

Public Accounts Committee

Oral evidence: [Clinical Commissioning Groups](#), HC 1740

Wednesday 9 January 2019

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[Watch the meeting](#)

Members present: Meg Hillier (Chair); Sir Geoffrey Clifton-Brown; Chris Evans; Shabana Mahmood; Layla Moran; Nigel Mills; Anne Marie Morris; Bridget Phillipson; Lee Rowley; Gareth Snell; Anne-Marie Trevelyan.

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

Questions 1-155

Witnesses

[I](#): Dr Paul Johnson, Clinical Chair, South Devon and Torbay Clinical Commissioning Group, Jane Milligan, Accounting Officer, North East London Commissioning Alliance, Dr Mark Rickets, City and Hackney Clinical Commissioning Group, and Julie Wood, Chief Executive, NHS Clinical Commissioners.

[II](#): Simon Stevens, Chief Executive, NHS England, Matthew Swindells, National Director, Operations and Information, NHS England, David Williams, Director General, Finance and Group Operations, Department of Health and Social Care, and Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care.

Report by the Comptroller and Auditor General

A review of the role and costs of clinical commissioning groups (HC 1783)

Examination of witnesses

Witnesses: Dr Paul Johnson, Jane Milligan, Dr Mark Rickets and Julie Wood.

Chair: Good afternoon and welcome to the Public Accounts Committee on Wednesday 9 January 2019. We are here today to look at clinical commissioning groups, particularly off the back of a National Audit Office report about how well they are running themselves. We have 195 clinical commissioning groups in England, and they pay out more than £80 billion of public money, which is around 70% of total NHS spending. To enable them to do that, it costs £1.1 billion for those CCGs to run themselves. Many are having challenges, with 24 of that number currently deemed by NHS England to be failing or at risk of failing.

Obviously, we are at an interesting time, with the NHS plan out and a lot of discussion about the landscape of commissioning as a part of that plan. With our first panel in particular, we hope to tease out what it is really like on the ground: what is working and what is not, and whether there are things that the Government ought to think about, especially as they go through the NHS long-term plan and try to implement changes.

I am delighted to welcome as our first of two panels of witnesses Dr Mark Rickets from Hackney Clinical Commissioning Group, and Dr Paul Johnson, the Clinical Chair of South Devon and Torbay Clinical Commissioning Group—it is a little further for you to travel, so I really appreciate your coming in, and at reasonably short notice. Julie Wood is the Chief Executive of NHS Clinical Commissioners, which is the trade body that represents all 195 clinical commissioning groups. Jane Milligan is the Accountable Officer of the North East London Commissioning Alliance, which covers a lot of areas but most importantly Hackney—to be completely biased, as Chair.

A very warm welcome to you. Apologies for starting late—we had an important vote today, which put us back a little bit. We are hoping that this panel will last about 45 minutes, so if someone says something you agree with, you could just agree with them—you do not need to repeat it. We will try to be short in our questions, too. I ask Anne-Marie Morris to kick off.

Q1 Anne Marie Morris: Ms Wood, given your overarching role, what are your three biggest challenges?

Julie Wood: Our members' biggest challenges, as clinical commissioning groups, are to continue to deliver locally for the populations they serve, within the financial allocations they are given, to make sure they are able to transform care so that it delivers improved health outcomes for their



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population. For people working in CCGs, it is to do that within a construct that is moving fast. Although, as the Chair said, we have 195 CCGs, they started their life only five years ago with 211. We are seeing CCGs reduce in number, but more importantly than that, they are working much more collaboratively without reducing in number.

We have the example of Jane and Paul and all the panel who are working across CCG boundaries with their provider colleagues to try to transform services. In effect, they are trying to work in two worlds at the same time—the world in which they were constructed statutorily as 195 CCGs, but a world that is based much more on collaboration, integration and working at big system level, as well as critically continuing to work at a local place-based level, so that they can deliver change at both ends. They would be the biggest things I would flag up.

- Q2 **Anne Marie Morris:** That is helpful. Ms Wood, are there things you would like to see the NHS or local government do to help the CCGs do what they need to do? You have huge challenges.

Julie Wood: Yes, there are. We have been working with our members over the last two or three years to identify what they will need to help them to deliver integration at scale and at pace. We certainly do not want another top-down reorganisation of the NHS. That would be hugely distracting and would stop CCGs and system partners from doing what they need to. But there are bits of the current system that make it clunky and difficult to integrate care.

- Q3 **Anne Marie Morris:** Can you articulate what those are?

Julie Wood: There are five main ones. CCGs have the responsibility for population health outcomes, but foundation trusts and NHS trusts have the responsibility just for what happens in their organisation. We want to broaden responsibilities so that both providers and commissioners have responsibility to improve health outcomes across a place and a system. That is one example.

Easing some of the requirements around competition, choice and procurement would also help. In some instances, CCGs have felt that they needed to go through quite expensive and labour-intensive procurement exercises which they did not feel was the right thing to do for patients, so easing some of those burdens on procurement, competition and choice would be really helpful. That is another one. Aligning and streamlining accountability and governance, so that again we are clear about what we need across a place and across a system—to assure once, not multiple times.

- Q4 **Anne Marie Morris:** To deliver that, would you welcome a suggestion that, first, we streamline, if you like, the bodies that are responsible for oversight; secondly, we look at integrating the budget properly, as opposed to artificially, as we do now; and, thirdly, we give clarity in terms of reporting lines that are actually across the piece, rather than double reporting, double accounting and double assessment?



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Julie Wood: Yes, we would. The suggestions that have come out in the long-term plan we would wholeheartedly support—they are within those, yes.

Q5 **Anne Marie Morris:** Even if they included legislation? Some of them—

Julie Wood: The worry is that if we rely only on primary legislation and we don't get enough parliamentary time to enable that to happen, then nothing might happen. We would like to explore as far as possible what we can do through use of existing legislation—perhaps to think differently about how we assure and how we regulate, without resorting to having to go just through primary legislation, because we are worried that that might not happen or would take significant time.

Q6 **Chair:** May I ask Jane Milligan something? You are working across a lot of different organisations—you are having to collaborate now—so what are the barriers to good working at the moment, and where do you think there is an opportunity to influence?

Jane Milligan: I should just explain: I cover all of north-east London, which is seven CCGs and eight authorities—well, seven boroughs plus the City of London—which is a population of about 2 million so, as you say, quite complex.

In many respects, just picking up on what Julia was saying, CCGs have not really stood still since they started in 2011-12. Certainly, where it makes sense to come together to make decisions, that has already happened, so there have been some big service changes. Particularly, for example, locally the Barts cardiac centre was actually agreed without any legislative changes, quite a number of years back.

In terms of the long-term plan, as I think you said, bringing together some of the current separate silos of assurance is certainly the direction of travel. We have a new regional director who covers both NHSI and NHSE—I think he starts in early February—which in many respects will make my life easier, because part of my role is working with Mark and colleagues to look at what actually is really important to happen in a local place or at borough level. But where patients, populations and citizens move across boundaries—local authority boundaries—to attend acute hospitals, it makes sense to have much more of a strategic and joined-up approach.

Certainly, that is critical. To be able to do my role—essentially, across a bigger footprint—you still need to have those local, borough-based relationships and arrangements, particularly working with local authorities, as you say. So the long-term plan will help us—

Q7 **Chair:** What are the particular barriers? Where do you have problems connecting with other CCGs or other local authorities?

Jane Milligan: Previously, to take an example from outer north-east London, with Barking and Dagenham, Havering, Redbridge and the system there, some of the challenges have been where you have got some CCGs with financial challenges, and a hospital—the Barking, Havering and Redbridge trust, or BHR UT—having financial problems as well. What we



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found was that we had separate assurance mechanisms, so that in many respects it was quite difficult to have a joined-up approach. But actually, over the last year, we have now worked towards having all of the assurance bodies—NHSI, NHSE, the financial special measures, the CCGs, the acute hospital and the community mental health trust—in the same place.

We have sort of done that already because we recognise that in many respects, as CCGs have developed and as health has sort of been challenged with different financial and population changes, we have had to work in a different way. So some of those barriers are still there currently, but we are certainly working towards doing it in a different way.

- Q8 **Anne Marie Morris:** Dr Johnson, may I ask you for your perspective, given the rurality of your CCG? I am conscious that when you merge, you will have one of the biggest CCG footprints in the country—you might tell me I'm wrong, but I think that is right—and therefore there is a real challenge about trying to ensure that you still get the local focus. In addition, you are being asked, going forward, to make another 20% of cuts. How realistic is that in a rural area, and what would you like to see Government do to help you make this work?

Dr Paul Johnson: I am currently chair of South Devon and Torbay CCG. We have had approval from NHS England and from our member GP practices to go ahead and merge with Northern, Eastern and Western Devon, so that we become a single CCG for Devon—that is the plan—from April. That does make us quite a large one: just over 1.1 million is the population. We have three large population densities and then the rest, as you say, is very much a rural, coastal and market town set-up.

The challenge about still being able to communicate, link and connect with our local population has been one that we have had to manage in Devon regardless of the size of our CCGs, and we have done it by being very clear that a commissioning body, whether that be for the whole of Devon or a smaller area, can work only if we clearly define what subsections, what places or local geographies, we need to work in. So whenever we have looked at clinical engagement, managers being involved or relationships with local authorities and town councils, we have had to do that at CCG level but also on those smaller footprints.

I think that has worked well. We have had the permission from our regulators to do that. One of the challenges that we face is that whenever we find that we are under significant financial pressures, which we have been recently and continue to be, there is the tendency to centralise. We have to fight that. The proposals that come through from NHS England saying that we have to focus on system and we have to get that involvement at that place level for the smaller communities right have been really helpful for us not losing focus on that connection.

- Q9 **Anne Marie Morris:** Is there anything that you would like to see the Chancellor or the Government doing? In my view, rural areas are heavily underfunded because of the way the funding formula works. You start off



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on a minus, so in a sense you are coming from behind and trying to catch up. In a rural area, with all the challenges and barriers, what could Government do to actually enable you to deliver what they want, which is integrated health and care in rural areas?

Dr Paul Johnson: As far as how we structure ourselves and how far we develop relationships is concerned, we have had a very permissive relationship with our regulators and top down. What we would want is for accountability to be across the whole population, to allow the money to follow those relationships for us to invest extra where we see it is needed—for example, in rural or more deprived populations. I think that will be much easier when we get the organisations that we work with being able to be judged on their system responsibilities, their whole population responsibilities, rather than just the responsibilities of their individual organisation. I think that would help us to deliver that much more effectively.

- Q10 **Anne Marie Morris:** Wouldn't it be better still not to have double reporting and accounting—just to move to a systems approach, rather than having the approach that we have now?

Dr Paul Johnson: I think Julie described that really well. I think that we and many other CCGs would echo what Julie has said about that.

- Q11 **Anne Marie Morris:** Although you have time to do it, 20% is a lot to take out of the system. Realistically, how is a rural CCG such as yours going to even start that?

Dr Paul Johnson: We have looked at how our costs have changed since we have come together—although we have not merged, we have in effect merged by getting a single team working across the whole of Devon—and we are not far off having, as a consequence, taken 20% out of our running costs. That was not an aim or intention; I think it has been a consequence that we were expecting. And the information that I have is that we will be judged on that figure, from that starting point, rather than from where we are at the moment. So I think that, just by doing things more efficiently over the whole of Devon, we have seen that that is actually feasible for us.

- Q12 **Anne Marie Morris:** I have one final question. You will have a large number of local authorities as well as a large amount of medical provision across the whole of Devon, because it is a big county. What about the cultural integration? Are you finding there is a challenge with getting local government and the NHS side of it working together?

Dr Paul Johnson: I think we have made some really strong inroads. As well as being the chair of the CCG and being a GP, I am also the deputy chair of two of our three health and wellbeing boards. I was invited to take on that role by the health and wellbeing board chairs. That was a statement from them, that they wanted that greater integration. We are in a process talking to them about them coming together when we are looking at whole-Devon planning, with the three local authority and health and wellbeing boards joining us as senior NHS leaders.



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So, we are on the journey. We recognise that our language is very different, between health and local government, as well as our priorities and accountabilities and we have got to work with all of that, but we have the preparedness to be in the same room and have those conversations, which is a very positive step forward.

- Q13 **Chair:** That brings me neatly to Dr Rickets, because in Hackney it is further down the line, I think it is fair to say. Do you want to explain how you are working with the local authority in Hackney and what the barriers have been to that joint working?

Dr Mark Rickets: Certainly. I think we are working very effectively with the local authority—indeed two authorities. Because we work with the Corporation of the City of London as well. They are very different organisations in and of themselves.

Yet we have been able to develop an integrated commissioning structure, which has led, for example, to our CCG having many staff buried in secondments into workstreams, which essentially means sitting cheek by jowl with the providers, with an overarching governance structure to assure us that things are going on properly, certainly at this time of change.

That has really led to a great deal of closer working. Some of the early wins of that are some very interesting ideas around estates. Some of our primary care estates are really not good enough, frankly. The local authority are looking at developments and how we can work together more effectively and looking at how levies can be introduced.

In Hackney, they have traditionally been put into the renovation of schools. Now they are looking at what they can do for health. There are many areas where we are working very effectively, as commissioners enabling the ICS to flow from that, giving that permission, as it were, to providers to come together and work much more creatively.

So, we have had a lot of success in that regard. Part of it is historically where we have come from. As a CCG, for example, we have never spent all our running allowance. We intended right from the start not to spend it all and we have put the savings into commissioning. Essentially, much of our 20% will come out of what we have redirected it into; we have currently managed to achieve that.

