HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Adult health screening, HC 1746

Wednesday 20 March 2019

Ordered by the House of Commons to be published on 20 March 2019.

Watch the meeting

Members present: Meg Hillier (Chair); Sir Geoffrey Clifton-Brown; Caroline Flint; Nigel Mills; Stephen Morgan; Anne Marie Morris; Bridget Phillipson; Lee Rowley.

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

Questions 1-202

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, Simon Stevens, Chief Executive, NHS England, Duncan Selbie, Chief Executive, Public Health England, and Professor Sir Mike Richards, Non-executive Director at the Department of Health and Social Care and Leader of the independent review of cancer screening services and diagnostic capacity.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Investigation into the management of health screening (HC 1871)

Examination of witnesses

Witnesses: Sir Chris Wormald, Simon Stevens, Duncan Selbie, and Professor Sir Mike Richards.

Q1 **Chair:** Good afternoon, and welcome to the Public Accounts Committee on 20 March 2019. We are here to look at an important National Audit Office Report on the management of health screening—obviously, that has been in the headlines for various reasons recently, as we will pick up on in our session.

Clearly, health screening is absolutely vital for the public health of the nation and for identifying potentially life-threatening illnesses at an early stage, but none of the health screening programmes that we are looking at achieved their standard target for coverage in 2017-18, and cervical screening missed even its lower target on those occasions. Clearly, we want to look at what is happening. We recognise that there are challenges with IT systems. We also recognise there are inconsistencies around the country.

We have in front of us witnesses from the centre—the top end of it—who are setting the standards and trying to make the whole complex picture work. There is also a lot of work going on to reconfigure and change things. HPV testing is starting in just nine months' time, and there is the reconfiguration of pathology labs, which we want to touch on in our hearing as well.

I want to introduce our witnesses. From my left to right, we have Professor Mike Richards, who is responsible for the national programme and for advising Public Health England. Through the Independent Review of Cancer Screening Services and Diagnostic Capacity, he is setting the policy tone from a clinical perspective. Is that a fair summary?

Professor Sir Mike Richards: I shall do my best to fulfil that.

Chair: You are the man who knows about it, and the others implement it.

Sir Chris Wormald: Yes.

Simon Stevens: Yes.

Chair: If we have any difficult questions, I will come your way. We then have Sir Chris Wormald, the Permanent Secretary at the Department of

Health and Social Care—welcome back; Simon Stevens, the chief executive of NHS England; and Duncan Selbie, the chief executive of Public Health England. Those three set the approach to how the screening processes take place. I will kick off by asking Stephen Morgan to start.

Q2 **Stephen Morgan:** I want to ask some questions about the performance of screening programmes. How content are you that none of the health screening programmes is meeting your standard performance targets?

Simon Stevens: I do not think we are content. The first thing to say is that the numbers of eligible people who are going through screening, particularly for breast cancer and bowel cancer, are continuing to rise: more than 400,000 additional people are getting screening through those services now than five years ago.

But we aspire to do more, so part of what we are doing is looking at whether we have the most modern screening modalities to encourage uptake. That is part of the reason why we are moving to a more accessible FIT test, for example, for colorectal cancer screening, which in turn will reduce some of the pressures on the endoscopy capacity. We are looking at new methods for breast screening. Part of the reason why I have commissioned Sir Mike Richards to do the screening review is to look forward as to how the screening programmes in the round, including breast screening, should evolve.

We also have to have a more differentiated approach to how we target uptake, because we can see big differences. The Report principally exemplifies them as geographical, but actually they are, to a large extent, demographic. We know that, for example, there is a big difference in the uptake of bowel screening. Ethnically diverse parts of the country have an uptake of around 38%, compared with 52% to 58% in other parts of the country. We can see there are differences between socioeconomic groups and so forth.

So we have to make the screening services more easily accessible with evenings, weekends, car parks and new approaches to case finding with low-dose CT scanning and so on. Mike is going to be setting all this out for us, so that we have a modern screening service in the round and we implement that alongside the big changes we have signalled in the long-term plan.

Sir Chris Wormald: I agree with everything that Simon says. The only thing I would add is that we have a look at how we benchmark internationally on this. That is quite difficult, because most countries do their screening slightly differently, but the benchmarks we do have show that we benchmark reasonably well in terms of take-up against our normal competitor countries.

There is very little benchmarking around the actual quality of screening, so it's quite difficult to tell about the effectiveness, although of course there are studies, including one earlier this week, about things like cancer survival rates, which are of great interest to us. I completely endorse

Simon's overall assessment of the position. We have quite a lot that is quite good about our screening, but there are quite a lot of things where we need to do better.

Chair: In summary, a lot needs to be done, which we will spend the next hour and a half or two exploring.

Q3 **Stephen Morgan:** Could you say a bit more about whether you think the coverage targets are realistic if you have not been able to achieve them to date?

Simon Stevens: We moved to a position where, instead of looking at what the previous year's coverage had been and then trying to push a bit, we, with Public Health England, looked at what we thought would be the baseline level of performance—the realistic performance that we would want to try to push people towards—and then a stretch ambition on top of that.

That is, I think, in principle the right approach, but what I would like us to do, particularly as part of our approach to reducing health inequalities, is see whether we can't decompose the aggregates so as to look more specifically at screening uptake from groups in the population that are not accessing these screening services, and have a particular effort there.

Q4 **Stephen Morgan:** I have been looking at that data across CCGs. Could you say a bit more about why we have a postcode lottery for uptake of screening?

Simon Stevens: Although the data are presented in figure 11 by CCG, CCGs are of course not actually the principal actors in running the various screening programmes, as set out in the NAO Report, so a lot of that will be confounded by some of the other variables I talked about, in terms of socioeconomic status, ethnicity and so forth, but there are sometimes particular issues.

As you will know, Portsmouth hospital has had a particular issue with staffing, and hence delays, in some of the screening services. Where that happens, our local teams obviously have to work very specifically with the hospital in question. The same has been true in Brighton, for example.

Sir Chris Wormald: Just on that point, Mike and I were discussing it earlier this week.

Professor Sir Mike Richards: I have been looking into this, with analysts, at CCG level to see what the differences are, and a lot of it is explained by either deprivation or, interestingly, the age of the population. For CCGs that have an older population, the uptake and coverage levels are higher. That does not explain the whole difference, but it does explain part of the difference.

Q5 **Chair:** What levers do you have to go in if a hospital like Mr Morgan's is having problems? It is challenging for you to sort that out from the centre. When you say that you go in and help, working with the hospital,

what does that mean?

Simon Stevens: We have a set of performance objectives. The funding agreement with each hospital is part of the overall NHS standard contract, so there are a set of escalation routes. In the case of Portsmouth, we are having a direct dialogue with the hospital. That was not the only issue that Portsmouth had. The new leadership at Portsmouth hospital is getting to grips with a number of the issues there, and we will track that very closely.

Duncan Selbie: We are concerned here with the four programmes, but all 11 programmes are part of a quality assurance process involving NHS England—the provider—and Public Health England. There are individual quality standards for each programme. Those are quite different from the quality standards set at national level; these are for individual programmes. We look at things like round length, the accuracy and quantum of tests, the return rate of tests and the experience and expertise of staff.

In breast screening, there are 18 standards. We always set two standards in the individual programmes—the, if you like, minimum acceptable standard that the programme must deliver as we need it to, and the stretch. As Simon said, for the first time those two levels were set nationally, but they have always been different; there is an acceptable target and an achievable stretch target.

There are literally hundreds of examples of how problems are identified and addressed locally. Obviously, there is an escalation route, which comes through commissioning and ultimately goes up to NHS England, and Public Health England is fully engaged in that.

Q6 **Stephen Morgan:** On that point, you talked about deprivation and demographics being key, but tell me more about how you share learning around areas that are doing well and others that are not doing so well.

Simon Stevens: One aspect is that we think there are opportunities to engage with communities in ways that are not standard for the NHS, such as when we would send a letter, and if they did not come we would send another letter.

For example, we want to work with faith communities. I was at a meeting three weeks ago of our Muslim health network, working with imams and others to increase our understanding and the acceptability of the uptake of cervical screening invitations and breast screening invitations among women.

In cities such as Leicester and Bradford, there is a very low uptake. We have to work with broader community leaders at one end of the spectrum. At the other end of the spectrum are some fairly straightforward things that are now being rolled out across the NHS, such as text reminders to people's phones and personalised letters that come from someone's GP, rather than the national screening programme, all of which have been shown to increase uptake.

Q7 **Caroline Flint:** I was public health Minister between 2005 and 2007, and we were using social marketing back then to identify the demographics that were most far away, if you like, from accessing services, so I do not think that this is new, is it, Mr Stevens? Could you clarify for me who is actually responsible for doing the proactive advertising and marketing work and initiatives to reach people who are distant from normal communications? Is that nationally—you—or locally, by CCGs? How much has the spend gone up or down in recent times?

Simon Stevens: For example, if we have work to do with Bradford, we need to do that with the Bradford hospitals, CCGs and community groups. However, local screening teams have a particular responsibility for tracking uptake and for working on those approaches.

Although you say it is not new, it clearly is, inasmuch as these things are not a universal part of what is happening where it is needed across the NHS. The number of people coming forward for screening has continued to increase since the period that you referenced, so we have been getting more successful at getting more people in screening programmes over the last decade.

