

Public Accounts Committee

Oral evidence: NHS correspondence handling, HC 929

Monday 26 March 2018

Ordered by the House of Commons to be published on 26 March 2018.

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Members present: Meg Hillier (Chair); Shabana Mahmood; Stephen Morgan; Anne Marie Morris; Lee Rowley; Gareth Snell.

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

Questions 1-82

Witnesses

I: Simon Stevens, Chief Executive, NHS England; and Paul Baumann, Finance Director, NHS England.

Examination of witnesses

Witnesses: Simon Stevens, Chief Executive, NHS England; and Paul Baumann, Finance Director, NHS England.

Q1 Chair: Good afternoon and welcome to the Public Accounts Committee on Monday 26 March 2018. Today we have two sessions on NHS issues: one on clinical correspondence handling, which we hope to deal with quite quickly, and the other on the challenging issue of emergency admissions to our hospitals. Our two witnesses for the first panel are Simon Stevens, chief executive of NHS England—welcome back—and Paul Baumann, finance director of NHS England. Mr Baumann, extraordinarily, I think it is your first time in front of us.

Paul Baumann: In recent years, yes. The last time was two or three years back, I think.

Chair: I don't know how you have managed to escape us for so long.

Paul Baumann: I have a very good friend.

Chair: So the fact that you are here today might speak volumes.

As you might expect, Mr Stevens, before we get into the main session, I feel honour-bound to ask you some questions about what the Secretary of State said yesterday about NHS funding, which has been well reported in the papers, including on the front page of *The Times* today. There is talk that there might be an extra £4 billion a year for the NHS. Is that something that you welcome and is it enough?

Simon Stevens: Last October, I set out the facts of the situation confronting the NHS and made the point that over the past seven years, as part of the NHS's contribution to the economic turnaround of the country, annual growth rates had been heavily constrained relative to our 70-year history. The National Audit Office pointed out in the Report we discussed a fortnight ago that over the course of that 70 years our NHS growth has been about 3.7% a year, but in recent times it has been under 2%. The point I made last October was that if we want a well-functioning NHS we will, as a country, have to change that. Therefore I welcome the notion of a five or 10-year clear funding commitment that would enable the NHS to plan the workforce, to set out the clear improvements for cancer services, mental health service, new technology and innovation. Whether and when that happens is obviously a matter for Parliament and for Government, but were it to happen the NHS would greatly welcome it.

Q2 Chair: Have you been talking to the Secretary of State about this?

Simon Stevens: I talk to the Secretary of State frequently about a whole range of topics involving the national health service.

Q3 Chair: I am sure you do, but that particularly? It is interesting that £4



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billion has been floated as a specific figure. Have you spoken to him specifically about that?

Simon Stevens: I don't know the source of that particular—

Q4 **Chair:** Is the £4 billion a year enough money? There was talk of a £20 billion gap, so there are different figures floating around. What do you think would be enough money for the NHS to do what you have just outlined?

Simon Stevens: I have pointed out before, including last October, that the outlook for the year ahead had been quantified by the Health Foundation, the Nuffield Trust and the King's Fund; I think that is where the £4 billion number came from. I think over time we will need a return to trend rates of real-terms funding growth if we want the kind of health service that we have had—

Q5 **Chair:** Just remind us what real-terms funding growth would be for the NHS annually in billions of pounds?

Simon Stevens: It depends somewhat on what's being asked of the NHS. I am not going to sit here this afternoon and kind of—

Chair: On a current basis, on what the NHS is currently doing, to continue what you are currently doing.

Simon Stevens: The sort of figures you are talking about are consistent with a trend rate of growth, and over the last five years we in the NHS—if we had had that trend rate of growth—would have had £8.8 billion more in the budget next year. We have therefore, cumulatively over the last five years, contributed £27 billion towards debt reduction, as part of the country's national economic turnaround.

Q6 **Chair:** Would you like to explain that a bit more?

Simon Stevens: I am making the obvious point that—

Chair: It may be obvious, but just explain it.

Simon Stevens: For most of the post-war period the NHS has been funded at north of 3% in real terms each year, but it has been very lumpy—feast or famine. I think the argument for a five or 10-year funding settlement, as advocated by the Health Secretary, is that with more predictability it would be possible to make smarter long-term decisions about workforce and about care improvement, and to be more efficient on the back of that.

Q7 **Chair:** Including the extra midwives who are being recruited. Have you had any hand in that discussion?

Simon Stevens: We are fully supportive of the additional 650 training places that were set out over the weekend, recognising that as part of the broader set of expansions we need to deal with a lot of the workforce challenges that are facing the NHS at the moment. Obviously the



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announcements that the Government made on NHS pay last week will contribute to that position.