Then there are our ways of working. We have been working with the Homerton, our key secondary care provider, the East London Foundation Mental Health Trust and with local authorities. We have been efficient over the years and it has taken us years to get to where we are.

That does speak to the fact that we have that coterminosity with those sorts of organisations. It makes it easier in that sense to be more locally focused, when you get a bit stuck—to have sensible conversations, saying, “Let’s go back to the experience of the person, the patient, the member of the public about what we should be doing here, and how we could do it better.”



- Q14 Chair:** That coterminosity is interesting. As it happens, at opposite ends of the table, Jane Milligan is trying to pull together seven, including Hackney. Hackney has got one borough. The borough boundary brings most services into one place. Obviously, it is a small geographical area; compared with Dr Johnson's area it is yin and yang.

Do you think that is what has helped make it work? Because it is easy to get good relationships when you almost walk down the road and speak to someone quite quickly—that you are physically located together? Has that been a consideration? Do you think that Hackney is unusual? Maybe Julie Wood could come in on that as well.

Dr Mark Rickets: It is unusual in that sense, that it has been able to maintain that sort of size, as it were. It is a credit to Jane and others to allow that to continue to flourish. Here we are, across north-east London: we have three systems essentially working collaboratively, where there are sensible discussions about what gets done best at what level.

We have interesting opportunities coming to our forefront about specialised commissioning and how we integrate that into the different levels that we work at. We work the three ICSs within north-east London very effectively, and we are building and developing those relationships.

- Q15 Chair:** You mentioned the physical capital issues and funding for those. How far have you got towards integration of your budget and the local authority's budget? Obviously, you cannot integrate them formally, legally. What barriers are there, and as Ms Morris was saying, is there anything that the Government could be doing?

Dr Mark Rickets: There are pooled budgets around the learning disabilities and the continuing healthcare budgets, but actually, a little while ago, there were aspirations to pool much more substantively. People sort of came back from that, and NHS England was not quite happy to let that much freedom happen suddenly, so rather than keep saying, "Well, let's just pool more and more" and go through the organisational requirements of that, we have been concentrating on aligning budgets and working more closely that way. Then, once those are up and running, the services are embedded and various of these services are under review, etc, pooling maybe comes at a later point in a "form following function" type of way.

- Q16 Chair:** Ms Milligan, you are nodding along to that. Is there anything you wanted to add before I bring in Mr Snell?

Jane Milligan: Only the fact that to some extent, as you say, the local authorities and CCGs for health do work differently. There are different cultures, as you say. The health and wellbeing boards bring that together, and there are some mechanisms we can use, such as the pooled budgets approach, to bring some of that together.

However, in many respects, part of the work around integrated joint commissioning—particularly that which has happened in City and Hackney, which is almost a blueprint that we are rolling out in other parts of north-east London—is at least understanding what the resource is and what the



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opportunities are. You can have different ways around some of the statutory arrangements, so as I say, part of what Mark was saying was about making sure that that is built on a very strong relationship and foundation of transparency and sharing. Actually, we have good examples of local authorities working together across London, in north-east London, in some areas where there are risks around sexual health. It is essentially about pulling those levers that already exist for us.

The health and wellbeing boards are certainly an area that I personally think we need to strengthen, or look at how best to get the benefit of, because that is the population piece. However, we also need to make sure we do not lose out on some of those conversations that need to happen over a wider scale, and as Mark says, that we look at things where it makes sense to do it across a bigger footprint. Obviously, workforce is a challenge for us in all areas, but there are some opportunities that we have done at a bigger scale, which actually is also about working with local authorities, because they certainly have challenges. We are starting to work not just within City and Hackney, but across a wider footprint with local authorities, providers and CCGs, exploring some of those opportunities and, again, using the framework that we have rather than trying to re-invent something.

Dr Mark Rickets: Another key element of that is the confederation of GPs that work together. All GPs are in that, and I just have some examples of how things can sometimes work well. We have an outbreak of measles in our area of north Hackney, in an area where the traditional immunisation rates are not great. When that became apparent, the numbers were starting to go up. A meeting came together with all the stakeholders—providers, Public Health England, and the confederation were represented—and within three days, there was a programme of immunising those children and people were flooding into those extra clinics. We should be careful what we wish for: we must never lose the ability to do that sort of work when it is required, and I believe that we would all absolutely sign up to that.

Q17 **Gareth Snell:** Ms Wood, can I ask you how many of your member CCGs—if you have this information—have merged to form larger CCGs because they felt that is what is in the clinical interests of the residents they serve, as opposed to being driven by the need to reduce their overall operating costs?

Julie Wood: As I said earlier, we have moved from 211 down to 195. That has been largely driven bottom up, but also linked to encouragement by NHS England to work across bigger footprints to help spend money wisely, get the savings out, and those sorts of things. It is a mixture of both.

Evidence from colleagues and elsewhere shows that the best way of doing this is definitely to do it at the right time, bottom up, and work from the basis—as Jane and Mark have said—of “What do we need to do at a very local level, and what can we do once at a much bigger level and bring together our functions? Even if you do not merge the organisations



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formally, act as though you are merged. Align them.” Then you start to see movement. I am not sure of the absolute number, but I think we have about 107 shared accountable officers now across the 195 CCGs. Although the mergers have not happened yet in all places, we have certainly got combined management systems happening predominantly across the country.

Q18 Chair: How much is that driven by the fact that the NAO point out that it is quite hard to recruit people to some of these positions?

Julie Wood: That is partly it, but it is also partly driven by the fact that it is sensible to do it to actually get the right clinical leadership in the right place and yield everything to happen at the right level.

Q19 Gareth Snell: Is clinical leadership not down to the clinical chairs, not the accountable officers, though, so merging accountable officers is not necessarily an increase in clinical leadership?

Julie Wood: We need clinical leadership and managerial leadership. We need both working closely together.

Q20 Gareth Snell: When clinical commissioning groups were first set up, I distinctly remember that in North Staffordshire we went from five PCTs to one PCT and then from one PCT to seven clinical commissioning groups. At the time, my predecessor asked why we were doing that. We were told that it was because the more locally focused they are, the more responsive they are to health needs, the better the service will be and the more response there can be to local needs.

Chair: Mr Snell, we can refer people to figure 1 on page 12 of part 1, which illustrates exactly what you are saying.

Gareth Snell: Now we have one cluster of CCGs in North Staffordshire with one accountable officer, although they retain their clinical lead. Is the rationale from the 2010-11 review that created CCGs, which says that smaller, more focused CCGs are more responsive to local need, something that your members no longer feel is important, given that they want to have larger footprints?

Julie Wood: No, I think you have heard from my colleagues the importance of localness. However, there is also the importance of scale. There is a tension, which I think comes out in the Report, about how you balance the need to retain localness and responsiveness to be able to redesign care pathways at a local level with being able to operate at scale. That is the tension that we have to find an answer to as we move towards a long-term plan. As Jane has described, before, you had a combined management team that had seven accountable officers who may have had different views. It is potentially harder to get an agreed way forward when there are seven people as opposed to one accountable person with support structures underneath them. It is about how you get the decisions taken about things at scale once, and how you get the decisions taken at a local level at that right local level. You need both.

Q21 Gareth Snell: Can I ask Dr Rickets and Dr Johnson, who do you think you



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are accountable to?

Dr Paul Johnson: I would say that I am accountable, as a clinical chair for the CCG, to the patient population that we serve via our member GP practices.

Dr Mark Rickets: I was elected by the membership of GPs, indeed, not by the population of Hackney. I have had a conversation with the Mayor of Hackney several times about that. Interestingly, it is true; that is the way it came about. The membership would like to feel that it represents the patients in public, but that is an issue, potentially.

- Q22 **Gareth Snell:** There was an Ipsos MORI poll commissioned by NHS England last year that suggested that only 28% of GP practices felt that they could actually influence the decisions of the clinical commissioning groups. If two thirds of GP practices do not feel that they can influence decisions or have any involvement, while they may be the people who hold you accountable, how are you actually held to account?

Dr Mark Rickets: I present myself for scrutiny to them every month. I meet them all the time at different meetings in different forums. Under our constitution, they can vote me out at any time. They can vote out our whole governing body at any time as well.

In terms of that survey, we fared quite a lot better than that average overall. It is all part of trying to keep people engaged and hearts and minds. Indeed, our patient-public co-production values have also won us great plaudits, so at the moment, I do not feel too much heat in that regard. I visit and attend their meetings regularly too.

Dr Paul Johnson: I think it is a real challenge and there are several reasons for that. One of the reasons is that we are expecting a set of professionals who are on the coalface and working extremely hard for extremely long hours also to be members of an organisation and influence that organisation. Are we creating enough space for them to be able to do that? One would argue that actually that is a really hard thing to do, because whatever space we create for that we have to take away from the frontline services that they are facing the pressure of. So there is that tension.

I think that partly there are a number of GPs—I know this from speaking to a number of my colleagues—who want the CCG to get on with its work and to do so in a way that allows them to do the job that they are interested in, which is the coalface general practice. But there are those who genuinely want to be involved in the CCG and it is those who we need to make sure that we give them the opportunity to do so.

- Q23 **Gareth Snell:** “Clinical commissioning group functions”—as in March 2013, and it is figure 5 in the NAO Report—says that one of the key areas where CCGs have a duty is to “involve the public in the planning of commissioning arrangements and when services are changed”. I appreciate that you may have different results to that of the survey, so I apologise for your having to speak for the whole country, but if two thirds



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of GPs do not feel as if they can have an influence on the decisions being made by CCGs, what possible influence do you think that members of the public might think they could have on the decisions that you take about the public health services that they have to engage with?

Dr Paul Johnson: That is very much about us being intentional in the way that we engage our public. I can only speak from a Devon perspective, but in our committees and in our structure within the CCG we involve members of the public. We involve and work very closely with Healthwatch. We have got a dedicated team that works within the CCG to ensure that public engagement and representation is key to any of the service redesign that we do.

So, we do everything we can and we take external critique from that, particularly around Healthwatch. Also, obviously we have learned a lot from our local authority colleagues, because it is something that they have done, and tend to do very well, and we have taken learning from them about how we can improve.

Q24 **Gareth Snell:** But you will understand that your local authority colleagues are subject to a ballot once every four years of the people who put them there, and in a public way.

Ms Wood, you were nodding along. Did you want to add something?

Julie Wood: Yes. I think CCGs have worked very hard in this area and indeed this is one of the indicators that features within the CCG improvement and assessment framework. So there is a leadership bundle of indicators that together make up 25% weighting of the overall annual assessment, if you like, of a CCG. One of those is about patient and community engagement, and the test is about compliance with statutory guidance on patient and public participation in commissioning health and care. An audit—quite an extensive audit—was undertaken last year by NHS England about this, to test out what CCGs were doing and that is a key part of that indicator.

Q25 **Gareth Snell:** How much public awareness do you think there is about your actual existence?

Dr Mark Rickets: It depends who you ask, doesn't it? Also, going back to engagement with GPs—that point—the other reason for engaging with the public enormously is the fact that we are asking them to change their ways of being and their behaviours, as well. If you want more work that was traditionally done in secondary care to move into primary care, funded in an appropriate way, built up gently but with support around the workforce etc., that is important.

Getting in the public is just how you go about embedding members of the public at every level of your organisation, and they also have individual forums. So, at our governing body, our lead member of the public sits next to me and I will always try to demonstrate those behaviours to kind of give that lead. That is probably inadequate when you compare it with a vote every four years, but it is the best we can do in the world we live in.



Q26 Gareth Snell: I agree that it is different. The point I am trying to make is that the former authority that I was on—a district council—would spend £15 million a year, for which there are 60 councillors accountable once every year to an electorate of a quarter of a million people.

Collectively, across the country CCGs spend £80 billion and I will say—hand on heart—that outside of those people who have to engage with you, nobody knows you exist. You are not accountable, realistically. My personal experience is that where you have a very dominant accountable officer—on the clinical leads, the Report from the NAO says that 11% of CCGs have a failure of leadership—they are essentially unaccountable, even to their own board if they can manage that. My concern from a public governance perspective is that a lot of public money is being spent by a lot of people who are almost entirely unaccountable to the general public, and that worries me. If you have a comment on that, that is fine, but I think that how we go forward with some of this stuff is questionable.

I want to ask Ms Milligan a question. Previously I have had to engage with the independent reconfiguration panel, as a result of decisions that were taken by my clinical commissioning group that were, frankly, appalling—the report that we got back was scathing. How effective do you think that is as a form of public scrutiny that currently exists to look at decisions made by CCGs?

Jane Milligan: Certainly if you are getting to the point that you have just described that is a bit of a failure, really. Going back to what Mark was saying—again, I suppose what I recognise in north-east London is that we have quite a lot of strength in our approaches to engagement and involvement. I would rather talk about patient involvement. I have tried to ban the word “engagement”, because I think that is a rather passive approach.

It is obviously disappointing when you get to referrals. To some extent, that has to be mitigated by the approaches that you take at a very local level. Also, picking up your point about clinical leadership—I think Julie made this point—I always think about it as a marriage really. I now have seven husbands, so to speak, because I think it is a very important relationship, hand in hand with the clinical leads, because essentially to make sure that you are getting the views and the voice of the membership and, to some extent, the wider population, it has to be through that route.

Having a very clear approach to very early engagement and involvement with any service change has to be the critical thing, and having a very clear clinical case for change. Unless you have that, you do not really make sure that you have clinical leaders involved, as well as your population too. That has to be something that people can get their hands around.