Duncan Selbie: I think it is connected. Can I give London as an example? The NAO very accurately said that, over the course of the last three or four years, locally, London working as a whole—because it centralised all the administration for the rest; the five areas in London still do their own local thing, but they have a whole centralised arrangement—have improved their uptake by five points. That has moved from 64 to 69. It is not where we want it to be but it is significantly better, for the reasons that Simon has given about texting, the GP, signed letters and so on; but also—recognising that parts of London are just harder to reach as they simply do not have an underground network: the further reaches of south-east London—mobiles going into those areas, so people don't have to travel into London.

A really positive thing has been using mobile phone numbers that GPs have. Young people particularly travel with their phones—never mind whether they have the same GP. Being able to use, directly, up-to-date numbers for texts has all made a difference.

We can and should and do seek to see that spread across the country, but I think Simon and Mike both talked about the three things that we know we need to do to make things more pleasant, and easier for people—which of the new tests are just less invasive and frightening. We need to make them more accessible, which I think might be talking, notwithstanding the things we have said, about other things we might do—stratifying, targeting and using social media. We will maybe talk at some stage about cervical cancer and what we are doing about the campaign there.

Q8 **Stephen Morgan:** That is a really good example in London, but what I am not hearing from you is how, where areas are not doing very well, that information is being shared and we are learning from good practice across all the CCGs. Could you say a bit more about that please, Mr

Stevens?

Simon Stevens: One of the indicators we are going to be using as part of the long-term plan implementation that we have talked about before is inequalities reduction. As part of the long-term plan implementation that is going to be drawn up by every part of the country between now and the autumn, they are going to have to show how they are reducing inequalities and using some of the inequalities funding that is built into the overall increase to do so. As part of that, this is going to be one of the things we are going to be looking at. Public Health England has already now published information on what best practice looks like around uptake and inequalities reduction.

Q9 **Chair:** Okay, perhaps Mr Selbie can tell us a bit about that.

Duncan Selbie: We have never done this before. The funding formula, going back many years, always had quite a sizeable element for addressing deprivation or need—

Q10 **Caroline Flint:** Sorry, but you have—

Duncan Selbie: No, about giving visibility to it.

Chair: What does that mean?

Duncan Selbie: It means that every STP, integrated care system, will have to show how they are using that element of the funding to close the inequalities gap. We have not done that. We haven't. There has not been visibility to that.

Simon Stevens: I think the distinction Duncan is making, just to clarify, because I can see puzzlement on Caroline's face—

Chair: Ms Flint's face.

Simon Stevens: On Ms Flint's face: the approach that was taken to health inequalities during the 2000s clearly did have targeted efforts and particular geographies and made a big difference. What Duncan is talking about, however, is that as part of the funding that a local part of the NHS gets, we build in an extra part specifically linked to the fact that you have higher health inequalities. What we have never done before is actually say, "Show us how you are using that extra health inequalities payment to fund some of the interventions that would make a difference." That is what we are now requiring.

Duncan Selbie: That will close that gap.

Q11 **Stephen Morgan:** Give me another example of how that work will lead to improved outcomes in the worst-performing areas.

Simon Stevens: If you take the case, for example, of low-dose CT scanning for lung cancer, we have tested that now in Greater Manchester and other areas, and as a result, again, in the LTP, are going to be rolling that out to high-prevalence parts of the country. Mike might want to talk about that, because there is something of an interesting debate in the

public health world as to the difference between screening and case finding in high prevalence areas. This is one of the things that Mike is going to be addressing explicitly.

Professor Sir Mike Richards: This comes down to the difference between so-called population screening and targeted screening, or high-risk screening. With lung cancer screening, we already have one published trial and another that has been presented in public—a lot that has not actually been published—both of which show that there is a reduction in death rate from lung cancer. So it is really very encouraging.

Q12 **Chair:** That is targeted screening.

Professor Sir Mike Richards: In their studies, they were randomised trials, but they were identifying smokers, basically. That was the targeting element of it. I think that would be the way that we would be going in this country as well. What Simon was talking about was that, based on the experience of those trials, and the experience in Manchester and other places, we are now setting up low-dose CT scanning, encouraging people to come forward for a health check based on the fact that they are a smoker. They come and get seen and assessed. They blow into a box, basically, to look at their lung function, and then they may get a CT scan after that.

We are very optimistic about what that is going to show. That is an example of targeting at a specific group. That group happens to be defined by smoking. In the future, we may well be targeting groups based on their genetic profiles as we know more about that. Indeed, we may be able to reduce the amount of screening for some groups with, for example, cervical cancer, where we have done the vaccination and we know that they are at lower risk than others. I think we will be seeing a move towards more targeted screening.

Q13 **Stephen Morgan:** You say that you are optimistic about the future. What sort of targets have you set yourself in terms of reducing the inequalities around the screening?

Professor Sir Mike Richards: As yet I haven't, but, for example, I was at a meeting of the advisory committee on cervical screening this morning and I asked that very same question to experts. Their immediate response was: "Can we get back to the uptake in coverage levels that we had a decade ago, which was more like 80% rather than 70%?"

We know that about half of those who do not go for screening people intend to go for screening. That is where I think the convenience element becomes so important. Can we make it more convenient for them to go? Can they go out of hours to their GP? In some places they can already; in some they can't. Can they go to somewhere near their work, for example? There is a range of different things that we need to look at to see whether we can make screening more convenient.

Q14 **Stephen Morgan:** Mr Stevens, the same question to you: what is your personal target of reducing the inequalities around the screening?

Simon Stevens: I am going to defer to Mike. Obviously that is the reason I commissioned him to do this work.

Q15 **Stephen Morgan:** You must have an ambition that you would like to achieve.

Simon Stevens: We do have an ambition, which it is to increase the proportion of cancer patients in England who get diagnosed at stage 1 or 2, when it makes most difference for their treatment and survival, from about half now—52% to 53%—to 75% over the course of the next decade.

Part of the way that we are going to do that is by improving screening performance, and part of the way that we will improve screening performance is by reducing inequalities in uptake. That is the overarching goal that was set in the long-term plan, and this is an important building block for it.

Duncan Selbie: If you put the question to me at the outset about whether I am content with where we are, of course I'm not. The most striking thing about all this is the variation and inequalities, which are predominantly to do with income and deprivation. Although there are very many good things to say about screening, and many lives saved, we clearly are not reaching enough, or those who are most vulnerable.

The reset of all the attention that is now being given to screening gives us the opportunity, building on the long-term plan and on Mike Richards's review, to be really ambitious. Screening and immunisation is second only to clean water in preserving and saving life, and it is not all right that we have these variations.

You asked: what should we be aiming for? It is that every individual who can benefit from a screening programme gets it. We are going to have to do things that we have not done before. We have not been sufficiently focused on this, to make sure that that is what we are aiming for.

Q16 **Stephen Morgan:** I would like to move on to cervical screening results. I can see that there has been some improvement more recently on those, but why have you failed to get so many women through the cervical screening results within the 14-day target?

Duncan Selbie: The key thing, which maybe speaks to the campaign that we have at the moment, is to get women to go and have the test. Clearly, 14 days is important, as is making sure that we get fast results to women. The key message we are trying to get across is that we want women to come forward to have this screen. We have all spoken about the new HPV first approach, which came out of the UK National Screening Committee. It is in women's interest. This will make a big difference, but it takes time. The transition is a longer one than we would have hoped for, but it is coming to a close. Next month there will be a decision taken by NHS England about where the regional laboratories will be, with the object of those all being rolled out by the end of the year.

Chair: We are jumping ahead a bit. I think Mr Morgan was asking about

the number of women getting cervical screening at the beginning.

Q17 **Stephen Morgan:** How long are they currently waiting, on average, to get the result?

Duncan Selbie: It varies hugely around the country.

Chair: It is very varied; we have had some results from our constituencies, and it is incredible.

Q18 **Caroline Flint:** What is the basis on the 14-day target?

Simon Stevens: I think Mike will tell us there isn't one.

Q19 **Caroline Flint:** There isn't one?

Simon Stevens: Yes.

Professor Sir Mike Richards: This was introduced about a decade ago, largely based on the fact that if a woman has been for screening, it is only right that she should get the result back in a reasonably prompt way. There was discussion at the time—I was the national cancer director then—about what the time limit should be. There were people who said it should be two days, but that did not seem reasonable at all, and it was agreed that it would be two weeks, as a target. The main problem at the moment, as Duncan has said, is this change over to primary HPV testing. That is testing for the virus that causes the cancer as the first test, and then reserving looking down a microscope at the cells for those who have an abnormal HPV. It is a much more automated test. In the end, far fewer tests looking at the cells will be needed, so it will be much more efficient, but during the changeover time, we are really pressed.

Sir Chris Wormald: To be absolutely clear on the question, as I understand it, there is not a clinical reason for 14 days, but a public service reason?

Professor Sir Mike Richards: It is a public service reason; I do not believe it is a clinical reason.

Q20 **Bridget Phillipson:** If that is the case, are you considering that time response as part of your review—to consider whether it is appropriate to tell people 14 days, if that is simply not going to happen?

Professor Sir Mike Richards: I am happy to consider that along with everything else, but, in practice, what we should do is aim to get back to that, because we were achieving it until a few years ago, and I think we will again now that we are changing the technology to primary HPV.

Q21 **Chair:** Is there a clinical optimum for when you need to know?

Professor Sir Mike Richards: No, it is as Chris said: it is about what is a reasonable service to be offering the public. That is the reason.