- Q8 **Chair:** Which brings me neatly to the issue of the pay rise. Obviously certain staff will be getting at least 6.5% over three years, at the cost of £4.2 billion, but as I understand it the Treasury has only committed funds for three years, so do you have any comfort that this is something that will be affordable in the long term, or will it be robbing Peter to pay Paul and, in the future, NHS institutions will have to take money out of other parts of the budget to maintain this pay rise?

Simon Stevens: No, I think this is a costed set of proposals that has garnered wide support from the staff side as well as from NHS employers. As part of this proposal, there are productivity gains, including improvements that we hope to bring about from reduced rates of sickness absence, which will contribute to the overall package, but this has been a costed package and the Chancellor has delivered what he has said he would do at the time of the November Budget.

- Q9 **Chair:** It is a costed package, so will we see this in the baseline funding, for example, of an NHS trust? Their staffing budget costs will be increased according to the number of staff they have got in those categories—on a long-term basis?

Simon Stevens: For the year we are about to go into—2018-19—the pragmatic answer is going to be to route the funding directly to individual NHS employers. For the year after—2019-20—we will work with our partners to ensure the best way of getting the money into the overall revenues that providers of NHS-funded care get. That might be through the tariff uplift or other mechanisms, but for next year we are aiming to passport it directly to the hospitals, community services, mental health trusts and ambulance services involved.

- Q10 **Chair:** Have you had any comfort given to you that this funding will be available to you in the base budget beyond the current three-year period?

Simon Stevens: That has to be seen within the broader conversation. Just to be clear, we don't have a concern about that point, but what the overall funding envelope for the national health service looks like in 2022 and beyond is obviously the subject of debate.

- Q11 **Chair:** Then there is the issue of doctors—one group that is not included in this number. Have you had conversations with NHS providers about how they will fund potential demands for increase in doctors' salaries to keep pace with the changes elsewhere in the system?

Simon Stevens: The position we have set out is that if the review bodies recommend funding increases above the 1% figure, which was factored into the NHS budget for next year and beyond, it would be a matter for the Government to decide whether they wish to accept those recommendations. If they do, it will need to be funded.

- Q12 **Chair:** So you are confident that the Government will fund that.



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Simon Stevens: That will be a choice for the Government when the Review Body on Doctors' and Dentists' Remuneration produces its recommendations.

Chair: So we could still be in a difficult situation in a year's time. We will obviously keep a very close eye on that. Although we welcome the pay rise, we are anxious to ensure it is not just being taken out of other parts of the NHS budget. We will be watching like hawks, as you would expect this Committee to do. Talking of hawks, I am going to bring in Mr Gareth Snell.

Q13 **Gareth Snell:** Very briefly, Mr Stevens, you said that you may end up paying it through the tariffs, but tariffs are dependent on the market forces formula. When you see an uplift in the tariff, will that be a blanket uplift on every tariff, or will the uplift in each tariff be dependent upon the market forces factor?

Simon Stevens: Well, the market forces factor is just one variable in the overall tariff, as you know, Gareth. Other pieces feed in, such as labour costs, the productivity assumption, the cost of capital and so forth. I am sitting next to the guy who really knows the answer, so perhaps it is time for you to declare your hand, Paul.

Paul Baumann: I don't think the market forces factor is particularly relevant to this question, because they are adjusted geographically.

Chair: We are going to move on to the main session, which we hope to do in about half an hour if witnesses and Members are brief and brisk in their questions and answers. That is an enticement, Mr Stevens: you may not have to stay quite so long if you answer in a short, sharp manner.

Simon Stevens: You have promised that before, and it never turns out that way.

Chair: Well, sometimes it is not our end of it that causes the lengthy delays, let's be honest. Mr Stevens, you are a master at the art of saying what you want, whether or not we want to hear it. Let's try to focus on answers to questions today.

Simon Stevens: That's almost a compliment.

Chair: That's the best you get from the Public Accounts Committee. I am going to hand over to Shabana Mahmood, who is going to set an example with her questions.

Q14 **Shabana Mahmood:** I want to start by looking at this letter that we have been sent by you, Mr Baumann, dated 22 March, with an update on where we are up to with the issues in relation to clinical correspondence. Can I start with your information? "There are 2 cases where expert consultant review has concluded that patient harm cannot be definitively ruled out." Do those two cases relate to issues arising from the Shared Business Services incident, or the new incident that we were made aware of in October last year?

Paul Baumann: They are both from the SBS incident—the one that was the subject of the last hearing.

Q15 **Shabana Mahmood:** Have the patients involved been told and kept informed?