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Certainly from my perspective, in being involved in any large-scale change that is always the place to start, and then using, as you say, the different approaches, or the different people and different groups, to test that out. Obviously I cannot comment on what has happened in your patch, but there are tried and tested ways of making sure. Starting with a very clear clinical case absolutely has to be the first step, which you have tested out with your patients.

Dr Mark Rickets: Of course we are accountable to NHS England. I do not know how reassuring you find that level of scrutiny that is placed on us.

Gareth Snell: I imagine you could guess.

Chair: We are asking them next.

Dr Mark Rickets: We can be judged by clinical outcomes as well, which are sometimes less easy to explain—how one adopts clinical evidence most effectively, and you can then track how well you are managing the blood pressure of people with diabetes, et cetera. It is on a population base, which on an individual level does not necessarily mean a lot, but actually if you averaged that out you can work out, potentially, the number of strokes that have been prevented. Some of those measures are incredibly important too.

Chair: I am going to ask Sir Geoffrey Clifton-Brown to come in, then Nigel Mills, and then back to Anne Marie Morris. If everybody could just bear in mind the time.

Q27 **Sir Geoffrey Clifton-Brown:** Very briefly, Ms Wood or Ms Milligan—or both—you have said that we have 195 CCGs. We have 42 STPs, and the 10-year plan makes it clear that everybody is expected to move towards these by 2021. How are we going to get there?

Julie Wood: We are building from where we are. Again, in parts of the country we are some way towards that. In other parts of the country we are further away. I think there is a task to be done to identify what functions that are currently undertaken by clinical commissioners need to be transacted at what level. That goes back to place, locality and system.

We then need to look at how you need to configure yourselves to deliver those, in terms of picking up the point about democratic accountability and governance, so that there is a clear line of sight as to who is accountable for what. Through that, we are doing the form following function piece.

The long-term plan says that typically there will be a single CCG per ICS, which I think and hope reflects the fact that there may be some atypical situations where there is not a one-to-one ratio. When you think about the complexity and different size of our current STP footprints—the 42 or 44—we are going from 300,000 at one level to 2.8 million at another. I am not sure that a one-to-one ratio in all instances will work. If it does, then for the larger ones we certainly need to think very carefully about how we support place-based working so that we do not just flip back to doing everything at a very high population level and lose all the strength at a



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locality level. That piece of work now needs to happen. At the same time, we have to deliver on all the aspirations of the long-term plan in terms of service improvement and taking out 20%. We will be working with NHS England to help support that with our members.

- Q28 **Chair:** Can you give us some precise examples of how you are going to do that? You have talked a lot about the theory, but can you give us some examples?

Julie Wood: Thinking about Jane's example, they are quite a long way down that route in terms of having combined and having one accountable officer. The thinking will then be about how we need to configure ourselves and the steps we need to go through, such as asking whether there are any joint committees in common—all those practical mechanisms.

- Q29 **Chair:** Is the danger not that they grow because of where they are geographically? You would not necessarily start to configure geographically the way they are emerging because the CCGs themselves are set up in very random ways and random sizes.

Julie Wood: There is some sense-checking of what the footprints of the 42 or 44 look like. Is it exactly as it is now? In the light of the STP working up until now, do we need to make some changes? We will be wanting to have conversations with colleagues about some of that so that we get the right footprints and then go through the process of making some of this happen.

- Q30 **Sir Geoffrey Clifton-Brown:** Thank you. Dr Johnson, the table says that your CCG—I sympathise, because I come from one of the more rural areas in the south of England—is in need of improvement. How are you going to get out of your present situation and move towards an STP?

Dr Paul Johnson: We are on the journey of going through that. One of the things that we found we needed to do was not think of South Devon and Torbay in isolation. Not only did we feel that that was too small a footprint to commission on, but the acute services we were providing for that community had a lot of co-dependencies with other areas of Devon. That is where we started in our working relationship with the rest of Devon—with Northern, Eastern and Western Devon CCG. Through a process that has been 12 or 18 months in the making, we have moved to a single executive team, committees in common and a single management structure. The movement to becoming a single CCG across the whole of Devon then becomes a relatively small step and the next logical progression for us.

What that will help us to do and how that will help us tackle what we need to do as commissioners for our population is that it will allow us to work with the providers for the whole of Devon. If you refer to that as the system, we can commission services for the system—for that population—rather than commissioning for separate services and then trying to work with the complexity that that brings.



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The other thing we have worked hard on, if we come back to our local authorities, is on how effectively our commissioned services run. That is so co-dependent with local authority-commissioned social care that by working across the whole of Devon we can work with those three to look at how we can co-ordinate that in a much better way. Through that, there can be a much more seamless experience for patients and less delay when they move from one part of the system to another.

- Q31 **Sir Geoffrey Clifton-Brown:** Given Ms Wood's answer about the size of CCGs merging to become STPs and so on, how much administrative cost do you think you will be able to take out by having one CCG in Devon, as opposed to two or three different ones?

Dr Paul Johnson: Going through the process that we have gone through at the moment, which is up to the point of merger, we have taken about £4 million out of our running costs, and we expect to take about another £1 million per year out of the running costs by going through the formal merger process. That takes us almost up to the 20% target that NHS England has set us.

- Q32 **Sir Geoffrey Clifton-Brown:** Do you think 1 million is the optimal size, after which it becomes too remote to provide this local service?

Dr Paul Johnson: I think it works for us. I can't speak for other areas and there are so many variables to take into account. There is the complexity of the number of acute providers, community providers, relationships with local authorities, rurality and whether there are particular pockets of need.

I don't think there is a one size fits all. For us, it works, as long as we get that local place-based relationship right, and we get the clinical leadership not just sitting as the single person for the whole of Devon, but throughout at all those levels and in those places.

- Q33 **Nigel Mills:** I think, Dr Rickets, you said that coterminosity—if that is the word—is very useful in getting everybody in the same place focusing on who they are trying to serve. As we start to rationalise the number of CCGs, do you think having that as a priority would be a good idea in how we map health services?

Dr Mark Rickets: It is difficult because it depends on how you want to map it. Sometimes you traditionally map it against the footprint, for example, of a large provider. Some very large hospitals have a footprint that spreads out and they are taking people from a much larger area.

I see that with my colleagues from the Waltham Forest, Newham and Tower Hamlets group of CCGs, who are working closely as an ICS within our north-east London patch. That is one of the reasons for that—the main reason really—because they have such a relationship with Barts Health, because they are on three sites—Whipps Cross, Newham etc.

It would be lovely in a way to have it like this, as long as you didn't end up wasting money on unnecessary levels of administration. I still maintain that we are a very efficient and lean organisation, and we invest heavily in



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clinical leadership in that regard, and engagement with the patients that I have talked about. It goes back to one size does not fit all. We have to think what the challenges are in an area, where the history has taken us, where the enthusiasm sits, where the population is and so on, and then work together. As I say, our approach is that collaborative way.

- Q34 **Nigel Mills:** It's just that that approach cost us five times as many CCGs as we now think we need, which probably wasn't a wonderful outcome on that.

Suppose I made you all-powerful for a few minutes and said, "Paint me the picture of the ideal NHS." I still feel we have got loads of different boxes on the organisation chart, and most of us have no idea what they do or why they exist. What building blocks do we really need? Do we need a CCG, an acute trust and whatever else we have locally? Could we live with just one or two of those? What would be the ideal? Ms Milligan.

Jane Milligan: I will take the example of some of the work that has happened in Tower Hamlets. They were one of the vanguards trying to take forward some of the new models of care—new models of doing things. As you say, part of the challenge is that CCGs have been part of a number of different situations.

If you just take the cancer pathway, for example, they have been just one of a number of different organisations involved in commissioning that pathway from end to end. You have got NHS England, Public Health England as well as local authorities. My vision would be that you have a partnership organisation that brings together those bits of the commissioning pathway, particularly the local authority, as well as the providers. That includes mental health, primary care, acute and community services working together to deliver that population.

That would be a partnership alliance, which is tested in a number of integrated care systems, and in itself makes sense to do, going back to Mark's point about that borough. It is also able to impact across a wider footprint as well, with the acute services. Certainly, it is about being able to speed that up. However, it requires a change in how business is done. It requires a different way for how the money is managed, how the contractors are monitored and managed at an acute as well, because you have got a real mismatch. Contracts are all rather different, so I would say, one single place-based contract.

- Q35 **Nigel Mills:** But you are sort of thinking of partnership, and maybe a few less bodies. I suspect you wouldn't tell me that we should just go to NHS Derbyshire and merge everything back into one, and abandon the whole structure. As a final question, just to be a little bit cheeky, what is the optimum size for a GP practice? Would it help you if you had a smaller number of larger GP practices, or is that a complete blind as well?

Dr Paul Johnson: I would turn that around slightly to say "What is the optimum experience that a patient should have from health?" If we talk about this, we talk about primary care specifically, and we need organisations that can deliver that optimal experience and deliver it in a



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cost-effective and sustainable way. I think that will vary depending on the geography, and depending on the chronic disease prevalence or the number of care homes that need to be provided.

- Q36 **Nigel Mills:** Okay, but roughly a number of patients—I mean, presumably a one or two-GP practice is very difficult now, but do you think 10,000 is enough? Do you think we should be aiming for 20,000 patients per practice? Is there a sweet spot, do you think?

Dr Paul Johnson: I think practices are self-determining, and in the same way—

Nigel Mills: If you say, “It depends on local need” once more, I’ll scream.

- Q37 **Chair:** Dr Rickets, one of your colleagues in Hackney put it to me that if every GP had personal responsibility for 300 to 400 patients, and actually personally had to make sure, that would be a better model. I do not know; that is an ideal.

Dr Mark Rickets: For those people who need that level of care, as it were, that would be great. It slightly depends on who you ask. We know that the outcomes for patient satisfaction for people who are registered with very small practices can be very high, because they enjoy immense continuity of care, which we know is incredibly important—not only in terms of the feeling of wellbeing, but because it also helps prevent people getting sick and getting admitted to hospital in an unplanned way. However, that is not necessarily doable; we do not have enough buildings to do that, and actually, in other respects, that is a very inefficient way of doing things.

- Q38 **Nigel Mills:** You are not surveying your landscape and going, “Oh God, I’ve got a couple of really small, risky practices there, and I think I would actually quite like to merge them into there. That would be better.” If it works, it does not matter how small. You are happy with that.

Dr Mark Rickets: The small, risky practices are something we had several years ago, but fortunately we have now left them behind. We are all CQC-rated good—one slipped slightly, but it is on the way back again—or outstanding, so it depends a bit on who you are asking. As you say, there is no easy answer to that.

Nigel Mills: There is no magic bullet.

Dr Mark Rickets: It is a bit like, “Why have there been so many reorganisations of the NHS over the years since its inception?” Because it is complex and complicated, and it was ever thus, a bit. In the current direction of travel, Jane is right about empowering providers to come together to work as effectively as possible, with some sense of overarching governance to check that we are managing the money properly, and care and safety are attended to. That is what we are all trying to achieve at the different levels that it needs to be achieved at.

Chair: As time is marching on, we are going to move on to Anne Marie Morris for one last quick question.



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- Q39 Anne Marie Morris:** Ms Wood, so far you have all painted an incredibly positive picture, yet there are a number of trusts across the country that are failing, and a number are in financial difficulty. What is the problem? There has to be something that is wrong, because I cannot believe that that many are going to be in that position just by chance.

Julie Wood: Yes. We cannot divorce, if you like, the success of CCGs from the success of the NHS as a whole. The NHS has been going through the biggest period of austerity for many years, so quite a lot of the failure—if you want to use those words—of CCGs that find themselves in the bottom assessments is because of the financial position that they have found themselves in. It is true that they are equally funded on a per capita basis for their running costs, but their allocations are formula-based, and you touched on some of that earlier. Basically, the money has not gone as far as the need and demand. That is the crux of the issue at one level. At another level, the system that CCGs found themselves having to navigate around is too complicated and complex.

- Q40 Chair:** Are you talking about the internal market?

Julie Wood: I am talking about the internal market.

Chair: Just to call a spade a spade.

Julie Wood: Yes. We need to unpick some of that so we make sure that we can deliver the vision that colleagues have talked about, and so that we can make the transformational change that we need to in a very speedy, efficient and effective way. It just isn't all connecting, but the money situation has certainly not helped. We are very appreciative of the long-term settlement, but we have to be mindful of what we can do with it and of where we are starting, because we have a lot of organisations—trusts and commissioning organisations—in deficit.

- Q41 Chair:** When do CCGs get the settlement? I believe it was going to be this week.

Julie Wood: Yes, allocations are this week or next week.

- Q42 Chair:** So you still don't know yet.

Julie Wood: No, not yet.

- Q43 Chair:** And do you think that will be feeding in from the plan? Is it linked? We have not seen any financial figures from the plans so far.

Julie Wood: You have to produce the plans by the 14th. Allocations are coming, but obviously the new money is being phased in, so it is about getting the right speed of delivery of the new things with the new money.

Chair: Mr Snell, do you want to ask one last short question?

Gareth Snell: No, I will save it.

Chair: We would love to keep talking, but we have the people running the Department and the NHS coming in to talk to us. Sadly, they are not in



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the room to have heard you, but we will send them a copy of the transcript.

May I thank you all very warmly for coming, particularly those of you who have clinical practices? We know you are busy seeing patients when you are not with us, so we feel your time is particularly precious. The transcript of the evidence that you have given will be published uncorrected on the website in the next couple of days; our colleagues at *Hansard* have taken verbatim notes of what you have said.

