon Stevens: It is going to increase as a proportion of overall spend because if the budget is going up by between 4.5% and 5% a year from next year, that is higher than the overall NHS budget is going up over this SR period. Therefore, as a proportion, our specialised services are likely to continue to increase.

Karin Smyth: So what are they increasing at the cost of?

Simon Stevens: They will increase at the cost of secondary care services, to some degree.

Karin Smyth: Because they are based in hospitals?

Simon Stevens: One of the problems of the past 10 years, as we have talked about before, I think, is that what happens in primary care, and to some extent in mental health, has been a residual, while everybody else has been looked after—had their budgets, their income and so forth—in the NHS. So the GP forward view that we published within the past fortnight explicitly said that we are not going to do that any longer; we are not just going to let hospital spending find its own level and then GPs have to deal with the crumbs, because, frankly, that has produced the huge structural imbalance in care that is now part of the problem in terms of patient access; in terms of the working lives and experience of GPs; and in terms of the demand offsets that that has for emergency admissions to hospitals.

What I am trying to say is that we are clear that we want to see primary mental health services growing, and we are likely to see specialised services growing, so that means that, relatively speaking, secondary acute services will grow less than those other two elements. That is, indeed, what we have explicitly set out in the allocations tables to 2020.

Q57 Karin Smyth: You pre-empted me; that was my comparison about the spend on GP and primary care. My earlier point was about how myself or Mr Mills—I am very concerned about Amber Valley, obviously—make sure that we are clear, on behalf of our constituents, that the proportionate spend of 6%, or wherever we are at, on GP and primary care is right, against the 14% on specialist care for our patients, and understand whether that is right for our constituents. And if it is not, how do we influence that discussion?

Simon Stevens: One of the ways we can help with that is by being much more transparent about how the pie is divided up in each geography, as we were talking about earlier. Previously, it was entirely opaque for people in Bristol as to how much of their total NHS pound was going on these specialised services, because the specialised service was not attributed to that population. Because we have now said, “Here are the place-based allocations”, people can see whether that wedge is coming at the expense of other parts of the total NHS availability.

We have actually moved towards fair shares for all CCGs being no more than 5% under their weighted capitation, their fair shares, in 2016-17; not just for their CCG spending but also for their primary medical, their specialised commissioning and their CCG spending in the round. It is the first time that, for CCGs, we have got a fair-shares formula for the total NHS pound, including specialised, and not just the CCG-commissioned element of it.

Q58 Karin Smyth: In what year will we see that, in reality? In 2017-18?

Simon Stevens: In this year, 2016-17, as a result of the allocations decisions that we made in December, every CCG is no more than 5% below its fair share for its total NHS allocation, including specialised, not just its CCG allocation, which we have achieved as well. Then, within the next week or so, we will be setting out indicatively for the 44 STP geographies what their 2020 allocation might look like, so that they can then chart a course from here to there. That will include a specialised element.

Q59 Karin Smyth: So we have that movement, both at the specialised end and at the primary care/GP end, which comes back to my earlier point about the squeeze on providers and where some of that extra cost is being held. It is a balloon, and it comes out somewhere, so some of it will be saved in costs—

Simon Stevens: Yes, it should be growth overall, but it is Garrison Keillor's Lake Wobegon effect—not everybody can be above average, so you have to make your choices.

Q60 Karin Smyth: So, as the trusts are very excited about finding out exactly what the deficit will be at the end of the year, the conversation will be around what proportion of that deficit is being managed in trusts to do with specialised commissioning and general secondary care. We will be able to understand that in the overall deficit pot, won't we?

Simon Stevens: You are saying we will be able to understand what share of the deficit is attributable to specialised services versus other services.

61 Karin Smyth: Yes, and what that looks like over the next two years.

Simon Stevens: No, I don't think we would be able to attribute an individual trust's deficit. The trust itself might be able to, but I don't think we would be able to attribute by service line in that way nationally.

Karin Smyth: They will be coming back to NHS Improvement to have that conversion then.

Simon Stevens: Yes.

Q62 Karin Smyth: Mr Williams, you described the conversation around some of these negotiations as "rich, engaged and extensive".

Simon Stevens: They must be different from the ones I go to!

Chair: Mr Williams is an optimist.