Paul Baumann: I should be very clear that we have not demonstrated yet that there is harm in these cases; we just haven't been able to rule it out.

Shabana Mahmood: I understand that. We take that as read.

Paul Baumann: With one of the patients, there has been a conversation with the GP concerned, in relation to the referral that was needed. The other case is that of a deceased patient, so clearly there has not been a conversation.

Q16 **Shabana Mahmood:** Has the deceased patient's family been informed?

Paul Baumann: We are trying to track down the next of kin at the moment.

Q17 **Chair:** When will you have done that by?

Paul Baumann: We expect to have sorted that particular case through in the next month.

Q18 **Shabana Mahmood:** Are there any other details that you can give us in relation to those cases, while allowing for patient confidentiality?

Paul Baumann: Not at the moment, unfortunately, given the status of the work that we are doing on them and the confidentiality reasons that go with that.

Q19 **Shabana Mahmood:** You said in relation to the patient who is still alive that their GP has been contacted. Have you made any attempt to speak to the patient themselves?

Paul Baumann: I meant the GP has spoken to the patient, which is the appropriate conversation to have in that context.

Q20 **Shabana Mahmood:** Okay. Have they been told that they should seek independent legal advice?

Paul Baumann: I don't think we can comment any further.

Q21 **Shabana Mahmood:** Okay. The 4,070 cases that you refer to on the second page of your letter are cases where you are still waiting for patient consent. It says in your letter that "Notes have therefore been included on those patients' medical records to prompt a review when they next contact their GP." What is the process by which that is going to happen? Are we relying on the GPs to make sure that the review is prompted? Who is going to contact who to say, "Get in touch"?



Paul Baumann: These are patients we have made extensive—I would say exhaustive—efforts to contact, both through their GPs and, where necessary, with direct contact.

Q22 **Shabana Mahmood:** Can you define “extensive” and “exhaustive”?

Paul Baumann: In most cases the GPs have attempted on a number of occasions to make contact with them, and then we ourselves have written to all these patients by recorded delivery to ensure that they have the opportunity to ask for a review, for which we need their consent to access their patient notes, because we cannot simply look at people’s patient notes without their permission. In all these cases, or the bulk of them at least—I should not be clearer than that with some of the exceptions, but in the main—these are patients who have chosen not to respond to that invitation to give their consent for the notes to be accessed, and as a consequence of that, we cannot carry out a clinical review at the moment. If at any time in the future, they should come along to their doctor and want a clinical review, there is clearly every opportunity for that to be done. Their patient notes have been marked accordingly, and we have a colour-coded tracking system, which means that we can get rapidly back from that particular request to the specific document in question.

Q23 **Shabana Mahmood:** In your direct correspondence with the patients, by recorded delivery, have you made it clear that if they should change their mind and want a review, they can give consent and it will be done?

Paul Baumann: Yes.

Q24 **Shabana Mahmood:** On the 1,800 or so cases, I am assuming those are cases where basically the GP still has not responded. Is that correct?

Paul Baumann: They are cases where we need to act upon the consent we now have to access the clinical notes of the patients, or most of them. To be precise, in the PCS case 1,316 of them are cases where the patient has said, “Yes, you can look at my clinical notes,” and we are waiting for the clinical notes and any outcomes of particular tests that have been done in those cases to be provided.

Q25 **Shabana Mahmood:** So in those cases, the GP would potentially be the delay, or the GP’s surgery and staff?

Paul Baumann: They are not a delay yet, because in most of these cases, the patient consent has been given within the last week or so. This is a rapidly changing process. But that is where the records clearly need to come from, because it’s the GPs who hold the notes for the patients.

Q26 **Shabana Mahmood:** Has there been a flurry of activity in the last week, then?

Paul Baumann: There has been a flurry of activity over the last several months, and certainly that is culminating in trying to get as far as we possibly can before the end of the month.

Q27 **Shabana Mahmood:** Under “Next steps” you say “business-as-usual”. Can you describe exactly what that means?



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Paul Baumann: We effectively closed off the incident, in terms of people covered by it, as at the end of December, so what we now have in place, since January, is a business-as-usual interim function, which means that any notes of this sort that come into the PCS service are forwarded at the moment to our incident team—the NHS England incident team, which is the same team that has dealt with all the flurry of activity you have been discussing so far—and will then be sorted, reassigned and sent back to the right place. That is not a long-term solution, because the incident team is clearly a temporary feature. From May, we have agreed with Capita that they will, as part of their routine service, perform the function of redirecting mail that comes to them. Clearly, what we will also be doing—it is an important part of the next steps—is reinforcing the message that, in practice, very few documents should be coming back to the PCS team in this context, because misdirected correspondence which is received by GPs should be returned to sender so that the root source of the problem is rectified, rather than having a kind of redirection service.