You are very welcome to stay for the next panel—there are seats behind you. We cannot tell you for sure when our report will come out, but it will probably be towards the end of February at the earliest. Thank you very much indeed for your time.

Examination of witnesses

Witnesses: Sir Chris Wormald, David Williams, Simon Stevens and Matthew Swindells.

Chair: I should alert our witnesses to the fact that our microphones are slightly tricky. They are voice-activated, basically, so if you make a sotto voce comment, it will be picked up fully.

Gareth Snell: Everyone's looking at you, Simon!

Simon Stevens: Thank you, Mr Snell—noted.

Chair: So we won't say anything rude about you if you don't say anything rude about us.

Simon Stevens: "That was a really helpful and brilliant hint—thank you very much," he said, sotto voce.

Q44 **Chair:** Thank you very much indeed for coming in, and welcome to the second half of this Public Accounts Committee evidence session on Wednesday 9 January 2019. We are looking at the running costs of CCGs. It is very pertinent timing, actually, because since the NAO Report came out we have had the NHS plan come out.

I will introduce our witnesses and then, as you will imagine, I will have a few opening questions. My apologies that we are running late—we had to vote, so I appreciate you hanging around. Well, you have no choice really, but I still appreciate it. I am always very mindful of the value for money of your time, and the longer we keep you, the more it costs. We are hoping that, because of the delay, we can whip through this in a reasonable time. Please keep your answers short, and only one of you needs to answer each question. If you agree with each other, just say so. We will endeavour to keep our questions short.

I will introduce the panel. David Williams is one of our regular visitors, and the Department of Health and Social Care's finance director. Welcome to you. You probably have a bigger title these days, but that will do—you are the money man at the Department. Sir Chris Wormald is



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the Department of Health and Social Care's permanent secretary, and is a regular attendee here. Sir Simon Stevens is the chief executive of NHS England, and Matthew Swindells is the national director for operations and information at NHS England. You have the longest title of the lot, although I don't know if that makes you most important or not.

First, to Sir Chris and Simon Stevens, I wanted to be clear when the detailed plan on funding is going to come through from the plan that was announced by the Prime Minister and yourselves on Monday. We haven't seen any announcement on NHS education or capital funding, for example. When are we going to get the detailed numbers—the figures behind the plan?

Simon Stevens: I will answer that in two parts. Tomorrow, we are going to be issuing the five-year funding allocations for every part of the country, linked to the 3.4%—the £20.5 billion—that we are getting over the next five years.

Q45 **Chair:** Which organisation is that for? Is that for CCGs?

Simon Stevens: That is for the NHS England allocations, including for CCGs.

Q46 **Chair:** CCGs, hospitals and all providers.

Simon Stevens: That's right—linked to the funding settlement that sits behind the long-term plan. Then, as the plan itself says, the Government will be making decisions on the capital, the Public Health England budget and the HE budget in the spending review. So when the spending review occurs, that is when those will take place.

Q47 **Chair:** In other words, we don't know yet. That will depend, Sir Chris, on lots of things.

Sir Chris Wormald: Well, it is a decision for the Chancellor.

Q48 **Chair:** What is your bet on when the spending review might happen? I could pitch you against other permanent secretaries.

Sir Chris Wormald: I am not going to bet.

Q49 **Chair:** Too cautious to bet, but I suspect—we all think—it may well be delayed because of what is happening with Brexit. Is that your general working assumption in Whitehall?

Sir Chris Wormald: No.

Q50 **Chair:** No. You are carrying on as though it could be the summer, which could be any time from June to December.

Sir Chris Wormald: Yes.

Q51 **Chair:** Okay, right. That helps us a lot, doesn't it?

I just wanted to touch on the workforce strategy, which of course Baroness Harding, as head of NHS Improvement, is heading up. I will not repeat all the conversations we have had about challenges in staffing, but



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we have a lot of concerns. What is she going to manage to do? I have a lot of admiration for Baroness Harding, but what is she going to manage to do in her strategy that is going to make a difference, compared with the problems we have seen over the years?

Simon Stevens: In a sense, that would answer the question of what is in it, and since it is being developed, that would be to prejudge it. It is going to be in two stages. There is going to be a spring interim report of that workforce implementation plan, and the full report will follow immediately after the spending review, when the budgets for education and training and some of the related costs are clear.

Q52 **Chair:** How long term is that strategy?

Simon Stevens: It is going to look out over 10 years. That was the point of having a long-term plan. Some of the improvements we want to see—the big improvements in early diagnosis in cancer, for example—rely on workforce expansions that are going to have to be phased over five and 10 years.

Q53 **Chair:** Clearly, you are going to want to front-load what you can, but there will be certain career paths that you just can't do quickly.

Simon Stevens: Exactly.

Q54 **Chair:** Can you give a couple of examples of where you think that could make a difference quickly and where there will be a longer-term lead-in?

Simon Stevens: Yes. There is actually quite a lot of detail on workforce in the long-term plan. It points to the fact that there are some things that we have got to do right now around ensuring that the ability for universities to expand nurse training places is capitalised on. We point to the fact that it is in some ways paradoxical that, at a time when we are wanting to increase the number of nurses, 14,000 people were turned away from nurse training. We allocate funding specifically to enable the NHS to expand the clinical placements to match the places that the universities will create. We can take immediate action, as we are, on new routes into nursing—7,500 more nursing associates next year and the year after. We are also looking at how the apprenticeship levy can be better used to support some of that, given that we have 1 million care assistants working across the NHS and social care and that many of them would be interested in being able to move into qualified professional nursing on a graduated basis. So there are nursing roles.

As you know, we have five new medical schools coming online, and a 25% increase in medical school places. We are going to ramp up the support we give in the meantime, as the domestic production of trainees grows, to international recruitment; and alongside that we are taking action—NHS Improvement is taking action—to improve the way in which local trusts look after the staff we have in the NHS right now, because more than half the people currently working for the NHS, we hope and believe, will still be working for the NHS in the 2030s. How we provide flexibility and development opportunities over the course of their careers is very important too.



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- Q55 Chair:** So if you were a person on the ground, and let's say you went into hospital this year and went into hospital in two or three years' time, would you envisage that you would see the difference that quickly? On nursing, for instance—

Simon Stevens: Obviously, we have got a lot of pressure across staffing in the NHS as a whole. The vacancy number has been well cited; but in a sense we are always running to catch up, because we have got 100,000 more staff working in the NHS now than we had five years ago, but we are going to need to continue to expand in order to deliver the service improvements we have got in the plan. We obviously want to see improvements next year, the year after and the year after that; but they are going to have to be phased based on the practical actions that can be taken and what Dido is going to be doing is looking at the things in the control of individual trusts, the things where employers collectively in an area need to work together better, and some of the more fundamental workforce changes we need nationally.

- Q56 Sir Geoffrey Clifton-Brown:** Could you just put a little bit of flesh on the bone in relation to nurses, if that is the right expression? On paragraph 4.15 of the 10-year plan, you have come up with quite an ambitious plan, and you say, "From 2020/21, we will provide funding for clinical placements for as many places as universities fill, up to a 50% increase." That seems very ambitious. Do you actually think you are going to be able to meet that?

Simon Stevens: What we are saying is that the NHS would stand ready to fund those placements, so that should not be an obstacle to universities being able to fill places with well-qualified candidates. We want to take that, as a reason, off the table, for not being able to fill places.

- Q57 Sir Geoffrey Clifton-Brown:** Let me go on to the next sentence in that paragraph: "And every nurse or midwife graduating will also be offered a five-year NHS job guarantee within the region where they qualify." I often think that the NHS provides all this money to train nurses and doctors and yet has no tie on how long they stay within the NHS. Are there any plans to do anything about that?

Simon Stevens: Obviously, and somewhat controversially, there has been a shift in student financing in nursing, to align it more closely with what happens with some of the other clinical professionals; but generally speaking people are very committed and motivated in wanting to come into nurse training, and the question is more whether the NHS has the ability to give guarantees about employment and flexibility of working. If we do that, I think people will readily sign up.

- Q58 Chair:** So that is voluntary. You mentioned retention earlier. Are you or Sir Chris lobbying the Treasury about the pension cap and the fact that it is causing problems for retention, for a lot of senior—

Simon Stevens: That is one for Chris.

Sir Chris Wormald: Thank you. I am not going to use the word “lobbying”. We do not lobby the Treasury, but, yes, we do discuss exactly that issue.

Chair: They make you crawl, do they?

Sir Chris Wormald: No, we have sensible discussions. It is well identified as an issue. As I think the Committee knows, it is not a straightforward set of questions, and it of course has implications for pension tax across the piece. There is not a clear-cut causation, although there does appear to be a relationship with people choosing to retire early, directly because of pensions. We have got evidence that it causes people to ask themselves the question; but, then, a lot of what drives decision making is some of the things that Simon was talking about—how you are treated as a professional, etc.

Q59 **Chair:** So you are talking to the Treasury. Is there any headway?

Sir Chris Wormald: We are discussing it with the Treasury, and any changes would be announced by the Treasury in the normal way.

Simon Stevens: In the meantime, one of the other big things that has been an issue for GPs has been the way the indemnity arrangements have worked, as you know. So one of the big changes being discussed with the BMA and the Government is relieving GPs of that pressure, which is one of the things they tell us makes a difference to partners and their decisions to continue, quite frankly.

Q60 **Anne-Marie Trevelyan:** On that, the other thing that GPs who are leaving in their early 50s say is that they have to re-register—that is not the right terminology—and go through a really complex process to justify their existence all over again. That is a huge amount of paperwork, because it is a massive audit. They just say, “I can’t be bothered, to be honest. Why should I take on that hassle when I have been doing this job professionally for 25 years?” That is something that I have raised with Ministers in the past. There is both the pension cap and the pressure of asking them in their 50s to reapply, effectively. Is that something that you are also looking at?

Simon Stevens: Yes, but the circle to be squared here is that the General Medical Council wants to ensure that doctors who are practising continue to have up-to-date skills and the right expertise.

Q61 **Anne-Marie Trevelyan:** But if they did the day before, why are they suddenly—

Simon Stevens: That is why there is periodic revalidation, which has been in place for a number of years. The question that has been put to us not just by GPs but by other doctors and professionals is, if you are planning to carry on but in a more narrowly defined set of clinical activities, is there a way in which your assessment could relate to them specifically, rather than the full portfolio? NHS England maintains what is called the performers list, which it has to administer linked to the GMC process. That is something we should explore.



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Sir Chris Wormald: I think what your questions highlight is that, when we are looking at GPs, it is no one thing. When you add together all these various types of pressure, it results in particular categories of GP feeling under quite a lot of pressure.

- Q62 **Chair:** We are heartened that you are considering it. We are just impatient to see more action. It was in this Committee with one of your predecessors, Sir Chris, that we first raised the issue of pensions and retiring clinicians. We were told that it wasn't an issue, but it obviously is an issue. I am glad that that is acknowledged, and that things are moving on. Briefly, the social care plan is obviously a critical part of the long-term plan. We hoped that we would see both at the same time. The social care plan is not yet here. When do you envisage it being issued?

Sir Chris Wormald: Both the Prime Minister and my Secretary of State have been answering this question over the weekend, and I will repeat exactly what they said: it will be soon.

- Q63 **Chair:** Actually, the Secretary of State said on Monday that it will be by April. I hope someone has told you that, because that is what he said. I did hear the noise of civil servants rather worriedly scuttling around the Department.

Sir Chris Wormald: I'll stick to soon.

Chair: Soon is your position. He says by April. There you go—you can have an interesting discussion when you get back to the office. Now Anne Marie Morris on some Brexit preparation stuff.

- Q64 **Anne Marie Morris:** Your Ministers, Sir Chris, have given us all sorts of messages about readiness for Brexit. "There is going to be a crisis." "No, there isn't, actually." "We don't need to stockpile medicines"—that is the latest. "It's all going to be fine." Then there is the provision for some NHS troubleshooting and recruiting new individuals. Where are we? We are now pretty close.

Sir Chris Wormald: It is important to distinguish between different types of message and what we are preparing for here. The preparations we put in for no deal, which we do in conjunction with our colleagues in the NHS, are about reasonable worst-case scenarios. All the things that we do on stockpiling, continuation of flow and all the other issues I have debated with the Committee are around the question of what is a reasonable worst case. That is not the same as what people either hope will happen or think will actually happen. It is exactly what it says: a reasonable worst case. The NHS and health services around the world do that on hundreds of issues every day. This is actually not that exceptional for us. We spend our lives preparing for things we hope won't happen. That is the position with our Brexit preparations as well. We have established a reasonable worst-case set of scenarios, and all the preparations we have announced are about meeting those reasonable worst cases. That is just how we do contingency planning.

- Q65 **Anne Marie Morris:** Right. I understand your premise. How many people



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do you still need to recruit? Are we now in a situation in which we are not stockpiling and don't need to stockpile?

Sir Chris Wormald: No, we are stockpiling. We haven't changed our position at all. We wrote to the pharmaceutical companies in August, asking them to take a series of actions. All that still stands. We have taken action to ensure we have sufficient warehousing, including our famous fridges, to facilitate that. We are in close discussion with our colleagues in the Department for Transport about securing flow not just for medicines but for all the things that the NHS would need in those reasonable worst-case scenarios.

Q66 **Anne Marie Morris:** In that scenario, what's needed is done. What about the people? How many people?