Duncan Selbie: Psychologically, no woman wants to wait any amount of time.

Q22 **Bridget Phillipson:** If you are told 14 days, and it is a lot longer than 14 days—

Caroline Flint: You think something is wrong.

Bridget Phillipson: Recently, I waited a lot longer than 14 days to get my results back, at which point you begin to think, "There is something seriously wrong here." I just wonder what impact that has on women coming forward, if you are left waiting a long time for the result in the first place.

Duncan Selbie: This is a difficult period of transition, and the conversation we hoped would be happening at a local level—because this is all organised through GP practices—would be that they are saying, "There'll be a bit of a longer wait." If people are saying, "It's 14 days," when we know there is a lot of variation while we are going through this period, that is obviously not helpful. We do not want people waiting.

Q23 **Chair:** But where is the communication on this?

Duncan Selbie: There is—

Chair: Saying, "You might have to wait longer. Don't worry"?

Q24 **Bridget Phillipson:** You mentioned the campaign you are running at the moment, and Simon Stevens also talked about differentiated uptake in terms of screening. How is your campaign targeted to ensure that we are reaching those groups—particularly when it comes to cervical screening—that are least likely to present for screening?

Duncan Selbie: This is the first campaign aimed at screening. We have had lots of other campaigns over the years on the signs and symptoms of cancer. Of course, that is not what screening is about, so there is a lot to learn about this campaign. It is running, as you know, for another five weeks, and it is aimed principally at people who intend to come for screening but who, for various reasons, have not managed to make the appointment. It is aiming at people who have an appointment, to say, "Please keep it," or, "If you haven't had one, please organise one." It is targeted using national television but also local media and social media—lots and lots of local work to reach the people we are trying to get to.

Q25 **Bridget Phillipson:** Why has screening reached a 21-year low? What are the factors behind that?

Professor Sir Mike Richards: The simple answer is that we don't fully understand why the coverage rates and uptake rates are going down. Interestingly, I asked that very question to the experts this morning, and their overwhelming view was that it is because people are living busier lives, and that we need to make it more convenient for them to get to screening. That is the key message from them.

Q26 **Bridget Phillipson:** But the same is true of other screening processes, and they are not necessarily suffering the same falls.

Professor Sir Mike Richards: That is true. Of course, there are different age ranges involved in the different screening programmes. A lot of the people who are eligible for cervical screening are young mothers or people who work all day, so there are differences in that way. I don't think we fully understand it.

Q27 **Bridget Phillipson:** Are we going to try to understand it?

Professor Sir Mike Richards: I think we should undoubtedly try to understand it.

Chair: Who is doing that?

Q28 **Bridget Phillipson:** Are we actually going to speak to any women about why that is?

Professor Sir Mike Richards: Jo's Cervical Cancer Trust has done a lot of work on this. Its chief executive was in the room with me this morning. There are concerns about fears, embarrassment, the virus and various different things like that. Again, they all came back to the point that making access easier was the way forward.

Q29 **Bridget Phillipson:** Was there any active consideration about whether the GP is the best route for women to access screening?

Professor Sir Mike Richards: At the moment, about 95% of all tests are done through a GP surgery.

Q30 **Bridget Phillipson:** But we know that that is at a 21-year low.

Professor Sir Mike Richards: That is at a 21-year low. That is where we need to be offering choice. We also need to have the IT systems, so if you have been screened in one place, you can get the result back from the main system. I am sure we will come on to that. Those sorts of convenience elements will need support.

Q31 **Chair:** Who of the three of you is responsible for trying to deal with the problems that Sir Mike has outlined? Duncan Selbie, you were itching to get in just now, so perhaps you can tell us.

Duncan Selbie: Although it is the first time we have campaigned in this particular area, we will be evaluating all the way through. As Mike says, it involves Cancer Research UK and Jo's. We have spoken to hundreds of women about how to land this. It has already been said that they think it is frightening, it might be painful, it might lead on to something quite scary, and it is not sufficiently convenient. There is a whole range of different things. We will learn from that and build on it. We will obviously share with you what we have learned through that and everything else that we want to do—the new light that we are shining on screening to close the gap.

Q32 **Bridget Phillipson:** I just wonder how we reach those under-represented groups if the regular, traditional method of going along to your GP surgery will always be the best way to increase take-up. For people who live uncomplicated, straightforward lives, who have a GP and who find it

easy to make an appointment, that is fine, but for groups that might be at a high risk of developing problems—

Duncan Selbie: We want to find multiple ways of making it much more convenient for people to be able to just walk in or, for HPV, do it at home. We are piloting a home test in parts of the country so people don't have to go in. There are lots of different ways. We are looking to Mike to present us with a whole series of things that we haven't even begun to think about, so we can join this up and make it more convenient.

Q33 **Bridget Phillipson:** It has to be geared to the needs of the woman, not the needs of the professional delivering the service.

Duncan Selbie: Absolutely. This is all about making it convenient and accessible for the woman concerned. It is not all right that we have got this low uptake. It is just not okay. The campaign is just one way of trying to talk to women about this.

Q34 **Bridget Phillipson:** I really welcome the campaign that you are running. How long will that last, and what will happen afterwards? Is there funding for subsequent campaigns?

Duncan Selbie: In the first instance, it is an eight-week campaign. We think we are quite good at doing this. We will obviously evaluate it to see what worked, what didn't and what we should do differently next time, and then we will have to make a choice about what we invest in. I cannot conceive of a future in which we are not doing more of this.

Professor Sir Mike Richards: I have a couple of things. Duncan was referring to HPV self-sampling. I think that has great promise. It has been tested in some other countries, and we are about to do pilots of it in this country. If we find that those are successful, that may well be able to reach people who aren't being reached by the current service. We always want to introduce these new things in a planned way to make sure that they are not going to have an adverse impact on the programme as a whole. We are doing that at the moment.

Q35 **Caroline Flint:** As someone who has had cervical cancer screening, breast screening and also the bowel scope—because I have reached that age—I want to say for the record that my NHS experience has been absolutely wonderful. All the people involved in it have been fantastic. But having said that, Mr Selbie—

Chair: There is a "but".

Caroline Flint: From the way that you are presenting information this afternoon, it sounds as if some of it has come as a bit of a shock or a surprise. It sounds very reactive. Obviously, Public Health England is responsible for looking at the data to see what trends are happening. Why is it coming across today that these dips, in terms of people coming forward and the problems that have been identified in the NAO Report, seem such a surprise to you?

Duncan Selbie: It is not. I am just being as authentic as I can be. At the end of this are people. There is so much to be proud of, as you have just described. Millions of people have benefited, and many thousands of people work hard every day to deliver the best service that they can. We know that. Equally, it is the case that there is variation in it, and that is not okay. The reset is a vital moment for all of us. It is a one-team effort here. We know that we need to pay more attention to this, and that is the commitment that we make in response to the NAO and to you this afternoon.

Chair: We are going to talk more about that.

Sir Chris Wormald: What struck me looking at this is that it is a continuously moving target, as it were. Screening systems have to adapt to the way people are changing their lives, the way demographics change and the way technology changes continuously. Our challenge on this side of the table is how we keep up with all that, as well as building—

Q36 **Chair:** Yes, but that is the bread and butter of it. That is what happens in all areas.

Sir Chris Wormald: Because this area has all of those elements to it in a way that most don't—I think you agree with this, Sir Mike, because we talked about it—there is a particular challenge for screening programmes beyond those of quite a lot of health programmes. You are trying to keep up with all those three things simultaneously. The challenges of 10 years ago are not quite the same as the challenges now and won't be the same as the challenges in 10 years' time.

Caroline Flint: Some of the challenges are the same.

Q37 **Bridget Phillipson:** Have the challenges really changed so much for your average woman in 10 years that cervical screening levels have dropped so far?

Sir Chris Wormald: I make the point because, very frequently, when we are looking at where the system is not working—and we are trying to be very straightforward about where the system is not working, which is why everyone wants to review this—it is not the average person. We are dealing with the people who, as it were, do not, as you said in an earlier question—

Q38 **Caroline Flint:** They existed 10 years ago.

Sir Chris Wormald: So they have different characteristics now. Sorry, Sir Mike—this was a point you made, so—

Professor Sir Mike Richards: I think there are changes. The really good news about cervical cancer is that the numbers of new patients are coming down. There are actually fewer people who are aware of a friend or a neighbour who has had the condition than there were. It is one of the great successes of screening. If you look at the cervical cancer incidence rate, it turned a corner when we introduced proper call and recall cervical screening.

Q39 **Chair:** So it is better than it was.

Professor Sir Mike Richards: Because of that, it is a much less familiar condition now. That is one of the changes. The technology has moved on. We brought in liquid-based cytology; we are now moving to primary HPV. Those are all improvements, and we will save more lives as a result of that. The vaccination will have another major impact.

Q40 **Bridget Phillipson:** As part of your review, has any consideration been given to looking at the evidence around the screening age, and particularly whether it is appropriate at the upper end? I know there has been a lot of focus on whether the lower age limit is set at the right point, but what about at the upper end?

Professor Sir Mike Richards: I think it is quite important to remember that I am not replacing the National Screening Committee, which makes those recommendations. I am looking at what shape the service needs to be to deliver the best results.

Q41 **Bridget Phillipson:** But we need to be well prepared if there were to be further extensions to screening programmes, to make sure that we are—

Professor Sir Mike Richards: Absolutely—I completely agree with that. But please do not think that I will make the recommendations on what age it starts or stops.