Karin Smyth: Indeed. To some of us that may sound quite lively. Do you want to expand on that for us?

David Williams: Not especially, as you might imagine. Throughout the Department and NHSE we pretty much have a shared view of the sort of changes we want to see in terms of Government support for the five-year forward view. Where that is going well, that's great. Where there are still choices to be made or where progress is not always as either we or, I'm sure, Simon would like, the conversation is livelier. It plays to the framework of accountability for NHS England, partly through the NHSE board and the role of the chairman and the NEDs, and then formally through the accountability to the Department and specifically to the Secretary of State for Health. We use the mechanisms at our disposal. The vast majority of the conversation is about a shared understanding of the challenges and a shared understanding of the best approaches to meeting them, but they are nevertheless a formal part of the accountability relationship between the Department, the Secretary of State and Simon and his organisation.

Q63 Karin Smyth: So when you are looking at the deficits of those trusts—the 80%—as they come through, do you have a view in the Department about the balance between the specialised commissioning element of those deficits and the deficits in trusts, and perhaps the primary care element, as we have just discussed?

David Williams: There are a couple of questions in there. In terms of the broad allocation over the spending review period of NHSE's budgets against specialised commissioning or other acute care—mental health, primary care and so on—those are formally allocations for NHSE, but the modelling projections behind that very heavily informed the spending review negotiations that we undertook in the second half of the last calendar year. We do not have any particular points of disagreement with those allocations.

In terms of what it means for provider deficits, I can pick up on Simon's earlier point: it is not particularly that we are looking at a service line or a hypothecated "What's the position provided by a provider for specialised commissioning or other elements of services?" Within the Department, we are looking at the overall position where the fundamental challenge is that the provider cost base has gone up faster than its income. Specialised commissioning will be an important component of its income, and the cost base that the provider has to deliver the services that are commissioned through the specialised commissioning basis will clearly be part of its cost base as well.

Essentially, over the past year there has been a mismatch between income and activity assumptions and the amount of investment that has gone into workforce and, specifically, temporary agency staff. Some of those may well be delivering services through specialised commissioning. I do not have that breakdown particularly to mind.

Q64 Karin Smyth: We have revisited the agency staff issue consistently. Forgive me—I forget this—do NHS Improvement report directly into you or back into the Department?

Simon Stevens: David holds responsibility for the Department of Health's DEL position, so the provider financial position aggregates through NHS Improvement to the Department.

Q65 Karin Smyth: So, Mr Williams, are you confident in the level of efficiency savings that providers are expected to make over the next few years?

David Williams: I need to make sure I am consistent with the evidence we gave to another Committee a few hours ago. Look, in terms of the headline efficiency assumption within tariff, the 2% assumption on which the tariff for 2016-17 and beyond is based seems to me difficult but realistic. It is consistent with the Five Year Forward View. For 2016-17 it is backed off by a larger average increase in prices, so actually the tariff is putting more money into the system.

When we look at the £22 billion challenge, only a part of that needs to be delivered through the provider side and we have got a good run at that through some of the work that is coming through the Carter productivity and efficiency report. There is more to be done there, but it does not seem to me to be a wholly unrealistic proposition. It is important that we engage providers—not only managerial staff but clinicians and the wider workforce as well—in delivering as much of those assumptions as we can.

The potential cost pressure of around £30 billion by the end of the Parliament, set out in the Five Year Forward View, is largely—not 100%—around a set of counterfactual assumptions about how costs would increase, so the £22 billion is for the most part around managing those cost increases to a lower level rather than actually stripping money out. That also is a situation that can give you a bit more confidence about delivery.

Q66 Karin Smyth: Okay. You may be the only person in the country who has said it is a viable proposition; we might revisit that another time. On the level of services, Dr Fielden, do we have the right number of services sitting in this specialised service portfolio? Are there too many services in there?

Dr Jonathan Fielden: Currently I think the number sitting there is correct, but as we work with our colleagues, particularly in the advanced guard with our devolved Manchester colleagues, we will look at those services that may potentially move out from the national portfolio in a devolved way. Having said that, we should only do that where we can ensure there is consistency, capability and capacity for that quality of care to be delivered. In between doing that, there is a lot we can do to work collaboratively with colleagues to ensure the pathways are linked from the benefits we get from national consistency back through to the local delivery, which is what patients see.