Sir Chris Wormald: People are a slightly different issue. Simon might want to say some things here. It is a much more slow burn issue than the things that are about the friction of the border and, as we have just been discussing, is in fact a subset of our overall workforce questions. We do not deal with Brexit and workforce as a specific workstream other than where there is a particular Brexit impact, such as the need to register via the Home Office system. As Simon said earlier, we look at the overall question of how we are going to have enough staff for the NHS and the international dimension of that.

Simon Stevens: We still have our operational response centre, and we are assigning up to 200 people between now and 29 March in terms of particularly no-deal Brexit preparation. As Chris and the Secretary of State have said, if everybody in that no-deal scenario does what they are supposed to do, the NHS will continue to see the goods and supplies flow. But we are critically dependent on the transport infrastructure: freight, channel tunnel and air. That is something outside the control of the NHS and will be the critical variable in whether we are able to continue operating normally.

Q67 **Gareth Snell:** In our last panel, two clinical chairs said that ultimately they were accountable to NHS England. Given what they have said, Simon, 42% of CCGs are rated as "requires improvement" or "inadequate". Is that therefore NHS England's fault?

Simon Stevens: Can we decompose the question? Yes, the accountabilities of clinical commissioning groups are as set out by yourselves in the Act of Parliament that established CCGs. They are independent statutory bodies with their own governing boards, their own accountable officers and their own external audit, but we have the oversight responsibility for CCGs, and I personally have the ability to appoint or unappoint the CCG accountable officer designation if I believe they are not going to be effective, or are not being effective stewards of public money, and there are other intervening routes available. Obviously, one of the recurring themes of this Committee is the accountability line that flows in the National Health Service. It would be churlish of me not to say that they are indeed as Parliament has laid out: accountable to NHS England.



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Secondly, the 2012 Act also requires NHS England to annually assess the performance of CCGs. We think it is important to do so in an objective fashion with quite a high hurdle of performance. I therefore think if you saw all of the CCGs assessed as brilliant, you should question the hurdle that we set.

Q68 Gareth Snell: I am questioning the ones that have been assessed as not brilliant.

Simon Stevens: Yes, but the fact that there are some that are not brilliant proves that we are driving an objective and hard-nosed assessment.

Q69 Gareth Snell: I've missed you, Simon. Your answers sometimes are fabulous. Long, but fabulous.

Let me try again. Of the 42% that are rated as either "requires improvement" or "inadequate", how content are you with that and will you fix that? Or is it even your responsibility to fix it?

Simon Stevens: Obviously, we are not content. We want to drive continuous improvement. Of course, that's what's been happening. If you look back two years, the number of CCGs that were assessed as "outstanding" was 10; now it is 20. If you look back two years, the number of CCGs assessed as "good" was 80; now it is 100. If you look back at the "inadequates", two years ago it was 26 and now it is eight. So there has been significant improvement, but we continue to ratchet the expectation of what they are supposed to be doing as we expect the overall NHS to improve year on year. So, no, we are not at all satisfied that some CCGs are struggling, and yes, we absolutely have a shared responsibility with them to help them raise their game.

Q70 Gareth Snell: When you say you have a shared responsibility, what practical steps does NHS England and also the Department of Health take to help individual clinical commissioning groups that are either having financial troubles or leadership troubles or are struggling with just the general existence of commissioning services? What do you practically do to help them?

Simon Stevens: A whole range of things. Why doesn't Matthew kick off? I am happy to come in behind.

Matthew Swindells: A significant part of what the national team and our regional teams do is working with CCGs to help them to improve. As Simon says, we have seen improvement year on year. You will also note from the NAO report that a significant part—50%—of the judgment we apply is around leadership and finance. The NAO pointed out that the biggest challenges are leadership and finance, so to an extent, we deliberately set the examination question around the hardest test.

We have a team that works in partnership with NHS clinical commissioners that goes in and provides development support alongside CCGs to help them to improve and to focus on individual areas. You will also have seen a significant increase in the number of CCGs that have shared



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management teams now, where we have taken proven successful management teams and asked them to look after another CCG. We have seen, where we have done that, that on the whole that has driven performance as well.

We have a combination of working with the teams that are there to help them to get better in either the specific problems they have or more generally to help them to work better with their local GPs, but we also change management teams and do regime change where that is appropriate as well.

- Q71 Gareth Snell:** Have you got any examples of where you have actually gone into a CCG to change the management team? Can you give me a sense of the number of times that you have exercised those powers with clinical commissioning groups that are either “requires improvement” or “inadequate”?

Matthew Swindells: We know how often we do it. We intervene with directions. We have a legal right to apply directions, which gives us the ability to take over or direct specific things that the CCG does. We try to apply those for short periods of time and then lift them, because if you end up with everybody under directions you just change the accountability regime. On the whole, in most places, we find that you can drive an improvement over 12 months.

We also have to recognise that the measurement of a CCG is not only about how well they are doing their job; it is also a reflection of how difficult the question is that they have been set. We need to be careful to differentiate between really good management teams that are driving improvement in really hard areas versus coasting management teams that have an easier area to deal with. We try to pick that out as well.

- Q72 Gareth Snell:** Sir Chris, where does the Department of Health and Social Care fit into all this?

Sir Chris Wormald: In line with the governing legislation, we would not intervene at the level of an individual CCG. That we leave to our colleagues in NHS England. Our level is to discuss the overall health of the sector with NHS England as part of our general accountability arrangements with NHS England. We would not get involved at the level that Matthew is describing.

- Q73 Gareth Snell:** There are 24 CCGs with active directions. Some of those have been in place since 2015-16. How long would you normally expect an active direction to last for a clinical commissioning group and how do you escalate that where a clinical commissioning group are not necessarily meeting the demands placed on them by that direction?

Simon Stevens: I think 47 CCGs have been under direction since 2015-16, of which three quarters have had management change on the back of that. Of those 47, I think I am right in saying that only nine are still under direction, so the bulk of them have improved and come out.

- Q74 Gareth Snell:** Timescale-wise, though, the NAO reported that as of



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October 2018, there were 24 CCGs with active directions issued between 2015-16 and 2018-19, so when you issue a direction, how long do you give a clinical commissioning group to action that and come up with the goods so you can either remove that direction or say, "Actually, you have failed to meet that. We're now taking further action"?

Simon Stevens: It depends a bit on what we are directing them to do, quite frankly. In some cases, if we have a concern about the governance arrangements, that can actually be a pretty quick fix: "You need to make these changes and then, within three or six months, you can prove to us you've done it," and that is it. If, on the other hand, you are in a part of the country with some very deep-seated problems around the services and budgets—issues that you are not unfamiliar with—then, frankly, that might be a much longer exercise. We try to set the directions in a way that is realistic for people to embark on, which could take significantly longer.

Matthew Swindells: There is not a simple time lag on that. When we put an organisation on special measures, which is a combination of several sets of directions and a lot of intervention, we do a capability review across the leadership team. We might start by changing the leadership team; we might decide to back them and try to help them improve, then review that judgment six or 12 months later if it does not have the impact we were expecting.

Q75 **Gareth Snell:** Going back to the 42% that are rated "requires improvement" or "inadequate", what is your expectation for the decrease in that figure over the next 12 to 36 months?

Matthew Swindells: As Simon said, we set the bar high, so it is not my expectation that we will get to a point where everybody is better than average.

Q76 **Gareth Snell:** I am not asking about everyone. Currently 42% are rated either "requires improvement" or "inadequate". Do you expect that in 12 months' time it will be nearer 30%, 25% or lower than that? By his own admission, Simon is not content with that figure, so it has to come down.

Simon Stevens: I think we would expect to see improvements across the CCG group on the clinical performance that is expected. We are not only expecting but seeing improved financial performance across the group this year compared with last. Given the weighting attached to managing money right, as Matthew pointed out, that will obviously feed through into CCG ratings as well. We do not want to prejudge, because we are not yet at the year end, and we need to see where the cards fall on 31 March.

Q77 **Gareth Snell:** Okay, so you don't want to prejudge. Fair enough. I know that getting a timetable out of any civil servant is quite difficult.

Simon Stevens: I have the great benefit of not being a civil servant; I am a public official.

Gareth Snell: I appreciate that you cannot give a timetable.

Chair: You're never going to get a timetable, Mr Snell.



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Gareth Snell: One day, before I leave this Committee, I will get a timetable out of a public official.

Simon Stevens: We will be doing the CCG annual assessment later in this calendar year, as we do every year.

Q78 **Gareth Snell:** What would be your personal ambition for the reduction in the number of CCGs that are rated “inadequate” or “requires improvement” next year?

Simon Stevens: It would be glib to give you an answer. I am not just dodging the question. The reason is that we are giving the CCGs the funding allocations tomorrow. We will clarify the performance ask for them and then we have a detailed process with NHS Improvement to agree the operating plans of hospitals, trusts and CCGs for next year. In the light of that, we will have a strong sense of where we would expect to be in March 2020 compared with March 2019.

Q79 **Gareth Snell:** On the frequent challenges between financial control totals and funding between providers and commissioners, I have an example of a clinical commissioning group trying to reduce its elective surgery to try to reduce its financial deficit, while at the same time the hospital trust that it mainly commissions with has been told by NHSI to increase its elective surgery to increase its income in order to close its financial deficit. Do you recognise that as a competing priority problem in the set-up we have, and where does NHS England fit in trying to resolve those sorts of problems?

Simon Stevens: I think that has sometimes been the case. That is one of the core arguments of the long-term plan published on Monday: we have to move to a holistic view on the care that people in north Staffordshire or Staffordshire require.

Q80 **Gareth Snell:** I didn’t say it was north Staffordshire.

Simon Stevens: I had a psychic sense that you might be talking about the University Hospitals of North Midlands, but I don’t want to put words into your mouth. The reality is that we want more funded operations on the NHS not just this year, but next year and the years after, but there are obviously deep-seated financial problems in your part of the country, including in your CCG. Parliament requires, perfectly rightly, that the NHS balances its books each year. We divvy up the money fairly between different parts of the country, so it is incumbent on each part to balance its books; otherwise it is spending somebody else’s money. That is just the reality of it. To your underlying question, are we trying to ensure that there is a single NHS view on the right thing to do in Staffordshire? We absolutely are, and that is at the core of the long-term plan.

Q81 **Chair:** The long-term plan is a good answer for a little while yet.

Simon Stevens: Well, it is a great plan.

Chair: Because what Mr Snell has just described is Kafkaesque.

Gareth Snell: To be clear, I didn't say that.

Simon Stevens: It is not Kafkasque. You can understand why those dynamics are at work, but we are saying that, collectively, that is not the right answer. There needs to be a shared view across Staffordshire as to what they should be doing, given those constraints.

- Q82 **Gareth Snell:** Putting Staffordshire aside, as difficult as that is, ultimately it sometimes feels like wooden dollars that get traded around differing components of the NHS, whether that be CSUs—I think that is a scandal waiting to come out, but that is a different conversation—or CCGs and their provider trusts. I want to understand how, perhaps later on, given that CCGs were set up to be clinically led and to meet local need, they seem to now be more about being arbiters of financial wrangling between individual competing provider trusts.

Moving this on a bit, Sir Chris and Simon, how confident are you that CCGs remain—if they have ever been—clinically led, as opposed to having the local GP being the face and the public persona, and actually still being run almost by professional bureaucrats who have come from the PCT days?

Simon Stevens: It can be both, can't it? CCGs are unique in the history of the NHS in having GPs as the majority on their governing bodies. In fact, I think we are the only industrialised country in the world where two thirds of our health service's budget is controlled by bodies on which GPs and primary care physicians have the majority. That is just a fact. However, it is also the case that they need strong professional management and operational support. Some of that is delivered at CCG level, and some is shared across CCGs. I suspect that the panel you heard from earlier talked about how some of that sharing is taking place to try to get the benefits of the best people out there operating on a broader canvas.

Gareth Snell: Sir Chris, without going into policy?

Sir Chris Wormald: Yes, we agree with the analysis that Simon has just given. I think there is a reasonably wide acceptance that the transaction costs of a number of these things have been too high. That is why NHSE, in conjunction with NHSI, came to us with proposals for their working more closely together at national level, to ensure that a single message went out to providers and commissioners. It is also, as Simon said, why the long-term plan is predicated around altering some of those conversations. That is not a fundamental change to the legal relationship, which we may come on to, but it is certainly a recognition that, while there are strengths in that system, for reasons that we have said, there are some transactional costs that can be reduced. That is where we are very much in line with NHSE.

Simon Stevens: I would also say that paragraph 3.3 of the NAO Report says: "Research by the King's Fund and Nuffield Trust indicates that the introduction of CCGs has improved clinical engagement in commissioning".



- Q83 Gareth Snell:** The Ipsos MORI poll that NHS England commissioner last year came back and said that only 28% of GPs feel that they can actually influence the decisions of clinical commissioning groups.

Simon Stevens: That is true, and it is right up to a point, but they do actually elect the governing bodies of their CCG.

- Q84 Gareth Snell:** But they do not feel as if they have influence. Does that worry you? They may elect their board, but they do not feel like they have influence over it. How can they be clinically led?

Simon Stevens: One thing going on here is that there is obviously a question about the influence on commissioning decisions of GPs, practice nurses and other primary care professionals, which is separate from the involvement of GPs in primary care provision.

We are discussing with the BMA and the Royal College of General Practitioners the creation of networks of individual practices across an area where a lot of the day-to-day work, in terms of reshaping services, as talked about in the long-term plan, will be done at that primary care network level between groups of practices. I suspect that that will be a lot closer to the action for many GPs than some of these commissioning decisions that are made by CCGs.