Q42 **Caroline Flint:** But it is fair to say—isn't it?—that with reform of screening and some of the problems you have identified, we can understand some things have not changed in terms of some of the problems, I have to say, and therefore it has actually been quite slow. It seems to me that 10 years is too long to wait to reform a screening programme.

Professor Sir Mike Richards: What I am hoping is that my recommendations will be out within a few months of now and I very much hope that my colleagues there will—

Chair: But you weren't responsible for the screening—

Caroline Flint: You are not responsible, Professor.

Chair: Simon Stevens—it's taken a long while.

Caroline Flint: It's the department of environmental health, Public Health England, NHS England—10 years is a long time to address some clear problems that have emerged. In fact, 10 years is too long, isn't it?

Q43 **Chair:** Let us look to Sir Chris, because, of course, you were at the Department for Education. You saw trends there in the pupils left behind; there was an awful lot of data on that. You have seen trends in the Department of Health. So 10 years is just too long; you could pick up things on this much quicker.

Sir Chris Wormald: This is what I was, slightly inarticulately, trying to get at before. I don't think it is correct that nothing has happened over 10 years; an awful lot has happened over 10 years—

Q44 **Caroline Flint:** Nobody is saying that. We are pinpointing that there are particular problems in the service, which are articulated in the NAO Report, which all of you signed up to, as far as I understand.

Sir Chris Wormald: We are not denying any of those issues, and as we have said, there is an awful lot that is right about our screening system, which, as I say, you and others have pointed to as well, and there's an awful lot that needs to improve, both to improve the core system and to make it ready for the kinds of change that Mike has been describing.

So, we are not trying to suggest that the things that are identified by the NAO—

Q45 **Caroline Flint:** Has reform in screening been too slow—yes or no?

Sir Chris Wormald: I don't think I am in a position to judge. There has been quite a lot of reform; there needs to be more.

Q46 **Chair:** In all these programmes of education, is anyone ever explaining to women, particularly young women, what a cervical smear involves? With due respect, some of us around this table have more experience than the four of you. It isn't a pleasant experience and I think that's not something that people talk about—

Caroline Flint: Do you want me to have a go? No. *[Laughter.]*

Chair: And we have given birth; let's just say that as well, because we might as well.

However, I think that it is easy to talk in theory; that is the point. But actually, you can have education and go and have it, but it's not something that you go back to your girlfriends, or your daughter, or your mother and say, "That was fantastic. Go do it!" There is a type of problem on the health side, which of course you've got to watch for, but there's also the experience side, which Ms Phillipson was trying to get out of you. Do you understand the experience of women?

We hear about making more convenient, but alongside this programme about going and having it done, is there any thought to having an education programme about what it actually involves, so that people are not surprised. Duncan Selbie?

Duncan Selbie: Each programme has very thoughtful literature about what you might expect, who is going to be called when, what you can expect and what the standards are that you should expect to receive, involving the people at the other end of it. So it's not only written by clinicians and scientists; it's written by, or with, people who have direct experience of the condition or who have had direct experience of the test or the screen. But we know that that's not sufficient.

I am not actually surprised at all. What I am concerned about is what we do about it, given that we have those gaps. And I think what you are seeing today in what the NAO has had to say is that there is a lot to be proud of but there is much to do, and you are looking at the people who are responsible for that.

With our first go at trying to talk to women, in a way that lands with women—and not because a man has said it, but because of very extensive work with women and the various charities—we will see whether that succeeds.

However, in itself, again that won't be enough. I know this is pedantic, but we have to make the tests and implement the tests that are going to be the easiest and most convenient to use. We have to find and increase the number of ways of reaching people in the lives that they lead. We have to find ways of communicating with people, using not just literature but all sorts of media, in ways that they hear. That is the challenge for all of us.

Q47 **Bridget Phillipson:** If you are going to make it so that women do not have to make a GP appointment to have the cervical screening test, for example, that is going to cost money.

Duncan Selbie: Well, maybe.

Q48 **Bridget Phillipson:** If we are going to open up access so you do not have to ring your GP and wait three weeks for an appointment, and so on, and if we are going to have a genuine walk-up service—

Duncan Selbie: Or to do home testing, which we are doing with HPV, and with lots of sexual health services as well, with some real success. We are reaching more people and reaching people who just would not go into a clinic.

Q49 **Chair:** Is there a cervical cancer home testing solution down the line? I think some of our minds are boggling here.

Duncan Selbie: Yes.

Professor Sir Mike Richards: Yes, there is. As I tried to indicate earlier, it actually is now being introduced in places like the Netherlands. It is particularly being used for people who have not responded—people who have not come for a screen. It would then be sent to the person through the post as a reminder.

Q50 **Caroline Flint:** Isn't there a danger here that there is always some innovation down the road, but, in the meantime, the basic stuff that is necessary, like making sure our GPs are more accessible at a time that people can use them and some of the work that needs to be done locally through spending on public health information, isn't happening? It seems like there is always some new idea—

Chair: I think Sir Mike is agreeing, but it is not entirely his responsibility.

Professor Sir Mike Richards: My view is that we need to do both. Yes, we do need to improve convenience for patients, with better access in

terms of out-of-hours services and in terms of being close to where people work—all those things—but on top of that, we may get to a different segment of the population by offering HPV self-sampling sent through the post. That is what we are beginning to see in other countries. We want to introduce that in a very measured way—

Q51 **Caroline Flint:** But you do agree with getting the foundations right first?

Professor Sir Mike Richards: Yes, I do. It is both those things.

Q52 **Nigel Mills:** I want to go back to the 14-day target for the letter to be sent. While my CCG, Southern Derbyshire, hit all the coverage thresholds, or at least the lower thresholds—

Chair: We should just be clear that it is not the CCGs that are responsible; you are referring to the geographical CCG area.

Nigel Mills: Yes. My area, at least, only managed to get 568 of 27,500 letters sent within that 14-day timeframe. That is a 2.1% hit rate. You said there was a bit of variation, Professor Richards. That is a little bit more than variation; it is nowhere near.

Professor Sir Mike Richards: My firm belief is that when we are through this transition, we really ought to drive very hard for all parts of the country to get back up to the 14-day standard.

Q53 **Chair:** Can anyone explain why Oxfordshire has exactly the same rate as Mr Mills's area—

Nigel Mills: Some other bits of Derbyshire are worse.

Chair: Yes, Mr Rowley also represents low spots—I do not know what is going on in Derbyshire. In Hackney—in inner-city London—only 9.1% of letters are getting out within 14 days. We will come on to some of the other issues in a minute, but why is it that those areas are particularly low compared with those represented by others around the table? What is going on?

Professor Sir Mike Richards: I do not have an answer to why those specific—

Q54 **Chair:** You are taking rather a lot of this, Sir Mike, but you are not really responsible for delivering the service. That is not to say that I do not respect what you are responsible for. Mr Selbie and Mr Stevens, why are they so low? That is really shocking.

Simon Stevens: What we are seeing across the country—we can certainly come back to you on those specific labs—is that, as we discussed a moment ago, the transition from the cervical screening programme we have to the cervical screening programme we are going to get later this year is such that there is going to be a big reduction in the—

Chair: These figures are for 2017-18.

Simon Stevens: Sure, but it has been known that there is going to be this big reduction in the number of labs and, as a result, a number of staff have voted with their feet, hence there have been these pressures on turnaround times in the labs. What everybody can see is that, as Sir Mike said, the new HPV screen inserted into the cervical process will reduce by perhaps 85% the number of screens that a lab has to undertake, which is why we are going to end up with only nine labs, instead of more than 45. A lot of this has been to do with the unavailability of staff in some of those labs during the transition. Is that right, Mike?

Professor Sir Mike Richards: That is entirely right.

Q55 **Chair:** That still does not answer the question why certain geographies are slower at getting letters out. Is it the letters, or is it the lab testing?

Simon Stevens: We will have a look at the specific one that Mr Mills mentioned. Some of these labs had maybe only one or two people. We had a large number of very small labs, and if you have one or two people, and one of them leaves, it is very hard to hire somebody back when they can see that they are not going to be there at the end of the year.

Q56 **Nigel Mills:** This is a whole year's data we are talking about, not a couple of months where someone went off sick and it went wrong. Do you not think that you would identify somewhere in the system where we were hitting 2% of the target and try to rectify that during the year, rather than not even know about it nearly a year on?

Professor Sir Mike Richards: What I would say is that efforts are being made to rectify that. Some labs have moved faster than was originally planned to introduce primary HPV testing. As Simon has said, that will reduce the need for people who look at the cells down a microscope, and those are the people, in some cases, who have already left, because they know that their jobs will not exist in the future.

Duncan Selbie: No one can argue that that level of response is all right, and we will write separately about that. To the earlier point about how quickly we have adopted new innovations, this was 2016. By 2019, every woman will have access to HPV. That is a pretty dramatic and fast move. The very practical effect of that decision is that everybody who has been doing cytology, who knows that they are not going to be doing that into the future, has had to think about, "What is that going to mean for my career and my job? What will I have to do to retrain?" It has not been a consistent matter around the country.

There are mitigations all over the place for that. If the Committee has the notion that we have just been watching this, it has completely misunderstood. This is a pragmatic effect or outcome of a change in technology that will bring huge benefits to women. It is happening quickly, but it is a painful and difficult time. There will be those variations; we hope to see those closing very quickly.