- Q28 **Shabana Mahmood:** We will come on to GPs and educating GPs later. Your interim solution is that the national incident team handle it. Are they still receiving between 5,000 and 10,000 misdirected pieces of correspondence?

Paul Baumann: I believe it is in that order.

- Q29 **Shabana Mahmood:** And that has never fluctuated below 5,000—

Paul Baumann: It does fluctuate a lot—that is why I am slightly hesitant with my answer. It does go up quite a bit week by week. But certainly if you look at the last couple of months of last year, that was broadly the rate at which it was.

- Q30 **Shabana Mahmood:** Do they have the resources they need to give us a quick turnaround, or are we going to have a big backlog that still needs to be dealt with over the course of the year?

Paul Baumann: They do have the resources required to do that. They are managing to cope with the workflow of both the incident as it is coming through and these redirections. We have sustained the level of resource in that team, and they are now a very well-practised team at doing the things that we have talked about.

- Q31 **Shabana Mahmood:** Aside from the SBS incident and the new incident, these current misdirections are also being actioned concurrently with all of the other work.

Paul Baumann: Yes.

- Q32 **Shabana Mahmood:** What is the rate of turnaround on actioning this new bit of work?

Paul Baumann: Days.

- Q33 **Chair:** So within a week of arrival.



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Paul Baumann: Yes—assuming, of course, that we can find the patient's correct address. Clearly where queries arise, it may take longer than that to establish the correct destination.

- Q34 **Shabana Mahmood:** On the straightforward ones where you can quickly and easily locate the individual and correct GP, you are saying you get it sent back within a week.

Paul Baumann: Yes. The team is very well versed in turning around those things.

- Q35 **Shabana Mahmood:** I don't doubt that now, but not turning these things around quickly enough is part of the reason why we are here talking about it. On the slightly more complicated cases, what is the general turnaround time?

Paul Baumann: It is extremely variable, because it really does depend on what inquiries are needed to try to track down where a patient might now be. Unfortunately, quite a large number of patients move—perhaps they go abroad and have not done the relevant administration around that, or they change location or change GPs and some of the systems get out of sync. So they can be quite complex inquiries, and I do not think I can put a meaningful time on the inquiry resolution.

- Q36 **Shabana Mahmood:** Are you completely confident that we will not discover other boxes of correspondence hanging around that somebody stumbles across—maybe even during a Public Accounts Committee hearing?

Paul Baumann: We haven't got any surprises to spring today, if that is any part of your question.

Shabana Mahmood: That is a relief.

Chair: You might have told us by now—Mr Stevens would never be able to hold back.

Paul Baumann: But let me give the answer in two parts. You will have been aware that there is a need for us to check—this is in the notes of the previous meeting—the substantial numbers of boxes that went with the archive to the PCS service in Darlington to be brought together: 20,000-odd boxes were part of that particular collection. Those have now all been carefully checked, both by Capita and by our incident team, who went and did an extensive process to establish whether there were any further boxes there. That is the source of a few of the extra boxes that were in my note, which we have added in and dealt with; but having dealt with those extra boxes, we are confident that in that archive there is no further box lurking that will come into this particular incident.

In a system as paper-driven and as distributed as it is, I cannot give you a further assurance that nowhere around the country in any depot, in any office or in any part of the NHS there is not a document or a box of documents which has not been acted upon—that would be a foolish assurance to give you. But I can tell you that all the checks that we



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undertook to make about the archives have been completed satisfactorily.

- Q37 **Chair:** Okay. But we are still seeing misdirected correspondence, as Ms Mahmood highlighted. Who is ultimately responsible for stopping that? You have just highlighted the fragmented nature of the system, but who is ultimately responsible? Is that you, Mr Baumann?

Paul Baumann: Let's not go into who within NHS England, because in fact I am only the interim person looking after this particular portfolio. You will meet another of my colleagues when we talk about the PCS service in the future. But—sorry, I have forgotten the question.

- Q38 **Chair:** Who is ultimately responsible for stopping it happening? You are describing what you are doing with it, but you are not stopping it at source.

Simon Stevens: There may always be a small flow of correspondence where a GP practice has received something and it is not clear to them where that belongs. That is why we have put back in place this interim solution and have commissioned Capita from 1 May—

- Q39 **Chair:** But the solution is always to send it back, isn't it? The proper solution is to send it back to the originator.

Simon Stevens: If you know who it came from, but some of this stuff—

- Q40 **Chair:** Can you give an example of something where you wouldn't know where it had come from? A scan result with no name on it, or something?