- Q85 Gareth Snell:** Sir Chris, without deviating into policy, are you and the Department of Health comfortable that the current set-up with CCGs actually meets the original policy expectations around being clinically led and improving patient care?

Sir Chris Wormald: In line with the long-term plan, which we have just published, we do want to see this system evolve. I don't think it is disputed that the 2012 Act has not played out exactly as it was originally planned; indeed, it did not pass the House in exactly the state originally planned. It has evolved between the passing of the Act and now, and what the long-term plan does is chart out the next stage of that evolution. I think the assessment that Simon gave you was spot on. There clearly has been a great expansion of clinical involvement of the type that was envisaged in the 2012 Act, but as I say, to move forward it has to evolve a bit.

- Q86 Gareth Snell:** Fair enough. Could I ask this, then? One thing that the NAO Report highlights is that attracting and retaining high-quality leaders is an issue. The pre-panel, the GPs, both quite rightly pointed out that you are taking people who are professionally a GP, with a practice and case load, and asking them, as members, to take on a much greater voluntary role—well, they are volunteering for a role within the clinical commissioning groups. Are you concerned about the ability of CCGs to attract and retain those high-quality leaders, and what is NHS England actually doing, tangibly, on the ground to help to support CCGs in that quest?

Simon Stevens: Yes, I think there is a concern. Life is all about trade-offs, isn't it? If you have a large number of smaller organisations, they will be closer to the GPs, to local authorities and to people in towns, cities and



counties across the country, but the flip side is that you have a larger number of small organisations and you do not have so many people—leaders—to go around. The circle to be squared is: how do you get that sharing of the best-quality management and leadership while nevertheless keeping the local accountability? As you know, 127 CCGs have shared management, with 38 senior leaders operating across those 127 CCGs. That is how they are seeking to square that circle. We expect there will be an evolutionary change to consolidate that into, probably, a smaller number of CCG governing bodies, but right from the start we have not proposed throwing all the cards up in the air; we need this thing to evolve in the way we have talked about.

- Q87 Gareth Snell:** Is it a concern that the shared management teams and the reduction in the overall number of CCGs are being driven, wrongly, by a lack of senior leaders willing to step up into those roles, forcing the hand of CCGs and making them come together where they may not wish to do so but have to out of necessity?

Simon Stevens: It is also being driven by the benefits of operating at a larger population scale and taking out significant money from our running costs—administrative costs. As you know, we are going to take another £700 million out of NHS administrative costs over the next several years, and that comes even as, today, new figures from the Office for National Statistics are published that show that in the most recent year NHS productivity has been going up by 3%, which is around three times higher than `productivity across the UK economy as a whole and should therefore provide great reassurance that the extra funding being voted by Parliament for the national health service will be used well.

- Q88 Gareth Snell:** We are going to get on to the reduction in the number of CCGs and the 20% reduction in running costs. Given that we started this whole process with almost 200 CCGs and that the long-term plan, which you have said quite a lot today—I don't know whether you're on commission to say it!

Simon Stevens: The timing has worked out really well. If it had been the long-term plan tomorrow, you would have accused me of obfuscation for not answering on what's in it. Now that we have got it out there and are discussing it with you, you say, "You're referring to the long-term plan." Of course we are.

- Q89 Gareth Snell:** Given that we started with 200 and the ultimate aspiration is for around 44, to match the STP ICA—

Simon Stevens: No, we haven't declared an end number of that nature.

- Q90 Gareth Snell:** Okay, what end number have you declared?

Simon Stevens: We don't think it would be the right thing to pull a number out of the air like that.

- Q91 Gareth Snell:** But we heard earlier, from the pre-panel, that one CCG working with one integrated care area or one—



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Simon Stevens: Typically.

Q92 **Gareth Snell:** Yes, so let's work on the basis that there are currently 44 STPs.

Simon Stevens: Yes, but that's not necessarily the same as saying there will be 44 integrated care—

Q93 **Gareth Snell:** Okay, but we are going to have significantly fewer CCGs than 200.

Simon Stevens: In all likelihood, yes, but recognising we already have these shared management teams covering the—

Q94 **Gareth Snell:** Was it a mistake to have so many focus on small areas when they were first established?

Simon Stevens: I was not around at the time, but that was a legitimate decision made by groups of GPs coming together in order to get up and going for 2013, immediately following the passage of the Act. Frankly, CCGs—as recorded by the NAO—have made a major difference over the course of the last five years. Just to pull out two points from summary paragraphs 6 and 7, the NAO says, “CCGs’ work has expanded”, and “Funding for CCGs’ running costs has reduced.” In other words, they are doing more for less and are having more impact along the way.

Sir Chris Wormald: I think the other point to make here is that one of the challenges with NHS reform over the decades has been creating very firm plans with very firm numbers that are fixed in stone until somebody reforms them again. Having a system where there is a much more continual state of evolution to whatever the next set of challenges and circumstances feels to me like a much better type of reform for a sector of this size and complexity than for Simon to sit there and say, “The exact right number of CCGs is X.” I would rather have a system that was in a much more continuous state of slow evolution.

Q95 **Chair:** To go back to a couple of things, you quoted paragraph 7. Mr Stevens said about doing more for less, but in the movement of running costs, some money has been switched to programme budgets, which means it is difficult to be sure that they are doing more for less and are not just hiding some of their money.

Simon Stevens: No, not at all. I had interpreted the complete opposite of that: there are strict criteria set down by the Treasury and tested by auditors for what counts as an administrative against a programme cost. To the extent that those administrative costs have come down against that definition, which they must have done with the external audit that goes alongside it, that has freed up money to spend on clinical facing improvements. That is a success.

Chair: Okay, I'll let that one go.

Q96 **Gareth Snell:** Finally, however many CCGs we end up with will be considerably fewer than we started with. From the Department's



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perspective more than Simon's, Sir Chris, does it concern you that in those early days, value for money was not achieved by the fact that we appear to be able to do considerably more for considerably less, with fewer CCGs and fewer staff?

Sir Chris Wormald: I will not comment on decisions in 2012 and 2013, but I think it is a much better system and way to approach value for money to say that we set things up, let them evolve and secured greater efficiencies over time. That is a better way of doing health policy. Could we have started at the beginning and created a master plan that got us exactly to where we are now and say that would be better? I do not think we could, actually.

Q97 **Gareth Snell:** Let's start now then. We have fewer than we started with but not that many. We have 190 or so institutions. There will be considerably fewer when the ICO arrangements are fully in place. Are you worried that by their own consideration, there are too many CCGs for the overall plan, and there is a value-for-money issue today?

Sir Chris Wormald: I think I would give roughly the same answer. We want to see the system evolve; we want greater efficiency over time, as we do with all parts of the public sector. To be honest, on this aspect of what the NHS does I do not have huge value-for-money concerns. We benchmark very well in terms of administrative costs compared with our international competitors, if you look at the Commonwealth Fund and elsewhere. Exactly as Simon described, we have seen the costs go down over time and money being reinvested. Do we want even more of that? Yes. Is this high up our list of value-for-money questions? Given what I just said, it is not.

Simon Stevens: The OECD data show that the UK NHS was spending 2p on the pound on administration, compared with 5p on the pound in Germany and 6p on the pound in France, so we start from a strong position.

Q98 **Gareth Snell:** Once you have implemented those reductions in administrative costs, what is the level of expected redundancies from job losses, rather than mergers or any other necessary actions?

Simon Stevens: It is going to be a phased cost take-out. People will have to come forward with their plans. There is obviously a natural churn, as you say. There are some vacancies in some organisations anyway, so that offsets the redundancy numbers, but we are quite clear that we need those costs to be repaid during the year in which they are incurred, so that taxpayers are a winner from the start, rather than having lots of up-front lump costs to bear.

Q99 **Gareth Snell:** Do you have any idea of what sort of costs, within the figures that you are going to be releasing, you are working towards with the costs of those redundancies?

Simon Stevens: We are going to work with CCGs themselves. Obviously, we have set the goal—Matthew has written to the CCGs with the 20%



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cost-reduction goal—and they will then be coming back to us with their plans and we will be stress-testing those.

Q100 Gareth Snell: A final point from me. The Chair mentioned the potential hiding of costs in programme costs. You said that you did not think that was the case, but what would explain the 89% increase in programme costs from 2014-15 to the figure now? It is almost double, so something is going on there.

Simon Stevens: Sure. One of the things that is going on is, obviously, we have had this big programme of improvement in cancer services and mental health services, and in the clinical contribution to safeguarding and a whole range of other areas. Those are programme-related costs and we are seeing increases.

Q101 Gareth Snell: But CCGs put £434 million of their staff costs in the programme costs. Are you confident that that is not an attempt to hide their own administrative costs?

Simon Stevens: As I say, there are strict definitions as to what counts as an administrative cost and those are subject to audit. None of the accounts that have been presented have suggested that there have been misclassifications that I am aware of.

Q102 Chair: We could ask David Williams, who always has something to say.

David Williams: I agree with the position that Simon has set out.

Q103 Chair: I am just thinking back to the capital issues and how capital was transformed into resource and how very clever things were done in the NHS budget. Are you absolutely convinced that it is all completely legitimate?

David Williams: As Simon says, this essentially reflects an increase in the scope of programmes delivered through CCGs, rather than anything else. When you look at the level of admin spend, as both Chris and Simon have said, it benchmarks well at around 1.4% or 1.5% within CCGs. That is a pretty good start point.

If you take the suggestion that, in some ways, any successful banking or future efficiency necessarily means that you were poor value for money to start off with, realistically, things take time to deliver. NHS England has set out its expectations for the next round of reduction in CCG admin and CSU costs over the next few years. That is an opportunity to bake in further efficiencies. But actually, as far as I can see, that is genuinely coming through either cost reduction on the CSU side or the benefits of operating back office support functions at scale where CCGs are choosing to operate jointly.

Sir Chris Wormald: The check on this is exactly as Simon said. It is a question of audit both nationally and locally. I think it is looked at specifically, both nationally and locally—

Robert White: For?



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Sir Chris Wormald: The split between admin cost and other is audited nationally and locally, is it not?

Robert White: Principally locally.

Q104 **Gareth Snell:** There is an upward trend of CCGs that are overspending on their budgets. I appreciate that you are not going to announce the financial settlements in the Public Accounts Committee, but I am going to try anyway. When those public announcements come out, is it your intention that, next year, there will be a reduction in the number of CCGs that are overspending against target?

Simon Stevens: Yes, and, in fact, it is our expectation that there will be a reduction this year compared with the last.

Q105 **Gareth Snell:** Okay. Part of the overspend last year was even though it included the risk reserve.

Simon Stevens: That is right. That is a very important point.

Q106 **Gareth Snell:** That will obviously not be available next year, but even with that, you are still confident that there will be a reduction in the number of CCGs that are overspending.

Simon Stevens: We are actually doing it a bit differently next year, in terms of a whole range of things around the financial architecture of the NHS, including the treatment of the risk reserve. For the year, Gareth, that you are looking at—2017-18—obviously there was also the one-time pressure from the generic drugs that CCGs had to absorb, and that has not repeated itself at that level this year.

Q107 **Chair:** You just slipped in there an architectural change to the finances of the NHS.

Simon Stevens: Sure—as laid out in the NHS long-term plan. And it is available for all to see in chapters 6 and 7.

Gareth Snell: If anyone wasn't clear, there is a long-term plan for the NHS now, isn't there? *[Laughter.]*

Q108 **Chair:** A new one. Let's be clear on the timings for that. When will we see that in detail, and will it have an impact on CCGs?

Simon Stevens: Tomorrow, there will be a lot of the detail on the trust financial regime, and then, next week, there will be further detail of the trust control totals.

Q109 **Chair:** Okay. Well, we will watch that. Before I pass over to Anne Marie Morris, I just need to go back to a point. Mr Stevens, earlier you talked about the improving trend in CCGs; you were very proud of the progress, but—



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Simon Stevens: I was just quoting the NAO.

Q110 **Chair:** Well, it has been brought to my attention that the 2015-16 improvement ratings were carried out on a very different basis—a significantly different basis—to what was set out for the 2017-18 ratings. It's not quite measuring like with like. So, I just wanted to be clear on that.

Simon Stevens: We have made it tougher since then. That's right.

Q111 **Chair:** Right. But just to be clear about it, it's not the same—

Simon Stevens: No—it's become harder.

Q112 **Chair:** It's become harder, but they have improved. Okay. I wonder whether Robert White wanted to add anything to that.

Robert White: I just wanted to get clarity on the trend that you have described and the number of organisations coming out of "inadequate" and "needs improvement" ratings, because there was a big reduction from 2015-16 to 2016-17. Our understanding is that the methodology for measurement changed, rather than that being on a like-for-like basis.

Q113 **Chair:** Are you saying it got tougher since 2015-16?

Simon Stevens: Well, it's both, as Robert says, but it has got tougher over time and will keep getting tougher year on year. Just to be practical about it, we said, "You need to have extended access for GP appointments—evenings and weekends—available across your area." Two years ago, we didn't have that, so we've ratcheted up the expectation that CCGs will deliver that. They have delivered that early so that that is in place ahead of March 2019—in place going through the Christmas period. That is an example of the sort of measure that has ratcheted up.

Chair: Sir Amyas, I can see you are itching just to clarify the situation.

Amyas Morse: The point is simply that the methodology has changed. I am not necessarily saying that that is not true; it's just not valid to compare the numbers.