I want to emphasise that having the test is the key thing—the key thing is that we want people to come forward for the test. The response rate is

about the psychological impact of being late on that, and we have spoken about that, but this will not alter—there is not a poor clinical outcome that flows from this. By the end of this year—

Q57 **Chair:** You are sure—you can say that hand on heart?

Duncan Selbie: I am listening to what Sir Mike Richards says, what the breast surgeons[1] say, and what the various people—the clinicians and scientists we talk to—say.

Chair: I just wanted to get that on the record for reassurance.

Q58 **Nigel Mills:** Were these numbers a surprise to you, Mr Selbie? Did you know that some parts of the country were hitting only 2% on time, or was this the first you had heard of it? I thought you might have spotted that, or the data would have been flagged up somewhere, and it would have been researched and you would be able to say, "Don't worry; it's all fine this year," rather than, "I'm going to go away and have a look."

Duncan Selbie: It must be obvious to you that we speak as a team here. The responsibility for the commissioning and the contract management of this rests with NHS England. My people are embedded in there and I feel very responsible for it, but no, I do not track this as Public Health England; I do not sit here—

Q59 **Nigel Mills:** Mr Stevens, did you know that we were hitting 2% of letters being sent on time in my constituency?

Simon Stevens: Those data are absolutely tracked, but the real-world issue, which we cannot get away from, is that if there are no staff in a number of these small labs in this next period while we move to the transition of HPV, I think the practical response is probably what Ms Phillipson said. That is, there needs to be clarity of communication to the women involved, including the reassurance, if that is clinically the case, as we are told it is, that there is no clinical reason why having a response in eight weeks makes a difference compared with two weeks or four weeks while we do the transition. Then, as Sir Mike said, we have to make sure that once we have the HPV screening in place for the primary, and there is the 85% reduction of volume, we get back to a quick standard and we communicate that clearly. The disconnect between the transition and the communication is the key thing that has to be got right.

Q60 **Nigel Mills:** Someone is monitoring this performance, so you were aware that, during the year 2017-18, some parts of the country were hitting only 2% of the target on time?

Simon Stevens: I have every reason to believe that those data were available to the relevant local teams, but I cannot specifically—

Q61 **Nigel Mills:** You are normally incredibly well briefed, Mr Stevens, so I am a bit surprised that, if that data was there and was being monitored, you do not have a briefing somewhere in your pack that says, "This problem

[1] Note: the witness meant to say "cancer surgeons".

blew up at these clinics and it was addressed like this and it was all fine by a certain date."

Chair: Given that there are two Derbyshire MPs on this Committee, someone did not brief you right.

Simon Stevens: I think we have said exactly that: there had been issues with staffing during this transition and, frankly, the likelihood as to being able to get new people to come and work in a service that they can see will disappear in 18 months or two years' time. Understandably, there has been this transition issue. The core of the matter is how quickly we can get to primary HPV, and whether we can better communicate with women involved. On both fronts, that is what we have to get right.

Q62 **Nigel Mills:** To get to a derisory level of performance such as 2%, the problem must persist for nearly the whole year. I am intrigued that it was not spotted three months into the year, and there was not some sign of improvement by the end of year. Presumably, there are lots of clinics that could send tests to different places to be processed, rather than keep sending them to the same one that cannot cope. Other solutions could have been put there. It looks like this was not spotted and was not dealt with for a whole year.

Simon Stevens: We will certainly get the local Derbyshire team to send you the information on what the position has been.

Q63 **Chair:** I think Ms Moran will be interested in Oxfordshire as well, and I will talk to you about Hackney separately. On the point of the laboratories going down from 48 to nine, that is a very dramatic drop and there are a lot of concerns locally, as you know. Why did you then have an advertising programme to encourage women to have their smears done, when you were going through this process? Have you not compounded the problem?

Duncan Selbie: We consulted very widely with the charities we have spoken about, with women directly and obviously around the table here. Of course, we thought about the timing, but we all concluded that none the less we should begin our work to say to women that they should come forward for this test. That was the judgment we came to; we were cognisant of the concerns, but we thought we had to begin to address the take-up.

Q64 **Chair:** I am puzzled why there is a backlog of 98,000 cervical screening samples sitting in laboratories. We know why on one level—because the technicians are not all there. You have this backlog, yet you have an advertising campaign. You are just adding to the backlog.

Simon Stevens: I am advised that describing that as a backlog is not accurate. At the end of each month, there will also be a number of samples in progress.

Q65 **Chair:** Fair point, okay. Do you have a record of how long they have been waiting? Do those samples perish at any point? Is there a point at which you might have to go back to the patient?

Simon Stevens: I defer to Mike, but I think they can be stored for six weeks.

Professor Sir Mike Richards: Normally, it is six weeks, but I am advised that extra chemicals can be added that will preserve them for longer.

Q66 **Chair:** That is an extra step in the process, though.

Professor Sir Mike Richards: But if they are not being looked at in that time, rather than expecting someone to go through a second examination, it is much better to keep that sample so it can be analysed.

Q67 **Chair:** There was a backlog already—not a backlog, I take Simon Stevens' point. There is always a number at the end of any month. Has that number gone up as a result of the advertising campaign? Are there more samples waiting to be tested at the end of a typical month?

Duncan Selbie: The campaign has been running for three weeks, and it has another five to go, so you could not say that one was connected to the other. Given it is the first time, we have made a judgment and we think there will be another 5% on the current numbers.

Q68 **Chair:** We have heard quite a lot that there is no particular risk to women involved. Sir Mike, you are the expert on this. What is the impact of waiting? If is not 14 days, is there an optimum clinical time by which a woman should have back her cervical smear test result?

Professor Sir Mike Richards: I do not think there is an optimal clinical time. I think it is about what is a good service.

Q69 **Chair:** That is what I am puzzled about. Can it wait six weeks? If it was eight weeks, would that make a difference to the outcomes?

Professor Sir Mike Richards: To be honest, if we go back 15 years, an awful lot of them waited at least six to eight weeks, which is why the turnaround target of two weeks was brought in.

Q70 **Chair:** My point is, if you have cervical cancer, what is the impact of the delay in getting your result telling you that?

Professor Sir Mike Richards: I think it is extremely important to remember that only a very small number of people who have a cervical screening examination have cancer. It is a test to find the virus that causes the cancer or, in the past, the test to find the abnormal cells that might develop into cancer. The actual chance of there being a cancer that is then missed—even then, the progression of a cancer is not that fast—

Q71 **Chair:** That is my point. How long is it? If it is eight weeks, is that not going to be a big problem in terms of outcomes?

Professor Sir Mike Richards: I would not be worried about that in terms of its clinical outcome, but obviously in terms of whether it is a good public service, yes, I would be worried about it.

Q72 **Chair:** Actually, the 14 days is really about reassuring women quickly, or getting them to understand that there is a problem quickly, but the

clinical outcome—you are being very clear—is not more risk to women if they wait eight weeks rather than two, for example?

Professor Sir Mike Richards: That is to the best of my belief, yes.

Chair: That is, I guess, reassuring for people out there. It is quite interesting.

Q73 **Sir Geoffrey Clifton-Brown:** May I ask you a technical question, Sir Mike? Presumably these laboratory tests are quite repetitive work. How much will technology come to our aid in producing quicker results in a laboratory?

Professor Sir Mike Richards: It is extremely repetitive work, looking down a microscope at cells to spot the one or two abnormal cells, or whatever it may be. The test for the virus, which will be the first test done, is automated, so that takes out that whole stack. As Simon Stevens was saying earlier, that then reduces the number of samples that need to be looked at under the microscope by 85%. That is the big change. And no, you cannot be doing this 40 hours a week—I think that would be absolutely unreasonable.

Sir Chris Wormald: But the technology—it wasn't about this programme, but I was at the Leeds Teaching Hospitals last week, which I think is the first hospital in the world to digitise its pathology fully, so it no longer has people looking down microscopes; they are now looking at screens. The efficiency of that is considerably greater. Simply how long it takes to go from one sample to the next is now about pressing a button, as opposed to taking a slide out and so on. In Leeds, they were hopeful that it would lead to quality increases as well, because you could seek second opinions so quickly—you have something to email someone else, as opposed to posting a slide—so there is undoubtedly a huge efficiency benefit to that, and possible quality improvements. That was before you got to anything that was AI—this was still the same people analysing the screen as would have been looking down the microscope. It wasn't, as it were, all the way to the future, and it is perfectly possible technology right now.

Duncan Selbie: The new HPV test will essentially be machine based.

Simon Stevens: On Chris's point, this week a new study from Leeds Teaching Hospitals in the publication *Radiology* has in fact shown that by using a 3D mammogram technique, they have been able to halve the number of women sent unnecessarily for breast biopsies—analyses of 30,000 women in Leeds, taking multiple images of the breast. There are all kinds of technological developments that will substantially change the accuracy and precision with which screening programmes can be targeted. They will move increasingly towards the more tailored screening opportunities for the individual, based on their combination of risks and their preferred way of interacting with the screening service, rather than the fairly undifferentiated, one-size-fits-all, single-condition screening programmes that we have had hitherto.

Professor Sir Mike Richards: For my review, I am obviously talking to experts about the new technologies, and to people who understand AI, to see what the potential for that is in cancer screening. That will form part of my review.

Q74 **Chair:** To touch on breast cancer screening, we know from a report that 8% of women waited longer than 36 months between invites for their breast screenings. Duncan Selbie, Simon Stevens, why is that still such a high figure? Is it to do with the women not rearranging appointments, or is it to do with the lateness of invitation?