Simon Stevens: There have been, in amongst the 1.13 million items of correspondence which we have painstakingly gone through—human eyes on all 1.3 million of them—examples of that nature. All I am saying is the team at the get-go were probably overly optimistic to think that there would never be a situation arising when there would be the need for somebody other than the practice receiving an item to review that.

- Q41 **Chair:** But that is a small, tiny subset. What are you doing at NHS England to try and get GPs to understand the importance of sending it back to the originator of the document, Mr Baumann?

Paul Baumann: In May, when the permanent solution is in place with Capita, which I described a little earlier, we will have a major communication campaign to communicate both the nature of that service, as it has been put in place, and the need for GPs and, more particularly, practice administration, to ensure that what you have just described happens in all cases.

- Q42 **Chair:** This is three years after the new system was introduced.

Paul Baumann: It is within a few weeks of now, and that is—

- Q43 **Chair:** Yes, but that is three years after GPs were supposed to send it back to the originator.



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Paul Baumann: That is true.

Q44 **Chair:** So if you can a communications campaign now, why didn't you then?

Paul Baumann: We did communicate it at that point. Clearly it hasn't had the required effect in all those—

Q45 **Chair:** So what sway do you have over GP practices? It is not, presumably, the GPs themselves. We are not fingering any particular professional group, but there might be a practice manager gap or training issue. Do you have any idea which GP practices are most prevalent in sending documents to the wrong place—i.e. to the shared service centre rather than back to the originator of the document?

Paul Baumann: Too many to have a targeted campaign, if that was the sense of the question, but once we have run the new system and done the communication campaign with the tagged system that will be in place with Capita in the transformed process, they will be able to generate statistics of where things are coming from and accessing this service. We will be able to be more targeted in what I hope will—

Q46 **Chair:** And what will you do with those statistics? Will you feed that back? If I was a practice manager of a GP surgery I would kind of want to know if there was something going wrong on our watch. Are you going to feed that back?

Paul Baumann: We would feed that back through the local offices that we run who manage our relationships with GP practices. In some cases, of course, that is now with CCGs to manage on our behalf, but that is the route through which we would do it, rather than as a national follow-up.

Q47 **Chair:** You say there are quite a lot of problems, but not enough to have a targeted campaign. Are there any particular areas of the country where more GPs are sending it to the wrong place?

Paul Baumann: I think the further north you go, the less the problem becomes, would be my best description.

Q48 **Chair:** Really? That is interesting. Any reason for that?

Paul Baumann: I don't think I can advance anything that would not be wild speculation.

Q49 **Chair:** We do not like wild speculation in this Committee so it is probably wise not to go down that route, but will we be able to have access to the information about where the biggest problems lie once you have done that?

Paul Baumann: Of course.

Q50 **Chair:** I am grateful. We will be in touch about that. What arrangements—now—have you agreed with Capita for any misplaced correspondence that it receives from GPs in error?



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Paul Baumann: That is the point. That is what I have just been describing. They are PCS England now, so they are the people receiving both legitimate things, because remember they do the archiving of records for deceased patients—

- Q51 **Chair:** When they receive something that is in error, they then—okay, that is fine. We have covered that. As I say, it was three years ago that GPs were told to send it to the originator. I still cannot quite grasp why it hasn't happened, and what purchase NHS England has over GPs. You have talked about going through CCGs or other of your offices that deal with GP practices. We know that the NHS is fragmented. Doesn't this rather underline the problems of that fragmentation—that when something as basic as getting important clinical data that has been misdirected back to the right place does not happen, you do not seem to have any power at NHS England to resolve it? Is that a fair comment?

Paul Baumann: I think if we can bring it down to a small enough number of places that are doing that, it becomes much more meaningful for us then to exercise the powers that we might have to do that. It seems to me, given the scale of the issue as it currently presents itself, that that is not a realistic option for us.

Chair: GPs receive quite a lot of money—Ms Mahmood is going to go into this a bit more—from NHS England, to do work that they did not always do, to check these records. Do you have any idea of where the worst-performing GP practices are in that respect, and are you going to try to get any of that money back?

Paul Baumann: We are reclaiming all the money from GPs who did not perform the function that they needed to perform for us on the SBS case.

Simon Stevens: Which was a recommendation of the Committee that we are dutifully following.

- Q52 **Chair:** Good. Do you know how much you have got back yet?

Simon Stevens: We have made £238,000 in further payments. We are reclaiming around £260,000.

- Q53 **Shabana Mahmood:** Following on from that and the earlier line of questioning on what you can do with GPs who do not play ball, one of the things that surprised me most in our last hearing in October was the complete lack of comeback you have when a GP does not respond to NHS England—the people who run the show. What, in your view, is lacking or could be done to try to rectify that situation?