Q67 Chair: When you are talking about changing, would that be by volume of patient? How do you decide what is not a specialised service any more?

Dr Jonathan Fielden: The definition of what comes in depends on the number of patients, which tends to be slightly smaller, on the cost of those, which tends to be on the higher end, and the providers that can do it. There are usually a smaller number of providers who can aggregate the teams and the kit in an appropriate way to be able to deliver the quality for that. There is also the degree of rarity.

So that is what defines what comes in. The Prescribed Specialised Services Advisory Group decides and meets and then advises the Secretary of State on which come in and which come out. Clearly we feed clinical and other data into that to ensure exactly what sits. That would be the official route for what is in and what is out, but how closely we work with our colleagues in our more devolved models, and particularly the devo Manc and sustainability and transformation plans, is something we are working closely on in the coming weeks and months to ensure that we can get those pathways linked together again, which is what patients want to see.

Q68 Chair: I want to pick up on a couple of points and then touch on the cancer drugs fund, picking up on a previous Report. We had some written evidence from the Epilepsy Society, slightly worryingly, given that we have also looked at neurological services fairly recently. They say: “There is little evidence, if any, regarding patient experiences outcomes for those specific aspects of services for people with epilepsy that qualify as specialist services.” This goes back to the question in the beginning about your objectives. I touched on outcomes. Dr Fielden, how are you measuring the outcomes for patients to show that what you are trying to achieve is actually being successful for patients?

Dr Jonathan Fielden: There is progress that needs to be made, particularly around the measuring of those outcomes in a consistent way and around bringing in experience. We are looking this year at how we can add in the experience element. It is not as straightforward for our specialised areas. A lot of the service standards, which we have spent quite a bit of time on this afternoon, are for process rather than outcomes, but where we have those outcomes available, we do feed into our hubs and then into either a review of the information we have or a peer review where appropriate, to make sure the right quality of service is being delivered. But we recognise that there is more we need to do. So we have got information, but also delivery on that side. Where we have done peer reviews—major trauma, for example—we have added to the benefits for patients.

Q69 Chair: It seems to me that when we have looked at these specialist services—often individually rather than all together—those charities and organisations that work with specialist groups of patients often know an awful lot about their day-to-day lives and experiences and are quite useful partners. Obviously they have high demands because they are fighting their corner, but do you plan to work with them to assess qualitatively as well as quantitatively what the outcomes are?

Dr Jonathan Fielden: We have patient and public involvement in all our clinical reference groups. We have a patient and public voice group that feeds into our specialised services oversight group. For that, there are about 150 patients who are involved or who represent patient groups within our systems. Yes, we do find it very important to have that level of input, and we balance that with our clinical input as well, so that we try to get the best balance between outcomes within the resources that we have available.

Q70 Chair: The Epilepsy Society say that they work with the Neurological Alliance on the contribution to the new neuroscience service specifications. That is the sort of thing you are talking about, where they actually get around the table. Can you give us an example of how that has made you do something different, or made it better for patients or more cost-effective—any or all of

those? Not necessarily for epilepsy in particular, but in general, is there an example where you have heard something from one of those expert groups representing patients that has made a difference?

Dr Jonathan Fielden: Patients have been involved in each of our clinical reference groups. The changes to our CRGs that we are bringing through now will involve a slightly greater proportion of their voice, so I think we will have many more examples going forward of how that involvement has had an impact.

Q71 Chair: I am not suggesting they should write the NHS budget, but it is helpful to hear what you have to say. I am sure we will get more on that.

I also wanted to touch on collaborative commissioning, which has come up in a number of bits of evidence we have received. I am talking particularly here about the MS Society, which sent in some useful thoughts. Mr Stevens, we have talked quite a lot about place-based planning, but there is some criticism of the chopping and changing about how co-commissioning or collaborative commissioning is working. The MS Society says it is beset with difficulties, saying: “In practical terms, NHS England did not clarify the implications of co-commissioning when the idea was first mentioned in November 2014, nor did it provide sufficient detail in its subsequent guidance on collaborative commissioning in March 2015.” Do you have any comments on that? Is there anything that you think you are doing to improve what we are now moving to in a model involving more co-commissioning?