Duncan Selbie: Those factors, and no doubt a number of others. The standard is 90%, and the NHS is meeting 92% at the moment. We think this is the key measure—that women will get another appointment within three years of their last appointment. It is even more important than the actual coverage that we can give that assurance. So 92% is a good number, but it is obviously not 100%. The 8% isn't spread evenly either. It means there is quite a lot of variation among the 79 screening programmes—the NAO have picked that up in particular. So, although the round length—I am not being complacent here—looks healthy at 92%, there are 22 parts of the country that are not meeting that, which means that that key quality indicator, which we know matters, isn't being met consistently. We are making decisions about whether we want to defer and wait a bit, which goes back to everything else we have talked about on convenience and accessibility.

Q75 **Chair:** How much of it is down to the creaky IT systems? We will come on to that in more detail, but is that a factor?

Duncan Selbie: It is a long story. The IT is hopeless, but it is not leading to people missing—

Q76 **Chair:** That is not the reason?

Duncan Selbie: No.

Q77 **Chair:** Do you know what is leading to the issues with the data?

Duncan Selbie: The difference between the 92% and the 100%?

Q78 **Chair:** Yes. Why is it that some women are getting invites on time and some are not?

Duncan Selbie: If I may, it is for all the reasons we have given.

Q79 **Chair:** Okay. It is demographic. So you are saying—

Duncan Selbie: It is also economic—

Q80 **Chair:** So there is a lot that comes down to the woman, rather than the system, is what you are saying.

Duncan Selbie: I wouldn’t start there.

Q81 **Chair:** We are going to come on to the system in a moment. I just wanted to touch on this: Jo’s Cervical Cancer Trust sent us some very

good evidence and I know that they wrote to both NHS England and Public Health England last June to ask how much budget is set aside for IT development. You have replied on breast and bowel screening, but neither of you have replied for cervical screening. Is there a reason for that? Can you tell us now, or could you write to us if you can't? What money is set aside for IT for cervical cancer? It is odd that you replied to one and not the other. We are puzzled by that.

Duncan Selbie: I have ownership of the awful breast cancer system, and aortic and bowel screening. Cervical is all part of—Simon?

Chair: Mr Stevens, you could give it a go.

Simon Stevens: The question is about the cervical screening system, which in recent years has been administered as part of the Capita primary care services contract. As you know, we have not been satisfied with the way in which that has been performing. As you also know, there was an issue last year that came to light when we were notified late by Capita about delays in letters going out. Therefore, today I am announcing that we are bringing the cervical screening service back in-house to the NHS from Capita, beginning in June and with a phased transition through the rest of the year.

Q82 **Chair:** So then we will know exactly what you are spending on IT development.

Simon Stevens: Indeed.

Chair: Okay. We will leave that there for now, but that is helpful to know.

Q83 **Lee Rowley:** Mr Selbie, you just said the IT systems around breast cancer were hopeless. Is that an acceptable statement for you to make?

Duncan Selbie: Well no, of course not, but it is a function of history—a legacy. The system is 30 years old, with some new technology—

Q84 **Lee Rowley:** So why haven't you changed it? If the problem has been there for 30 years, why haven't you done anything about it?

Duncan Selbie: Since Public Health England became responsible, we have been making improvements. I am not describing where we want to get to, but we took responsibility in 2013. In 2015, we strengthened the technical oversight of the national breast screening system, which has 79 different local systems to it. We got Hitachi—

Q85 **Lee Rowley:** This is description. The reality is that you have had half a decade to amend the system and you haven't done it, and you are still describing it as hopeless. Correct?

Duncan Selbie: No, I am not. Let me finish. May I?

Q86 **Lee Rowley:** I would prefer it if you would just answer my question. You have had half a decade to change the system. You haven't done it. You are still describing that system as hopeless. Those are the statements you have just made.

Duncan Selbie: I was endeavouring to say that we took responsibility in 2013. In 2015, we strengthened the main system that supports the 79 individual systems, and we appointed Hitachi to do that. And in 2016, we introduced a new system, Breast Screening Select, which has brought a number of benefits, not least visibility of the problem that we then identified and have had to be dealing with this year.

What I am not describing is a system that any of us would be content with. Over the last two years, we have been working on an end-to-end system, a new system, for breast screening. We have just completed the alpha phase for that, but there will be a whole series of other choices that we now need to make about what we do about IT for screening. There is a very good argument that we should not be having a platform for breast that is separate from cervical and so on, and that we should be looking to a platform for screening as a whole. The Government's response to the independent review of breast screening said that this was something that we should do, and NHS Digital is undertaking a review of that at the moment.

I am not taking responsibility for the last 30 years of—

Q87 **Lee Rowley:** I'm not asking you to take responsibility for the last 30 years; I'm asking you to take responsibility for the last five years, and you have just told me that you didn't do anything for the first three.

Duncan Selbie: No, I never—

Q88 **Chair:** In 2013, you took responsibility. In 2015—

Duncan Selbie: Yes, but these things don't just arrive.

Q89 **Chair:** No, but perhaps you could explain that, then. What did you do between 2013—

Duncan Selbie: I am trying to. In 2013, we took responsibility. In 2015, we strengthened the support to the 79 local services through the appointment of Hitachi.

Lee Rowley: I did hear you the first time.

Duncan Selbie: And in 2016, we introduced this new system. It takes time. A whole series of benefits have been brought by the new system, which I can run through—

Lee Rowley: I don't require that.

Duncan Selbie: But it's not sufficient; I know that.

Q90 **Lee Rowley:** I was part of the process of changing an entire IT platform for 20 million customers, so I'm aware—

Duncan Selbie: It takes time.

Q91 **Lee Rowley:** And we did it within three years, so I'm asking you why you haven't done that.

Duncan Selbie: We managed it within three years.

Q92 **Lee Rowley:** You haven't done it, though. You are still saying the systems are hopeless. You can't have it both ways.

Duncan Selbie: I was talking about staging. Breast Screening Select was something we began to work on, and it has meant that local services now have visibility about the history of the screening that happens in their area. They can now draw down how they batch the women they call for screening locally; they don't rely on the central arrangement for that. And it brought visibility to the age of the women who were being called. This was not possible before.

Q93 **Lee Rowley:** The challenge on batching was known in 2009, according to the breast screening review, which I read prior to coming here. If it was known in 2009, why was nothing done about it until this new system discovered it in 2016?

Duncan Selbie: We took responsibility in 2013.

Q94 **Lee Rowley:** Excellent. So you had at least three or four years before the problem appeared.

Duncan Selbie: And we have been progressively improving the IT, but you have 79 local systems that do not speak to each other, platforms that are not sufficiently robust—we need to replace the whole thing.

Q95 **Lee Rowley:** So where was the strategic review to do that when you took over in 2013? Why did you wait three years?

Duncan Selbie: We did not wait three years. We began that work in 2013, and it took us to 2016 to introduce this new system.

Q96 **Lee Rowley:** But you have just told me that that system does not do other elements of the process. You can keep coming back to this point—that you have replaced one small part of the process. I'm not arguing about that and I haven't been throughout this. You did not do a review, or did not action anything out of that review, until 2016, I think you said, in terms of changing everything else.

Duncan Selbie: The National Screening Committee said in 2016 that we should move to develop a single platform—a database, if you like—for breast screening, and that has taken longer than I would want, but we have now completed the alpha phase for that, and we will be making decisions with the Department and NHS England about moving to a new platform. Whether that is a single platform for breast screening or for all screening is the judgment we now need to make together.

Q97 **Lee Rowley:** A committee told you what to do; that sounds very passive. Why didn't you make that decision internally? You were in charge of this. You took responsibility for it. You owned it. Why haven't you actually done something about it?

Duncan Selbie: Well, it's not a linear thing. It's—

Q98 **Lee Rowley:** It is a linear thing.

Duncan Selbie: No, it is not. Let me explain. Can I give you an example?

Q99 **Lee Rowley:** You cannot come here and tell me that it is not a linear thing. It is very linear. You had the responsibility, you did not do anything with it, and now you are giving me lots of words to suggest that it was all very difficult.

Duncan Selbie: If I take aortic—

Q100 **Lee Rowley:** No, we are talking about breast screening.

Duncan Selbie: The point is that we have IT that really works.

Q101 **Lee Rowley:** That's lovely, but I am not talking about that. Let's talk about breast screening.

Duncan Selbie: I acknowledge that it has not been an easy end-to-end system. That has been a big part of the problem that we now have to address.

Q102 **Lee Rowley:** So it is all very difficult. The breast screening review clearly states: "Public Health England was slow to develop a clear understanding of the incident and the causes of the failures in the breast screening programme." Why was that, particularly if you had tightened up the governance around it?

Duncan Selbie: If I can start with the fundamental problem that the independent review— Before the review, there was a mismatch between the specification written in 2013 and how the service had actually operated for the 30 years before that. It only became possible for that to be visible to us because of the Breast Screening Select programme that we introduced in 2016.

Before 2016, it was not possible to see, unless you went out to the 79 services, that there was a difference between what the specification said about what women could expect—the promise, if you like; 70 and 364 days—and how that was being interpreted across the system. There was inconsistency on whether it should be the day of somebody's 70th birthday or when they were 70 and 364 days. That was not visible before 2016.