Paul Baumann: In relation to this incident, or in relation to—?

Chair: Generally.

- Q54 **Shabana Mahmood:** Generally, but on the specifics of this: when you are getting in touch to try to repatriate correspondence and they do not get back to you or do not do so in a timely manner, or appear unable to understand that they now have to deal with misdirections themselves and not send them to Capita, what can you do?



Simon Stevens: Maybe I can weigh in slightly in defence of GPs on this. I was down in Plymouth on Friday, talking to a group of GPs there. One of the things they were saying was that they had, in some cases, received correspondence back and had duly done it, but were then being chased by us for affirmation that it had been done. I think their point was that, given everything else they are dealing with in terms of the pressures over winter and all the rest, we should feel confident that, as responsible professionals, they are doing the right thing when they get the piece and they do not necessarily have to fill in forms to tell us they have done so. That is the view of many GPs, and we have to recognise that GPs in your area and across the country are under real pressure. I just put that into the equation, to balance the forensic line of questioning that you are understandably embarked on.

- Q55 **Shabana Mahmood:** Well, I am glad you have opened that up further. First, you would think that you would have been able to trust GPs not to charge money for a service they did not then do, which was what happened with some of the review work, so we are right to be sceptical and challenging.

Simon Stevens: We have dealt with that issue, and we have made sure that—

- Q56 **Shabana Mahmood:** Winter pressures in the NHS are not an excuse for that. I have to say, I understand if my constituents who live life on the absolute edge of survival feel pressured and cannot deal with lots of complicated paperwork. I do not have the same sympathy with GPs, who have staff to manage it for them. I do not expect GPs to be sitting there. I expect their staff to be on top of it. I put the question to you again: what can we do to make highly paid professionals with a full complement of staff at their surgeries do what they are supposed to do?

Chair: Do you have any levers?

Shabana Mahmood: Is there any lever you can pull, or a lever that you need in order to get this job done?

Simon Stevens: We have worked our way through just short of 1.13 million items of correspondence and, for the most part, in the vast majority of cases, GPs have done what was asked of them. We have supplemented that with our own team of GPs and our own team of consultants from Leeds where additional clinical review was required. The whole system has mobilised to get the result we have seen today: a pretty massive clean-up effort for a series of administrative consequences that go back many years.

- Q57 **Shabana Mahmood:** That is a valiant attempt to make out that this whole exercise has been some sort of stunning success, but it does not answer my question. What levers do you have to get GPs to do what they are supposed to be doing? Or do you need some levers? Should we be considering recommendations to Government about other things you need in order to get GPs to play ball with information that is really quite important?



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Chair: That is an open goal for you, Mr Stevens

Shabana Mahmood: Pitch something to us, Mr Stevens. You can't be impressed with how this whole episode has gone down. It doesn't look good.

Simon Stevens: I am not impressed by the fact that the episode happened in the first place, but I am impressed by the way people have subsequently responded.

Shabana Mahmood: You can't be sitting there knowing that you have had to spend time and staffing resource chasing GPs to give you information that should come in when it is first required. You know all those things are problems for you; that is why you are here with a full complement of staff behind you. Again, make a pitch. Tell us what you need in order to get GPs to do what they are required to do, to help you to do your job, clean up messes on the first time of asking, and not spend lots of money chasing around highly paid professionals to do what they should be doing first time round.

Simon Stevens: The premise of that long point of view is not quite right.

Shabana Mahmood: Question, actually.

Simon Stevens: It is not quite right, because it was not GPs' fault that the original 709,000 or 708,000—

Chair: We have acknowledged that.

Shabana Mahmood: We have established that. I am talking about the very specific cases where you—

Q58 **Chair:** We are not hammering GPs, but you are not answering the question. If you answer it, we will quickly move on.

Simon Stevens: I am not joining in the hammering, and that is what I am being hammered for.

Chair: You are not being hammered; you are being asked a question. Ask the question in very short sentences, Ms Mahmood, so Mr Stevens can concentrate on the question and then the answer.

Q59 **Shabana Mahmood:** What further levers do you and NHS England need in order to be able to chase GPs more effectively to give you information that you need at first time of asking?

Simon Stevens: I think we have done as well as reasonably we can under the circumstances, and GPs have responded effectively in the round. Where there have been concerns about whether payments were being made for work not done, we have addressed that—retrospectively for the first tranche and prospectively for the second—to safeguard taxpayers' resources.

Q60 **Shabana Mahmood:** And on the issue of having to chase them for responses to your letters requiring further information, do you need more levers to get them to play ball and respond to you in a timely fashion?