Simon Stevens: First of all, the role of patient groups in many of these areas is absolutely central, not least because, as you say, it is very important to hear the voice of those who advocate on behalf of people who often have very complex needs and who sometimes get passed from pillar to post between different parts of the health service, but I also suspect that it illustrates the trade-offs and shades of grey in the conversation that we were discussing with Ms Smyth. If you are going to have a conversation about the whole NHS in Bristol, that means you cannot just have a single national conversation with the patient group for a particular condition. With some of those patient groups—for understandable reasons, given that often they are quite small and not terribly well resourced—the thing they don’t really want is these more distributed local place-based conversations, because it is much harder for those groups to engage in them. There is no kind of completely right or completely wrong answer there, but in the real world those are the shades of grey we are dealing with.

Q72 Chair: Dr Fielden, do you want to add anything? No. Wonderful—we like it when witnesses just agree with each other.

I just wanted to touch on the point you made earlier, Mr Stevens—or it might have been Dr Fielden—about hepatitis C; actually, I think it was you, Mr Stevens. You talked about phasing the treatment and limiting the number of people being treated to 10,000 in this financial year. Is this the start of a trend about rationing drugs that have been agreed through NICE, particularly where there is a large volume of them, or is it just a one-off?

Simon Stevens: We believe we are following what NICE recommended in this case, so I think we are congruent with their suggested approach and that approach makes a lot of sense, given that you cannot necessarily wave a magic wand and do everything all at once when there is a large patient population. The thing to do is to start with those patients who need the new treatment first—whose need is most advanced—and that is what we did with 5,000 or so patients with

cirrhotic conditions being treated over the course of the last year. Now we are kind of expanding the net to encompass larger proportions of the 167,000 patients; I think that was the number that NICE talked about.

We think that a phased approach is, in the real world, probably the right way of striking the balance between just not being able to do it because it's not affordable versus saying, "Okay, it's a big bang and this will get funded at the expense of anything that needs doing with mental health services, or cancer services, in 2016-17."

Q73 Chair: Do you have a trajectory—I mean, there may be other examples but you mentioned hepatitis C—of when that will begin to drop off, because it will become more of a regular treatment, if you like, rather than the catch-up that you are doing for patients at the moment?

Simon Stevens: Yes. The hepatitis C case is somewhat unusual in that it is a treatment that NICE has deemed cost-effective, but when you multiply it by large volumes obviously there is a big affordability issue. There is therapeutic competition for some of the genotypes but not all, so we are running procurements every six months for matching halves of the country to make sure that the NHS is getting as good a deal as we can.

Q74 Chair: Sorry, you just went through that very quickly. You are running procurements every six months?

Simon Stevens: Yes, covering half the country, so that as more therapeutic competition arises we can use the money we have to treat more patients, because at the moment for genotypes 2 and 3 we effectively have a monopoly provision situation.

Q75 Chair: That is interesting. Is that something you are doing with other types of specialist treatment?

Simon Stevens: We are doing them all, but the recommendation from NICE is that clinicians should think clinically appropriately about what the right treatment combination is, so as to get it right for the individual but also to maximise the number of patients that the NHS can treat.

Q76 Chair: So you are seeing the costs go down, Dr Fielden?

Dr Jonathan Fielden: I was just going to pick up on the clinical side. There is a strong clinical element. The operational delivery networks will deliver this, with 22 across the country. There is very strong clinical input with strong clinical leadership to ensure that we treat those patients that are in most need at the rate, and then as we can treat more, as they come through, and as ideally we can drive down the cost of the treatment, then we can treat more coming through. There is that very strong working relationship that we are building around this. So I think it is a model that potentially could work in other examples, but clearly there is a huge focus around this, because of the potential cost and—

Q77 Chair: Can you give us an idea of how much you are driving costs down, either as a percentage or a figure?

Simon Stevens: We want to be commercially thoughtful on this one—

Q78 Chair: Percentage-wise, or overall, from the first year to the last year that you are doing this?

Simon Stevens: I would rather reflect on that and write to you, if we can do so in a way that preserves our negotiating position—

Q79 Chair: We know from previous conversations that we are quite concerned about—well, we are not the only Committee that is concerned about it—the cost to the NHS. The problem with commercial confidentiality is, of course, that we cannot see the cost. I suppose that is the point of confidentiality, but we do not like that.