AgeX brought that to our attention. I can talk to you about how, but essentially the Breast Screening Select system brought visibility to the age, and AgeX brought it home, so that we could see for the first time that there were women in their 70th year who were not being called for a screen.

Q103 **Lee Rowley:** That is a lovely answer, but it has nothing to do with the question I asked. "Public Health England was slow to develop a clear understanding of the incident and the causes of the failures in the breast screening programme." That is a criticism of your incident analysis and of your evaluation of that incident. It is nothing to do with screening and a new system and all the rest of it. Realising that you had a problem and questioning its underlying issues was not done sufficiently quickly.

Duncan Selbie: We fully accept that this was not our finest hour. It was not only Public Health England. We had a whole range of people involved, including clinicians and my colleagues here, to try to understand and look over 10 years of data across dozens of different systems, lots of legacy systems and archived data and lots of migration going on at the time.

It took us from January, through March and into April to understand the fundamental issue. It was an issue about IT, but that was not the fundamental issue. It was an issue about AgeX, but that was not the fundamental issue. The fundamental issue was that difference, and we acknowledge that it took us a long time to see that. However, we were working to understand the problem. The independent review speaks as if that was PHE alone, which was not the case. We had a clinical advisory group with breast surgeons and frontline people in the NHS all trying to get their heads around 10 years of data and what it meant.

We had a real choice about whether to say that the system had worked in that way for 30 years, leading to variation, and that that is okay, or whether to say that women—at least since 2013-14—had been made a public promise that they could expect to have a final scan up to and including the eve of their 71st birthday. We chose to go with the women. That was at the heart of this. The IT did not assist us with this, but it was not ultimately an IT problem.

Q104 **Lee Rowley:** But then you don't understand your processes.

Duncan Selbie: We were understanding them, and it took us time to understand them. It is not as if it happened in 2013; this was going back years.

Q105 **Lee Rowley:** That's irrelevant. There are lots of things that go back years. People work out their operating model, get people to process-map and look at their system's architecture. Where was all that, particularly if you've had ownership for four years?

Duncan Selbie: We fully acknowledge that we did not have a sufficient understanding that there was a difference between what the specification had to say in 2013 for 2014, and the way that the service operated in practice. It was not visible to us, and it was not visible to anyone before 2016. It only became visible to me in January 2018.

Q106 **Lee Rowley:** It was invisible only by omission—by not doing things. You own those processes, those systems, and that operating model. You don't understand your own operating model. That was your issue. It is not some kind of random thing that just appears on one random Tuesday morning.

Duncan Selbie: It was not possible for it to be visible until 2016. When it did become visible, we—

Q107 **Lee Rowley:** That is a fundamentally incorrect statement to make. If you own the operating model, it is absolutely possible to work out what your operating model is or is not doing. If you don't know what your operating model is doing, you don't know what your control model is, what your

risk model is or what your risk appetites are. It is absolutely incorrect to say that. Otherwise, you have no idea what the process was doing.

Duncan Selbie: At the danger of sounding complacent, over the 10-year period that we looked at the number of women affected was less than half of 1%. It is very difficult to say that anyone would have spotted that when you were working to 79 individual systems that did not talk to each other. I do not wish to sound complacent, but I think that it would defeat anyone to spot that level of variance. It was half of 1% over that period.

Q108 **Lee Rowley:** Yet that variance was responsible for 122,000 letters not going out. Okay—let's move on. How many systems are involved in cervical screening—systems that you have just announced today, Mr Stevens, as coming back in house?

Simon Stevens: It will be the system that is currently operated by PCSE, which is part of Capita.

Q109 **Lee Rowley:** How many systems are in the operating model?

Simon Stevens: Well, they use what is called NHAIS, which is a system with 83 instances, which is what was inherited at the time that the service was consolidated nationally. What we want to do is to replace the dependence on the NHAIS system with something called the personal demographics service, which NHS Digital will operate.

Q110 **Lee Rowley:** So is it one system with 83 instances, or were there more systems than that in the entire end-to-end process?

Simon Stevens: There are more systems. They are laid out in the annex to the NAO Report. They are shown at figure 23.

Q111 **Lee Rowley:** So how many are there?

Professor Sir Mike Richards: There's a figure of 360, but I think it is important to recognise that once somebody has been through the screening process—they have been identified through NHAIS, they have been called for screening and they have had their screening—some of those patients, a relatively small proportion, need to go on to the next stage of testing: colposcopy testing. That is where we have a whole lot of different systems, because they are run by individual hospital trusts. In the future, there is a case for saying that we need an end-to-end system, instead of having 120 or 130 different colposcopy systems.

Q112 **Lee Rowley:** How can an operating model effectively work with 360 systems? The control model around that cannot be correct. It just can't. You can't reconcile that.

Professor Sir Mike Richards: I would agree.

Q113 **Lee Rowley:** Okay, so who is doing what, and when?

Simon Stevens: Yes, we completely agree. That is why we think that we have to move to a unified cervical screening system.

Q114 **Lee Rowley:** But you haven't done it yet.

Simon Stevens: For reasons that the Committee has previously discussed, we do not have confidence in Capita to undertake that transition. That is why we have determined that we will take that in house and, together with NHS Digital, we will do that ourselves.

Q115 **Lee Rowley:** Is that to replace all 360?

Simon Stevens: It is to replace the dependence on the 83 instances of NHAIS. For the reasons that Sir Mike just set out, hospitals will use local systems for the subsequent checks, but I don't think that is illegitimate.

Q116 **Lee Rowley:** Either that is not an answer to the question, because it means that there are still multiple hundreds of systems, or it is going to have to—

Simon Stevens: The answer is that hospitals that have to do the follow-on checks will still be doing the follow-on checks, and they may have local systems for doing so. The question is not, are there local systems? It is, are the systems connected?

Q117 **Lee Rowley:** You cannot have a risk model that effectively works with hundreds of systems. Either you are telling me, between you all, that you will go down to a smaller number of systems—in the tens.

Simon Stevens: It is certainly going down to a smaller number.

Lee Rowley: And you are going to want—

Simon Stevens: Except that the whole of the NHS, for better or worse, operates on distributed technology systems at hospital and GP level. The big thrust is to get interoperability and connectivity. That will be true for part of the delivery chain for the subsequent testing that cervical screening shows up. For the bulk of the programme, that will be using an integrated system that will be delivered on our behalf, led by NHS Digital.

Q118 **Lee Rowley:** I know the origin—360—but I don't know the destination. What is the destination number?

Simon Stevens: The destination, as I say, is that the 83 will consolidate into a single service, which will then connect, where necessary, with follow-on systems in local hospitals. That is not, at that point, the screening piece per se. That is the subsequent testing that the screening says is needed.

Q119 **Lee Rowley:** It's 360 to 270, then?

Simon Stevens: Well, there are obviously some other changes happening in hospital IT at the same time.

Q120 **Chair:** A perfect storm.

Simon Stevens: It's not a perfect storm. We can't have it both ways.

Q121 **Lee Rowley:** I just want to know the number. What's the number?

Simon Stevens: No, I can't just give you a number, nor would it be reasonable for me to tell you now what individual hospitals would be doing on some of their pathology systems. That is going to be laid out as part of—

Q122 **Chair:** Somebody in the system is going to want to be looking at this from test letter to actual result. You will have a way of tracking through that.

Simon Stevens: Absolutely, but that is not the same as saying that we are going to end up with 10 systems covering all hospitals, or a single number that, as you said, will be necessary for a risk—

Q123 **Chair:** No, but you will be able to track through, however many systems you have.

Simon Stevens: Yes.

Q124 **Lee Rowley:** A control model can't be effective with multiple hundreds of systems.

Simon Stevens: It depends on your definition of a system, I suppose.

Q125 **Lee Rowley:** Either you are saying that your control model doesn't work, or you are saying you will reduce it to a number that makes it work. I don't know which one it is. You choose; I don't mind.

Simon Stevens: Well, we have several hundred acute hospitals. If you are saying, "A priori, there can only be 10 or fewer systems," that's a big statement to make.

Q126 **Lee Rowley:** I'm letting you decide what the number is.

Simon Stevens: Right.

Q127 **Lee Rowley:** Which is?

Simon Stevens: What I am saying is that the key weakness, in our judgment, in not just the cervical screening service but a number of others, is the reliance on the NHAIS system. That is what is going to be delivered through NHS Digital. The transition will not be managed by Capita, as was previously in prospect. That is why we are taking responsibly for that back in-house to effect that transition.

Q128 **Chair:** When will that happen? When will NHAIS turn into Spine, or whatever you are now calling it?

Simon Stevens: Between now and 2020.

Q129 **Chair:** It was going to be 2017.

Simon Stevens: We put it on hold because we didn't have confidence, based on all that we've talked about, in Capita's ability to manage that transition safely.

Q130 **Chair:** We are now very close to 2020. Is it still on hold now, or is it progressing?

Simon Stevens: It is going to be progressing in a fundamentally different way, given the announcement that I am making today about transitioning that service from Capita back to the NHS.

Q131 **Lee Rowley:** What's the cost of that delay?

Simon Stevens: I don't think there is going to be a cost.

Q132 **Lee Rowley:** There has to be a cost, because you must be developing more and testing more. You must be doing something. You have three years with an extra project. At the very least, there are additional projects.

Simon Stevens: Oh, sorry. You are quite right. There is a cost to sustaining NHAIS for the additional period. It was priced at around £14 million, but there are costs avoided as a result of not having the new costs associated with the system, so there will be a netting effect to those two. We have a new unit that the Secretary of State announced called NHSX, which is bringing together all the digital capabilities that sit in the relevant bodies. One of its first tasks will be answering this question.