Q114 **Chair:** Can we just be clear, so that it is clear on the record, that we are comparing different criteria?

Simon Stevens: Absolutely, yes.

Q115 **Anne Marie Morris:** Just a couple of detailed points first of all. The generic medicines problems that we had—are we going to repeat them this year, or do we think we've actually sorted the cost pressure from those?

Sir Chris Wormald: As you know, we had a whole hearing on this. The total cost of generic medicines went down as the concessionary price went up, which is an important piece of context. We are not seeing the same challenges around generic medicines that we were seeing in that year, around concessionary prices, but it requires constant vigilance.



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As you know, we took new powers to improve our information flows, and it is not the kind of thing where we would ever say that the problem is solved. This is a commercial market where prices go up and down. We have to look at it continuously, and we have to be take action of the type that we took with the problems that I'm describing—

Q116 **Chair:** We know that. As you say, we've done a whole hearing on that.

Sir Chris Wormald: So we are not seeing the same sorts of challenges at this moment, but that's not the same as saying that the problem is solved forever, basically.

Q117 **Anne Marie Morris:** As long as it is managed and kept on your radar—

Sir Chris Wormald: The key thing is that, as we discussed before, this was one of the lessons of the generic problems. The right action was taken, and it could probably have been taken quicker if our information flows had been better. In the future we want to identify those kinds of problems earlier and then take the right corrective action. That's not the same as saying that we can head off the issue before it starts, as it were. It is about taking continuous corrective action.

Q118 **Anne Marie Morris:** Okay. Great. Why are the CCGs reporting concerns about the performance of the commissioning support units? That came out in the NAO Report, I think.

Simon Stevens: Right. They have a choice as to how much to use them.

Matthew Swindells: The CSUs contract directly with CCGs. They can choose to insource and do the work themselves, or to outsource. On the whole, the satisfaction ratings that CSUs get from CCGs are good and have been improving year on year. We have seen some insourcing, but we have also seen some significant productivity improvements. If you look at CSUs since they were set up, they have reduced their costs by about £300 million. Of that, about half has been not a saving, but a cost transfer back to CCGs where they have chosen not to buy it; the other half has been a productivity improvement that CSUs have delivered. While there are always ups and downs in a buyer-customer relationship, on the whole we do not consider the CSUs to have a problem with the CCGs that they serve. If they did, we would see a wave of insourcing, and we really do not see that.

Q119 **Anne Marie Morris:** So you are planning to keep them and leave the choice whether to use them or not up to CCGs?

Matthew Swindells: I think CSUs are going to need to evolve quite significantly. Part of the challenge for them is that they have sat on the CCG side of the equation, but frequently what they have been doing is acting as the challenge to hospitals over invoice processing and the like. As we move to a population health focus and integrated care systems, CSUs will have to reinvent themselves as system support units instead of commissioning support units. They need to be valued by the providers as well as by the commissioners in future.



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Q120 Anne Marie Morris: Okay; that is another piece of change you need to then factor in. Finally, before I move on to the bigger picture and future issues, continuing healthcare has been the bane of CCGs and, frankly, our inboxes as MPs for a long time. There are challenges about consistency and timeliness. Can you tell us where we are with that, Mr Swindells, whether we have actually improved the timeliness of the preparation and the allocation of a proper plan, and whether we have improved consistency across the country?

Matthew Swindells: Yes, it is a challenge. That is a good question and one that we are focused on. There has been an improvement: the target is that 80% of referrals should be assessed within 28 days. It has improved from 67% to 71%, so it has got better, but it is not as good as it needs to be. The point you make about variation is also something that we are looking closely at, because there is significant difference in different parts of the country in the number of people accessing continuing healthcare per head of population, and there are elements of this pathway that we do not measure at all or that we are just starting to measure, such as how long it takes for the package of care to be in place once a decision is made. There is variation, but that is not something we routinely capture, and we need to, because it is part of our much wider strategy that says, "There are too many people staying in hospital longer than is good for them." Part of the pathway that we need to fix is getting people rapidly assessed and rapidly into the right package of care, be it a nursing home or their own home. That fits alongside the work we are doing through the Better Care Fund and with local authorities to improve the social services side.

Simon Stevens: Just one other fact on that, which I think is interesting: we know that you get a better quality of decision about what somebody needs if the CHC assessment is made when they are not stuck in a hospital bed, but up and going. As you remember from when we previously discussed this, one quarter of those assessments were being done in hospital, and we wanted to get that down to 15%. We have succeeded in that. We have gone from one quarter of the CHC assessments being done in hospital the spring before last to 12% in the last data we have. We have halved the proportion of CHC assessments that have been done while somebody is stuck in hospital, and that will have a big impact on the quality of the decisions that are being made about the support for independence that people need.

Q121 Anne Marie Morris: Great for the money, but not great for the patient, in my constituency.

Simon Stevens: No, that is great for the patient, because you are much more likely to be able to make a realistic assessment of whether somebody with the right support at home can continue living at home, where most people would rather be, as against, for example, being sent off to a care home—a decision that does not get reviewed as often as it should.

Q122 Anne Marie Morris: Correct, but the system does not work like that. In one of my hospitals, for one of my patients, there was no assessment



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made, yet there was discussion about that patient, who is 96, going by the end of the week. But for her son, who pressurised for a proper assessment to be done, she would have got out before she was ready. She still went out too early, and came back in with pneumonia, which then puts more pressure on secondary care. If that can happen in one of my hospitals—the assessment is not done at all, never mind properly, and unless there is somebody there pushing for it, it does not happen—and if that is written across the country, then your statistics are out the window.

The other concern I have is that when I did my Christmas visits of patients, a couple raised with me a new policy that has been introduced of “You’ve got to get them out within seven days.” I agree that you don’t want people in hospital longer than necessary, but the reverse is happening in some of my hospitals: they are being targeted to get them out in seven days, so hospitals are not looking as carefully as they should about where people go from there, and the plans are not being put in place. I leave that with you to take away and think about.

Chair: I think you are being invited to visit Devon.

Simon Stevens: I love my visits to Devon. Of course—not just thinking about Devon—Musgrove Park hospital was featured on the BBC news on Monday, showing how a return-to-home policy that the hospital established was producing real benefits for patients. We’ve got to get it right in the way that you describe, but equally, it is very bad for people to be stuck in hospital when they would much rather be home.

Anne Marie Morris: I totally agree.

Simon Stevens: That is one of the reasons why—I am being quite serious about this—one of the big investments set out in the long-term plan is an earmarked improvement in community health services, which frankly have been squeezed over the past several years. That will help, because we are going to have waiting time standards for urgent response for community support, including re-ablement.

Q123 **Anne Marie Morris:** Right. My parting shot on this is that I would like to ensure that you check that there is a proper system in place to make sure anybody in hospital cannot be discharged without that plan being made, and that there is a way of actually checking it. I do not think it is right that any patient should be discharged without the proper plan being in place.

Simon Stevens: If we could confidentially have a look at the example that you gave, then we will absolutely discuss that with the hospital.

Q124 **Anne Marie Morris:** Great. Turning to the big picture now, the NHS commissioning landscape is changing; it has been changing very fast over a number of years, and your 10-year plan changes it even further. We have had debates about how we get this integration to work across the CCGs and the local authorities, and then, if you like, the STPs and integrated care systems, which do not have statutory authority behind



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them.

In this 10-year plan, as I read it, to get that integration to work properly, you are beginning to look at accepting the need—which I think we have always promoted—for some change in the legislation to avoid the duplication. We have duplication in terms of reporting systems; we have conflicting and duplicating accounting systems, in terms of being held to account by the regulators, which has led to a very inefficient system and stopped people focusing on system objectives. What has been done about that? What are you going to do in 10 years to get us to a point where, actually, the system works?

Simon Stevens: We have a twin-track approach, I suppose. We are proceeding with the integration of care that we are able to do, and we think we can deliver what we say in this plan, based on the current statutory arrangements, but we think we could accelerate progress and take out some of those friction points were there to be adjustments to the legislative framework. In saying that, we are obviously responding to a request from the Prime Minister and from the Health and Social Care Committee to identify aspects of the current legislative arrangements that, were Parliament so minded, would benefit the NHS. That is what we have done in the plan.

Q125 **Anne Marie Morris:** That is encouraging. Let me ask you this, then, about commissioning: integration is leading to a merging, if you like, of commissioning decisions across local government and the NHS, which is right. However, there are very different reporting requirements for those bodies, so, in the grand scheme, are you looking at trying to create a body—whether it is the ICSs or not—that will commission across both?

Simon Stevens: Under the current legal framework, we can do that through the voluntary pooling of resources for selected patient populations, client groups, people living in a place—however you want to describe them—which obviously goes back to section 75 of the 2006 Act, and not the famous section 75 of the 2012 Act, and then, over and above that, things like the Better Care Fund. We have discussed further acceleration of that move on many previous occasions.

As it stands, that is a voluntary endeavour between the two consenting parties, and the accountability for the NHS funds that are put into those joint pots obviously sits, for the most part, with the NHS accountable officers. They then report ultimately to Government and to yourselves on how those funds are being used. The accountability is different, given that Parliament is voting that money down the NHS line, rather than down the local government line.

Matthew Swindells: Can I add something on the voluntary nature of that? I was down in your patch a couple of weeks ago. What you have in your area is some of the best examples of CCGs looking more widely. The clinicians of the two CCGs have voted to say that they want to come together to be able to think about the whole county's population. The STP in your area is jointly chaired by the chief executive of Plymouth hospital and the chief executive of the county council. When I was there, Phil



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Norrey, the chief executive of your county council, was talking to me and Pat Flaherty, the chief executive of Somerset County Council, about how the way the county councils are working together could be replicated in how the NHS works together.

Despite the regulations and the rules, really smart people are beginning to ask themselves, "How do we get health and local government working across boundaries to solve problems of populations?" To an extent, the long-term plan reflects not, "Here is a new set of marching orders," but, "Here are the marching orders that the NHS and local government have been inventing for themselves over the past 18 months." It is about trying to memorialise that and set it as a direction for the ones struggling to pick their way through the forest.

Anne Marie Morris: I take the point. Where there are good, bright people—I am extremely lucky, because I have good, bright people—it works. That is not true across the whole country. I have other hats on, and I can tell you that that is not the case. Mr Stevens knows that. How soon are you going to look at beginning to move on this legislative idea to ensure that, across the rest of the country, we can get this best practice happening?

Q126 **Chair:** It is interesting, Mr Stevens. When you appeared in front of us quite recently, we were reflecting that you were saying that we can make it work in the way that other people have described today, but then it was felt you were very gung-ho on Monday about the legislative agenda. What has changed?

Simon Stevens: Yes. As I say, it is a twin-track answer. This plan can be implemented with the framework we have, but I was able to be as explicit as I was because we have used the past six months to go out and genuinely draw on the experience around the country and answer the question we were posed by the Health and Social Care Committee and the Prime Minister. That is what we have done.

Q127 **Anne Marie Morris:** Okay. So there will come a point where you will make a decision about the need for some legal action.

Simon Stevens: The Government and Parliament will make that decision.

Q128 **Anne Marie Morris:** But you will advise.

Simon Stevens: Indeed, and we have begun that process by publicly promulgating our advice.

Sir Chris Wormald: To be clear, we have welcomed the advice that Simon has given. The Government will now consider legislation in the usual way. We expect views from this Committee and the Health and Social Care Committee on what Simon has proposed, and then Government will decide whether to bring forward legislation in the usual way and Parliament will decide whether to pass it. On your specific point about the integration of health and social care, just to be clear, no one is proposing any form of mandated change in the statutory responsibilities of local government and national Government. We are in the business of



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looking at how we remove the barriers for people who want to work together. In terms of the basic responsibilities of local government to provide adult social care and the basic responsibilities of the NHS, that is not one of the things we are promoting.

Q129 Anne Marie Morris: I wish you luck. I think you are going to find that more than a challenge. Moving on, while we have this greying of the issue around how we look at commissioning, we also seem to have a greying of provision. Many years ago, we divided commissioning and provision, and we seem to be bringing that back together again. Am I reading that correctly? If we are talking about integration, that is not only about commissioning, but provision, too.

Simon Stevens: Yes. The way I would say it is that in future, we do not envisage—there is clear benefit from having distinction between the planning and funding functions and the day-to-day delivery of clinical care, because you need to be able to look across a population and say, “How do services need to change?” If you think, for example, that a higher proportion of the growing NHS budget should go into mental health, that is a planning and funding—AKA commissioning—decision. If you just want to reproduce the status quo by giving more money to reproduce what is going on, you do not need that function at all, but we think you do need that function.

That is not the same as saying that you actually need the flow of funds to say, “How many clicks of the turnstile should there be for the outpatients in ENT?” In fact, it would make much more sense if integrated providers across primary care, community health services and hospitals could, in a way that is agnostic to the payments system, make the right choices about how to redesign care. We suggested, for example that 13 million out-patient appointments potentially will not be needed in future. We are not trying to remove the funding for the clinicians who are providing care; we want to give the freedom to enable those clinicians to use their time differently, to support people in better ways. That means we have to change the mechanics of the funding system. That is not the same as saying that there is not a strategic commissioning decision being made there, because that, by definition, is setting the agenda for the change we want to see.

Q130 Anne Marie Morris: Clearly the functions need to be carried out. However, I would challenge you to achieve that without making some very significant legislative changes, but let’s leave that there. If we are going along this journey of integration, across commissioning and provision, so that we are much more place-based, what is the point and purpose of so many different organisations, your STPs—or, in future, integrated care systems—your CCGs and the social care piece of local government? Surely you do not need three bodies?