Simon Stevens: No, but that gives me an opportunity, with your permission, to make one other gratuitous point. The voluntary PPRS, which has served this country well since the 1950s, is getting a bit leaky around the boundaries, so thinking about how to deal with that is something we have also got to pay attention to.

Q80 Chair: Absolutely. I remember having an interesting conversation with one of the Ministers responsible for that—which brings us neatly onto NICE appraisals. Under the reform of the cancer drugs fund NICE will have a time limit for appraisals, which means that it will have to have more resources. Have you agreed the resources yet for NICE to do its job on CDF or its replacement?

Simon Stevens: Yes, we have.

Q81 Chair: Is that all in place? Is it under review?

Simon Stevens: It is in the process of ramping up. The new scheme is expected to go live on 1 July. They will then be working their way through assessing the stock of indications that are in the CDF mark 1, which is closed for new drugs precisely because it is so oversubscribed in its mark 1 incarnation.

Q82 Chair: Can I just be clear? When we talk about resources, obviously there are financial resources, which is the bit that you provide, but are there people available? I don't know how qualified you have to be to do a NICE assessment. How fast can NICE ramp it up? You tell us that the money, the financial resources, are there. Are you confident that it can move at the pace it needs to, to deliver the changes that you have promised?

Simon Stevens: There are various safeguards in place, in that a drug will not be removed from CDF coverage until such time as NICE has had a chance to look at it. If NICE is slow, then the status quo ante persists. Obviously, under the CDF mark 1 there has been a clinical assessment

process and many of those experts under a new NICE process could potentially be brought to bear as well.

Q83 Chair: So you think there are enough scientists and experts in place?

Simon Stevens: Yes, in this country, absolutely; but it is going to be done on a phased, rolling basis. We deliberately did not say, “Big bang on 1 April.”

Q84 Karin Smyth: I wanted to check one final thing. In terms of controlling the cost, we talked quite a lot about potentially managing the market and we talked about drugs and cost, but I don’t think we talked about demand in particular. Is that an area where you can realistically manage demand in the system?

Simon Stevens: The overall use of specialised services?

Karin Smyth: Yes.

Simon Stevens: Yes, in some areas, where we connect the specialist end of the spectrum with the upstream end of the spectrum.

Q85 Karin Smyth: You are going to talk about CAMHS, aren’t you?

Simon Stevens: I was actually going to talk about bariatric surgery, but I can talk about CAMHS as well. Weight-loss surgery for the morbidly obese has been found to be cost-effective, but it would be even more cost-effective to take concerted action to reduce obesity rates, as indeed the Government have committed to do over the course of the next three to five years. That will be a classic example of where, if we did all the obesity surgery that in theory could be indicated right now, the cost of that would be £8.4 billion a year—which, incidentally, is precisely the total increase in funding available to the NHS in 2020. So we could spend all of our growth on obesity surgery, or we could do some of the other things we are talking about.

Q86 Karin Smyth: When we have the strategy for obesity, we will look forward to matching those two things up. Dr Fielden, is there anything else you would like to add about managing demand? Presumably, those are areas that you are looking at along the pathway that we discussed earlier.

Dr Jonathan Fielden: Yes. One of the key things is to join those pathways up. Very often, by the time a patient arrives in specialised, the service needs to be delivered, so it is more difficult. If we join those pathways up—we heard about obesity surgery; cancer is another one—then we can have that earlier intervention, which hopefully will allow us to reduce some of the pressure and demand on specialised services. That is the way that we need to get into controlling demand.

Of course, the other aspect is that as we increasingly personalise our medicines, which will disproportionately affect some of the areas of specialised, hopefully we can reduce some of the harm that goes with some of the treatments we have. Some of the drugs we have at the moment are fairly widespread indication. We can target with our genomics, for example, and get much more

specific drug targeting for a particular cancer; then that reduces some of the harm and some of the cost, and overall will reduce some of the pressure on the budget that we have got. So linking those pathways, and greater personalisation and focus, will allow us to prevent some of the demand coming through to specialised.