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Simon Stevens: What sort of levers are you thinking of?

Shabana Mahmood: It is not for me to say.

Q61 **Chair:** It is not for us to think about that. You might not need any. You might just say, "None." Is that what you are saying? We don't want to go down the rabbit hole on this.

Simon Stevens: In respect of this incident, yes, I think the system has mobilised as effectively as it can.

Q62 **Chair:** We are quite interested in what Mr Baumann was saying about data on practices that do better or worse on this, and it would be interesting to see whether that relates to local management or whether there are other gaps, as Ms Mahmood has highlighted. We will wait and see what we get from that.

Simon Stevens: That's fine.

Q63 **Chair:** Hopefully you will be looking at that data, too.

Simon Stevens: Indeed, yes.

Chair: We will pause that one for now, because we will probably come back to it at another point.

Q64 **Shabana Mahmood:** Mr Stevens, when did you know specifically about this second incident?

Simon Stevens: I don't have a date in front of me, but surely it was before I came to speak to you last time round. As it happened, the estimate I gave you was an overestimate of the number of cases that would require clinical triage. I think I said around 160,000 and it turned out to be 30,328, so I overstated it. I overstated the problem.

Q65 **Shabana Mahmood:** So you are saying you either knew just short of that hearing in October 2017—

Simon Stevens: Are you talking about me personally? I suspect so, but I don't know whether Paul has—

Q66 **Shabana Mahmood:** Mr Baumann, were you aware of the incident before then?

Paul Baumann: It was escalated to senior management, including Simon, in August 2017.

Q67 **Shabana Mahmood:** But of course, as we now know, it was known about from May 2016 onwards. Why did that escalation not happen more quickly, given that the Shared Business Services car crash was already well under way by then?

Paul Baumann: We were officially told in October 2016, as the Report points out. From then, the teams were trying to get a handle on exactly what the issue was, the scale of the issue and the nature of the documents—it is a very complex area of multiple document types and so on—and in good faith, I think, trying to put in place a solution to the



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repatriation of this documentation, in partnership with Capita as the providers of our PCS service. It took them a fair while to work through all that and have a proper view of what the data was, and it was not escalated to senior management in any concrete form until August 2017.

Q68 **Shabana Mahmood:** Define “any concrete form”.

Paul Baumann: Clearly, as an incident that required escalation.

Q69 **Shabana Mahmood:** You already had a national incident team dealing with the correspondence issue in relation to Shared Business Services, though. I am just trying to understand why coming across a whole bunch of other misdirected correspondence does not automatically get you into the same space of referring it to the national incident team. Why do you need a whole other process to come to the conclusion you have already come to under Shared Business Services?

Paul Baumann: There is an important difference, because what we had with SBS was historic stuff. This was, in the main, reasonably current materials for which we just did not have a process in place that was working. The logical response to a current process that is not working is to try to fix that process. That is what they were trying to do for that period, and it then became clear that that was not going to work, so we decided it was appropriate, as you suggest, to put it through the remedy process that the incident team was running. Clearly, on top of that came the closing depots and the boxes that were found in those, which made it more logical to combine it with the incident.

Q70 **Shabana Mahmood:** Did you say August 2017?

Paul Baumann: That was the escalation, I believe. I think it is in the Report, in the timeline.

Q71 **Shabana Mahmood:** Mr Stevens, do you feel that you might have inadvertently misled us when you suggested at the last hearing, in October, that this additional correspondence had been discovered as a result of various institutions within the NHS being thorough and having a belt-and-braces approach, rather than, actually, it was something that was known about for over a year beforehand?

Simon Stevens: That is exactly how it had become known so no, I don't.

Q72 **Shabana Mahmood:** You didn't say at that hearing that actually you had known about it for over a year, or some part of the NHS had known about it for a year, and it hadn't been escalated. It is not information you came to that last hearing with, but presumably you would have known that.

Simon Stevens: No, what I think I said at the last hearing was that we had, in addition to the SBS, come across these incident cases which were arising as part of the PCS transition, and we were going to apply the same process to them expeditiously, which is what we have done. As it happens, I overstated the size of the problem.

Q73 **Shabana Mahmood:** I understand that you overstated it. Were you aware at that time that in fact it had been known about since 2016?



Simon Stevens: I honestly can't remember. I think I found out about it August or September, or something like that, so it was shortly before I came to the Committee.

- Q74 **Shabana Mahmood:** But at the time that you found out about it, in August or September, or any time prior to the hearing, you would have known that it was an incident of some duration that went back to 2016.