Simon Stevens: Correct. They are going to converge. We have described quite precisely what an integrated care system is in the plan. We say that typically we think that that will be in a one-to-one relationship with the CCG and there will not be STPs.



Q131 Anne Marie Morris: Okay, I am confused. We have three bodies; two are statutory and one is not. Will the non-statutory one—which is supposedly the umbrella, and which will be the ICSs—be the body that survives in the long term?

Simon Stevens: It is a bringing together of the bodies that are the statutory bodies in an area, together with voluntary sector partners and so forth. In most cases, typically, it will have the same geography as the CCG. Until the law changes, if indeed it does, there clearly has to be a CCG for Devon that will in all likelihood correspond to the integrated care system.

Q132 Chair: Looking at figure 1 on page 12—which is a useful reminder of the history of NHS reorganisation—which of those models is closest to where we are going? Because it sounds like—

Simon Stevens: No, not at all. We are actually going to somewhere that this country has never been.

Chair: It is a new one. How innovative! I am being cynical.

Simon Stevens: I would point out that this is the first time that the NHS itself has suggested how we should be evolving. All of the changes that you see in that Report have been done to the NHS, not by the NHS.

Chair: But you are in charge now, so it is all right.

Simon Stevens: There is a wide consensus that we have to integrate care and everything else is just a means to that end, including the administrative superstructures.

Q133 Chair: It feels like we have gone from PCTs to CCGs. They have become small, now they are getting bigger. Are you reducing the running costs—forcing a running costs reduction—in order to push the mergers of the CCGs?

Simon Stevens: We are reducing running costs, because we think there is an opportunity to redeploy some of that funding for frontline care.

Q134 Chair: But it doesn't have to have the effect of forcing a merger?

Simon Stevens: It incentivises it, certainly.

Q135 Chair: Are you happy about that?

Simon Stevens: Of course.

Q136 Anne Marie Morris: Can I ask one more question? It is a great plan. I love the idea. I think you will be challenged in delivering it. When will you produce a framework, so that we can see how you are measuring your success and, hopefully, ensure bitesize chunks?

Simon Stevens: I can answer that very precisely. We are producing the framework for local parts of the country in spring and we will publish the implementation plan straight after the spending review in the autumn.

Q137 Anne Marie Morris: When will you report against that framework?

Simon Stevens: Yes.

Anne Marie Morris: When? When will we hear for the first time how you are doing on your journey?

Simon Stevens: For the year we about to go into, 2019-20, we are issuing the clear expectations of what the NHS will do tomorrow, so we will be reporting against those during 2019-20. The implementation framework and plan, which we will be developing with the NHS, to land a time in the spending review, will then be reported from next year for the subsequent four years of the five-year funding settlement.

Anne Marie Morris: Right. I look forward to seeing that.

Simon Stevens: Absolutely.

Q138 Gareth Snell: On that point, you said that the reduction in running costs was to incentivise mergers.

Simon Stevens: No, I didn't say it was to incentivise; I was asked, "Does it have that side-benefit or effect?" and I said that it did have that effect. I was then asked whether I was happy with it. Obviously, if I was not happy with it, we might not be contemplating doing it.

Q139 Gareth Snell: An important distinction, I admit. Where you have clinical commissioning groups that have a shared management team, which ideally would be merged but are refusing to merge because their local members will not accept a merger, do you have powers to force a merger and would you use them?

Simon Stevens: We have powers to— Well, the statute puts the onus on GPs in an area to come forward with their answer to the question, but the statute also enables us to step in where we have concerns about the effectiveness of the CCG.

Q140 Gareth Snell: So you would have to have a concern about the effectiveness to operate any powers to force a merger between CCGs that were reluctant to do so.

Simon Stevens: Yeah, which is perfectly sensible. If we didn't have concerns about their effectiveness, why would we?

Q141 Gareth Snell: And have you set a baseline for what that concern about effectiveness is so that you can't be accused of just saying, "We think they are not effective, so we are going to merge them"?

Simon Stevens: We have the CCG assessment framework. That is obviously one benchmark. As we just discussed with Anne Marie, we will have the implementation framework for the long-term plan, which will guide us further.

Matthew Swindells: We are increasingly judging the performance of a system, not just of the institutions within it, so the point you made at the



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beginning about the shifting of deficits backwards and forwards between organisations will no longer allow anybody to be a winner. You can't be a successful hospital if what you have done is bankrupt your CCG and you can't be a successful CCG if you have bankrupted your hospital, so we will also judge system performance as well as individual institutions. That means that if they cannot get round a table and have an adult conversation, the chances are that they are unlikely to be successful in the next generation of the metrics that we use.

Q142 Chair: I hear what you say; it's come through quite strongly in both panels. Nevertheless, the institutions' effectiveness has to be measured. We haven't even got a full evaluation of existing CCGs. They have also changed in shape and size over the last five years. Do you think that will be a problem as you go ahead?

Simon Stevens: There is a slight difference of nuance. We assess annually. The Report says that the Department has not done an evaluation in the round, but in a sense our long-term plan is that evaluation. Having taken account of the experience, what we are saying is, "Here is how we should now develop." That wasn't available to the NAO at the time.

Sir Chris Wormald: To defend my friend, the NAO was absolutely right that previously the Department had said it would do this after five years, and it hasn't. The NAO was correct to point that out. As a result, we reviewed that and have formally decided that we are not going to do that kind of review, for exactly the reasons that Simon says. So the NAO was correct to say that we had said we would do something that we are not now going to do.

Q143 Chair: One of the big concerns that was always around CCGs was their different sizes and different natures. We can let a thousand flowers bloom up to a point, but we have seen challenges with that. You talk about it coming from the bottom up. You have then talked about setting a framework from the top down. Where do you see the shape of the NHS at this level coming from? You have set out a plan that gives a framework, which is still to come. The budget will make a difference. How much real local say will people have? Mr Snell has helpfully highlighted the poll that shows that GPs do not feel they have an influence. There is the issue about local populations having an influence. As these changes have gone through, there has been a lot of suspicion about the STPs, for instance, because there is often very poor accountability to the local areas. How will you bridge that gap, Mr Stevens?

Simon Stevens: As we have talked about, part of the issue with some of the original STP work was that they would have to do it under incredibly constrained financial circumstances. Now that we have got an improved financial outlook for the next five years, that will clearly help. The first thing I would say is that, on the spread of population sizes for CCGs, as figure 4 points out, that is hardly a new development when you look at the spread for PCTs as well. What that tells us is that the geography of England is such that we do need some heterogeneity.



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Q144 Chair: But there was an important difference there because PCTs were coterminous with council areas for the most part, or at least where they were for two areas, whereas some CCGs were very tiny with a handful of GP practices, and some were much bigger. So there was a difference there. Are you content to see that sort of difference continue or do you think there is an optimal size?

Simon Stevens: We would expect that most of the ICSs will not have a one-to-one relationship with an upper-tier authority, but will not generally cross the lines of upper-tier authorities. There may be a small number of exceptions, as there are now, but that would be clearly one of the considerations that we would bear in mind when having that discussion with them as to what they propose.

Q145 Chair: You were clear that you did not think there would be 42. You were not going to set a number, so you do not have an optimal size.

Simon Stevens: I am not going to set a number today. This is a conversation we are going to be having with people between now and the autumn as we, as Anne Marie said, sort out what their implementation framework will look like.

Chair: So do you have anywhere in your mind—or in NHS England—

Gareth Snell: What is in your mind, Simon?

Q146 Chair: Well, what's the difference? Sometimes I wonder. Anyway, I mean whether something is too small or too big. Devon is obviously a big county. Hackney is a fairly big London borough, but with a small geographical footprint. Is there somewhere that, if a proposal came forward, you would just know it would not work, or that you have decided you would rule out—that is just not going to be cost-effective?

Simon Stevens: The way we have been discussing it with people—with GPs, with hospitals, with local authorities, and patients' groups as well—is that, really, there are three levels of action. There is the very local—the immediate neighbourhood, really. That is the groups of GP practices—maybe a 30,000 or 50,000 population level or something like that. Then there is what local government calls “place”, which is maybe a few hundred thousand people. Then in some areas there is a much bigger aggregation where a lot of the health service planning across individual hospitals and other services might need to occur. So really the question that, pragmatically, has got to be answered by the NHS locally with its partners is “What is the biggest geography that you can have while still retaining the sense of ‘us’?”.

Q147 Chair: Can I give you one example. I do not usually use personal examples, but as you may know, I have had quite a lot of experiences as a mystery shopper in the NHS. I crossed three borough boundaries, by complete fluke of geography, to discover that if you bring a bit of equipment home from a major London teaching hospital to a neighbouring borough, it is difficult, because the district nurses are not able to provide support, because they do not have that equipment.



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Something as simple as that can make it difficult to take a patient home. Is that something that the integrated care system can solve? It is a very simple thing, but it is a very big thing.

Simon Stevens: I think that makes the point well that simply organising services on a Hackney basis—Hackney is a wonderful part of London—

Chair: Absolutely. Glad you have got that message.

Simon Stevens: But there are other, adjoining parts of London that also need to be considered. Probably—that is a great idea and you did— it should be addressed to the previous panel, given that you had the accountable officer for the CCGs in your area on it.

Q148 **Chair:** It is interesting, because the hospital will commission its own equipment on probably a good procurement basis. How is that kind of level of detail—tiny procurement, really—going to be made to integrate? That is a small one. It is not what most people think about, with integrated care, but it is a significant issue if you have not got bits of equipment—

Simon Stevens: It is, and I think it points to a slightly different question as well, which is not just about the commissioning arrangements, but which is about what is happening inside community health services. Frankly, one of the big opportunities for expansion, but also with a big efficiency opportunity, is inside community health services. It has been a bit of a sort of opaque part of the health service, albeit a very important part, but as they are now coming into prime time, there is going to be a lot more engagement with the community health providers as to exactly how those services are working.

Q149 **Chair:** So all of that is part of your vision for integrated care.

Simon Stevens: Yes, because we are spending about £27 billion between primary care, community health services and outpatient services. Those are in three different funding, employment and clinical team buckets, and they have got to join together because the people they are looking after do not distinguish in that way.

Chair: Exactly.

Q150 **Anne Marie Morris:** Am I not right, Mr Stevens, that in terms of medical devices, in future they are not going to be procured locally by CCGs? There is going to be a centralised procurement body. Is that not the plan?

Simon Stevens: I would distinguish between medical devices versus equipment—wheelchairs, crutches, or home aids and adaptations—but, yes, there will be a new funding guarantee for medical devices, medical tech, that has got a NICE cost-saving designation. For things like the new glucose monitoring, we are going to be funding that nationally, so that every CCG should be making that available from April as part of our upgrade for diabetes care.

Q151 **Chair:** Will they be able to return, then, to any places in the NHS?



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Obviously we have seen the recent publicity about that.

Simon Stevens: Well, that is a point that has been raised around being able to give crutches back to hospital when you have been discharged, overcoming some of the waste that exists there, quite frankly. Hospitals do need to do a better job on that—no doubt about it.

Chair: It is interesting that, talking to nurses on the frontline, they do not like letting things off their ward, in case they do not get it back, let alone out of the hospital, so there is some way to go there.

Mr Snell has a brief point, and then I have got one last thing.

Q152 **Gareth Snell:** May I briefly ask about overlaps? When the Government set up LEPs they allowed them to overlap because they felt that there would be a benefit. In communities that are on borders of regions or of counties, people may access other facilities. Stoke is a prime example; lots of people use Leighton hospital in Crewe, which is not only in a different county but a different region.

Will ICOs be flexible enough to respond to that, so that for service delivery at region points, and even on the Shropshire-Wales border, the interaction will be such that the money will follow the patient sufficiently, so we do not end up forcing people to travel to the other end of the county to use a facility just because it happens to be in the right postcode, as opposed to using the one that is nearest?

Simon Stevens: Absolutely. To coin a phrase, the money needs to follow the patient. As you were saying that, I was thinking back to when I was last in your local hospital's A&E—not this Christmas, but last Christmas. Obviously, many of the west midlands' ambulances come to that hospital from all around, and vice versa, so yes, we absolutely have to keep that flexibility.

Q153 **Chair:** I have a quick question. We have obviously looked a bit at the rising cost of clinical negligence across Government. I wondered, Mr Williams, whether there has been any progress on tackling that?

David Williams: The Bill has now received Royal Assent. That is the main element of progress. The legislation provides for a review before the discount rate is changed. My expectation is that that will allow the discount rate to be changed in the second half of 2019, if that makes sense.

As you know, in terms of our previous hearings and engagement, relatively small changes in the discount rate have quite a large impact on our future liabilities. I think as we have set out in our annual report and accounts, a 1% increase in the discount rate would reduce our assessment of the future liabilities by around £10 billion. That is probably the main thing I would highlight. As we discussed last time—

Q154 **Chair:** I haven't kept up with the progress of the Bill. You said it has been published, or drafted—I did not quite hear.



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David Williams: I think the Bill got Royal Assent. It is just that the legislation provides for a review period before—

Q155 **Chair:** So it is now an Act—forgive me. When will it make a material difference in the accounts?

David Williams: Not this year, but conceivably, should action be taken to change the discount rate, in the next financial year.

Chair: Okay—that is helpful for us to keep an eye out. Thank you all very much indeed for your time. As ever, the transcript will be up on the website in the next couple of days, and we will be producing a report some point in February probably. Thank you very much indeed.