Q87 Chair: There is a list of 146 here. I do not think I can pronounce some of the 146—they are clearly very rare syndromes. We have talked about obesity and a few others. I would not want to hazard a guess as to which ones you could deal with more upstream, but roughly what percentage or number of the list do think you could manage demand on? If you are born with a particular syndrome, that is presumably not something that is easy to resolve.

Dr Jonathan Fielden: Many of the syndromes listed here are quite rare and are in very small numbers.

Q88 Chair: So out of the 146, what is ripe for the—

Dr Jonathan Fielden: I would not want to put a particular figure on that.

Q89 Chair: Roughly—10%? 2%?

Dr Jonathan Fielden: Linking more to the pathway idea and how we are looking more towards the devolved aspect, somewhere around a third of these may be getting closer to linking to the devolved aspects. There are a lot of aspects that we need to get towards that point, as well.

Chair: We are a long way off that.

Simon Stevens: It is not a substitution.

Dr Jonathan Fielden: No, it is not a substitution, it is linking more closely. Particularly within the rare syndrome areas, it is much more about how we control the costs of those drugs, in particular, with our strong work with NICE and with pharma.

Q90 Chair: I imagine it will be very different for those rare conditions. So, you think around a third you can look at helping along by getting in earlier upstream?

Simon Stevens: I think, if you look at figure 11 on page 30, you can hypothesise that the level 3 items indicated there might be some of the more obvious connections, and possibly some of the level 2 items. You have got to look at it on its own terms.

Q91 Chair: Some of that could take quite a long time. Tackling the obesity crisis is not going to be something that you can do in the next two years or in the next Parliament. What is your timescale? What will success look like and when will it happen?

Simon Stevens: Success in the round will look like progress on the goals that we talked about at the start, in terms of improving outcomes and experience for patients, driving value from that £15 billion and doing so affordably, given the constrained funding growth for the National Health Service in the round. Those are the three things that will be central to managing this portfolio successfully over the next 36 to 48 months.

Q92 Chair: It is a big chunk of the budget. I am going to bring in the Comptroller and Auditor General.

Sir Amyas Morse: It just occurred to me as I was listening to the conversation on efficiency targets that they are applied through a tariff. Are there any efficiency targets applied to specialist services, or do they just get what they need for their budget?

Simon Stevens: As you know, 40% of the £15 billion is tariff-reimbursed, so that is affected by that. In terms of the 35% that are price negotiated, as it were, the default is that we apply the national efficiency assumption. As we discussed earlier, we are seeking now to have a more targeted efficiency ask, based on where people are along the benchmark prices compared with other comparators. Indeed, as we move towards a more granular reimbursement mechanism for specialised services—the move to HRG4+, which will give us 2,100 price points, compared with 1,657—there is a question whether more of the stuff that at the moment is locally priced can in future be covered by those mechanisms. That is a debate that will play out during the course of this year. We are open to consultation on that.

Sir Amyas Morse: So, just to be clear that I have understood that—sorry if I am being slow—for the nationally negotiated prices, despite there being a default setting in your mind about efficiency, you do not say, “Well, here’s the budget, now we’re taking 2% off it.” You just say—

Simon Stevens: We should get at least that. That is because we knew that that was part of the overall portfolio, but the opportunity will probably be greater in some areas, given the greater dispersion of financial performance in the locally negotiated prices piece. On the 25% that was the pass-through drugs and devices, as we were saying earlier, a national procurement operation for that will enable us to drive efficiency there as well. For some of it we are running tendering processes. I think the report refers to the PET-CT tendering process we were in for about half of the country, which secured us an 18% price reduction.

Chair: It is going to be a challenge. Of the headlines that have struck us, one is that it is such a large chunk of the NHS budget, and because of NICE and other constraints, it is actually quite hard to control. A lot of these are long-term problems and long-term aims, like the obesity issue that we touched on. I thank all three of you for coming along today. It is a marathon; I had not realised you were in front of the Health Committee the same day. We know you come to us often. We look forward to seeing you again in a few weeks and repeatedly. We will be welcoming you back at some point no doubt, Dr Fielden. We like to see people more than once in the Committee. As ever, the uncorrected transcript will be up on our website in the next couple of days. Please let us know if you have any corrections. Given the various recesses, the report may be out in early July, if we are unlucky as we our schedule our publications.