Simon Stevens: I would have to go back and look at my notes on that. As far as I recall, it was an issue that had been escalated to us rather belatedly internally, and that is an issue for NHS England. We have got our own work under way to understand what the moving parts are on that. But as soon as it was escalated, I think we have taken effective action, and I actually want to thank Paul for having stepped up to do that.

- Q75 **Chair:** So you have got some work under way and are doing an internal review of this?

- Q76 **Simon Stevens:** Yes.

- Q77 **Chair:** Will that be something we can see?

Simon Stevens: Yes. The context of this, as well—just to add more—is that obviously this is when the whole SBS to PCS transition was going on. It was only because of the PCS transition that the SBS matter came to light in the first place. As I think you know, it has not been a completely smooth transition from the legacy arrangements to the new arrangements anyway, so that team, who were the people who Paul said were dealing with this concurrent process issue, were also the people who were managing everything else to do with that transition. It was a pretty torrid time, quite frankly. Anyway, that is the context.

- Q78 **Shabana Mahmood:** It will be helpful to see exactly the timelines and obviously we want to satisfy ourselves that all of these incidents were treated with sufficient seriousness by every part of the NHS. Mr Stevens, what are the wider lessons that we should be learning about administration, paper-based systems, within the national health service?

Simon Stevens: There are several. As I said, the fact of the SBS matter came to light during the move towards the establishment of a national information-sharing service across the NHS, so we had a highly decentralised arrangement that involved not just Sopra Steria and SBS but also Anglian Community Enterprise, Serco, and various local offices. It was the process of putting in place a more streamlined national process that exposed the fact that the prior local processes were not working as they should. I think the root of the matter is, obviously, we want less manual paperwork around the NHS, and so the move towards things like e-referrals for GPs, electronic medical records properly digitised—all of that will take out a lot of the paper flow, which is obviously at the heart of the issue here.

If I could suggest another lesson, it is that it is very easy to take a pop at administration and administrators in the national health service, but



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actually they do very important work and when that is not working well you see the kind of situation that we were having to clear up here.

Chair: On a scale of one to 10, or a percentage, how good would you say administration is? One consultant put it to me that it ranges between the 1950s and the 1980s, depending which hospital you are in. That was amusingly cynical, but possibly quite accurate from the experience that some of us have in the health service. You have just given us a round view. Give us some practical examples of what is going to happen, and what will make it better for patients, easier for administrators, and more cost-effective for the taxpayer.

Simon Stevens: We are obviously a very administratively lean health service. As you know, we spend about 2p in the pound on administration in the NHS, compared with 5p or 6p in the pound in France or Germany. We have made significant cuts in our running costs to reinvest in frontline patient services since 2012. Something to the tune of a third has come out of the national running costs since those changes, and there are more reductions to come. When we, at some subsequent hearing, discuss the PCS matter, one of the things that you will see is that, on the back of that, we have saved taxpayers between £20 million and £30 million a year. We have taken £20 million to £30 million out of the costs of running services.

Q79 **Chair:** Are you saying that savings on admin are more important than getting it right with the balance?

Simon Stevens: No, we have to do both. I am saying that this is in the context of very significant cost take-out in the administrative overhead in the national health service, in a system that is already very lean.

Q80 **Chair:** Are you saying that too much has come out of administration, so that you are lacking that backbone of information?

Simon Stevens: No, I am not saying that.

Q81 **Chair:** You are saying that you are quite lean, and you are very different to France and Germany. That has highlighted some of the problems when things go wrong. How confident are you that the patient records administration of the NHS is fit for purpose?

Simon Stevens: There are a lot of legacy issues that we are having to contend with. As you move towards transitioning from paper-based models to digital or national automated services, you expose what some of those legacy systems were. That is across a range of areas, including this one.

Q82 **Chair:** There is a lot more that we may want to probe over time, and we can debate other things about the administrative side of things. It is a hidden part of the NHS, but when something is in the record it is seen as the record, and if it is wrong it gets very difficult for patients. A number of our constituents have raised with us over time issues about when things are wrong on the record. That is perhaps the wider issue that we draw from some of this.



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Simon Stevens: One point of context. Throughout all this, we have had fewer than 10 complaints from patients, despite all the notifications. This is a highly undesirable situation to be clearing up, but I think we can take some solace from that.

Chair: Well, you can take solace from that, but I think most patients would just be grateful that something has been found, and are perhaps worrying about their health rather than other things. Anyway, we will let you take solace from that for your own comfort.

Thank you for your evidence this session. Mr Baumann will leave us now, or he may stay to support the second team up. Mr Stevens will stay in place, and we will have the second panel. I remind you that the transcript from this part of the hearing will be up on the website in the next couple of days, uncorrected, and all witnesses will be sent a copy.