Q133 **Lee Rowley:** So we don't know what the additional cost of the delay is.

Simon Stevens: Well, I've given you the figures, as we have them.

Q134 **Lee Rowley:** The cost of extending the life of NHAIS is nearly £14 million, right?

Simon Stevens: Not necessarily the incremental cost. A running cost per se, but that might not necessarily be a net incremental cost, given that there would have been other costs of moving to the new system.

Q135 **Lee Rowley:** And you were not expecting any cost savings as a result of moving to the new system?

Simon Stevens: We have had significant cost savings out of the Capita contract; in fact, I think we have had savings of tens of millions of pounds, which again, the NAO has previously reviewed and we have discussed with the Committee. We have saved very significant sums of money—

Q136 **Lee Rowley:** Were you expecting any savings in this particular element of the Capita contract?

Simon Stevens: The contract was not decomposed in that way. We were buying a comprehensive service. You have had the chief executive of Capita here before the Committee and he has explained that Capita are out of pocket as a result of the deal that we negotiated on behalf of the taxpayer.

Q137 **Chair:** Can I be clear though? You say that you are bringing it in-house, and then you said just now that you are fundamentally changing it, so it is not really the plan that was paused in 2017. Are you saying that you are having a different IT system? What is the change of plan? What is the difference?

Simon Stevens: The plan has always been to transition from NHAIS to PDS. There are various changes that have to be made to PDS to be able to effect that, including its connections to the GP—

Q138 **Chair:** So Spine is gone, is it?

Simon Stevens: No. Including its connections into individual GP systems, from which a number of those data are drawn. In order to be able to operate the screening systems, you need a set of functionalities that PDS currently does not have. The original idea was that Capita would be contracted to effect that system redesign. As we have just said, they are not now going to do it. NHS Digital is going to do it for us.

Q139 **Lee Rowley:** How much will it cost to change PDS and then to roll it out?

Simon Stevens: That is what, as I say, we have sized as part of NHSX's work programme. It is not going to be an enormous expense, but I do not want to give you a number—

Q140 **Lee Rowley:** Why do you not want to give a number?

Simon Stevens: I want to give only accurate figures to the Committee. Until that work has been done, given that we now have to change the delivery model in the light of the announcement that I am making today—when we have that number, I will be certain to give it to you.

Q141 **Chair:** Will you still deliver it by 2020?

Simon Stevens: That is what we are gunning for.

Chair: The end of 2020?

Simon Stevens: During 2020.

Chair: I see it will not be the beginning of 2020, as we are a quarter of the way through 2019.

Q142 **Lee Rowley:** Is it millions or tens of millions?

Simon Stevens: You are tempting me to give you an answer that I do not want to give, if it is not going to be wholly accurate.

Chair: You must know the order of magnitude.

Q143 **Lee Rowley:** We are trying to understand value for money, so I would like to understand what my baseline is for assessing value for money—

Simon Stevens: Precisely; until I have seen and had a chance to scrutinise the business case in detail, I would not want to suggest anything that might not be value for money.

Q144 **Lee Rowley:** Did you not expect us to ask this question when you came here today? Could you perhaps have had a look at the business case before?

Simon Stevens: It is not a question of expecting. I do not want to give you answers that are not yet complete.

Q145 **Lee Rowley:** I look forward to your letter on it. I have a final question to Mr Wormald. I must pick you up on this point: "Has reform been too slow?", "I am not in a position to judge." You must be in a position to judge.

Sir Chris Wormald: No, sorry, what I mean by that is that obviously people can argue about whether reform can be slower or faster in a particular area. That is not an objective thing. There is no mathematical way of saying that reform has been at the right speed or not. Therefore, it is not for me personally to judge. People will have their own—

Q146 **Lee Rowley:** It is, because none of your screening programmes met their coverage targets during 2017-18. That is a pretty good proxy.

Sir Chris Wormald: What I am saying is, whether reform should have gone faster or slower in a particular area is quite clearly a subjective question that people will argue about—and indeed, do. We have made—

Q147 **Lee Rowley:** It is not subjective when you are missing all your targets, is it?

Sir Chris Wormald: We have been very clear as a panel throughout this hearing about what we think about the overall position of screening, which is that there is a lot that is good and there is a lot that needs to improve. You get no arguments from us at all that we need to improve. You are also getting no arguments at all that a number of things have happened that were not good enough. That is why we have had an independent review of our breast screening and why Simon is doing some of the things that he is doing. The question of how fast you reform a particular area is a fundamentally political question.

Q148 **Lee Rowley:** Other than, none of your screening programmes met their coverage targets. If reform is a proxy for changing—

Sir Chris Wormald: In the vast majority of cases, they met our threshold target, as we have described during this hearing, and did not meet our stretch target. We want to do better—

Q149 **Lee Rowley:** Unless you are disagreeing with the Report, and we do not tend to have disagreements on Reports in this Committee, so I hope that is not the case: "None of the adult screening programmes met their 'standard' coverage target during 2017-18"—page 7.

Sir Chris Wormald: The situation is exactly as I just described, and is exactly the position described by the National Audit Office Report.

Chair: We are going to move on to the future, I think.

Q150 **Anne Marie Morris:** The governance was not up to scratch, I suspect, when these two incidents took place—the cervical cancer one and the breast one. How have the governance arrangements changed, to give the Committee some comfort that incidents such as that would be spotted in future?

Sir Chris Wormald: Again, the position is exactly as described in the independent report on the breast screening and then by the National Audit Office Report. The governance arrangements looked quite good on paper but did not work as they should in practice. One of the things we have asked Sir Mike to do is to bring us recommendations on what the governance should be in future. We will listen carefully to what he recommends. I do not think you are in a position to say what you will say straight away, are you, Sir Mike?

Chair: Can we take things through the Chair, please?

Q151 **Anne Marie Morris:** So basically, nothing has changed and you are waiting for Sir Mike to tell you what to do.

Sir Chris Wormald: We are running the governance process that was set up after the 2012 Act. We all agreed with the action Simon took in commissioning Sir Mike's review. If you commissioned a review from an expert, you listen to the results carefully.

Q152 **Anne Marie Morris:** Of course you do, so let's hear from Sir Mike. Your original focus was primarily on the cancer piece, but with a broader remit. It sounds like you have the remit on overall governance. Can you tell me what you think—clearly, it is still preliminary—could be done to improve the governance structure?

Professor Sir Mike Richards: I really am not in a position yet to make a judgment on that. I am only halfway through the review, as I have said. The one thing I can tell you is that no change will not be the answer. Exactly what the changes are I do not yet know. I am talking to colleagues at NHS England, Public Health England and the Department of Health and Social Care, and also to people across the service. So far I have met hundreds of people in various roundtables and individual meetings.

Q153 **Anne Marie Morris:** When are you likely to be able to?

Professor Sir Mike Richards: Simon Stevens has asked for my review to be done by the summer, so it will be done by the summer.

Anne Marie Morris: Okay, so you guarantee that it will be done by the summer.

Professor Sir Mike Richards: I will do my level best.

Q154 **Chair:** That means you get it to Simon Stevens and NHS England by the summer. How long do you have to sit on it and think about it?

Simon Stevens: Given it is Sir Mike, it will be brilliant and therefore it can be published almost instantly, I would imagine.

Chair: We will hold you to that.

Q155 **Anne Marie Morris:** Even though you are only halfway through, halfway is quite a long way. What do you think is currently wrong with the governance structure in place? Perhaps three headlines.

Professor Sir Mike Richards: Honestly, I do not want to commit on that until I have made further judgments on what is the right way forward. I think it would be premature and I may well find myself saying something completely different in two months' time.

Q156 **Chair:** We will flag that up to our sister Committee, the Health Committee.

Sir Chris Wormald: I think we can say what the exam question is, even if Mike cannot answer it. The arrangements after 2012 put in a particular division between Public Health England's role, NHS England's role and DHSC's role. That put the commissioning and management of the services with NHS England, a lot of the expertise and the advice with Public Health England and the Department holding the wheel, with decisions about how screening works taken by a section 7A agreement between the three of us.

The question for Mike is whether that division of accountabilities, expertise and decision making is the correct one. As Mike has said, I do not think anyone believes in the light of the experiences of recent reviews—this was a finding of our independent review of the breast screening incident—that that division is correct. Clearly, there are a number of things that you could do to that division of labour so that is different from now—it is pretty self-evident how you might change it. Which of them is optimum for the world of screening that we are going into, which Mike has described, is quite a complex question. That is why we wanted him to answer that question.

Q157 **Anne Marie Morris:** Thank you. Mr Stevens, isn't one of your challenges that this is a national programme and therefore your ability to control the actual operation of the providers, which is done locally, is almost impossible. Is that something you have added to the mix for Sir Mike to look at?

Simon Stevens: Obviously, Mike is going to answer the question that you have posed. For all the reasons we have been talking about, my hunch is that, frankly, the arrangements are overly complex and that we have got a triple fragmentation. We have got a fragmentation between the relevant national bodies; we have a fragmentation between the individual vertical screening programmes; and we have a fragmentation between the national perspectives and the local delivery chains.

I think that one of the things that we have got to do is to simplify quite radically what that looks like, but we want to do that by future-proofing the screening programmes in the round and not just trying to fix all the things that we have been talking about today in terms of the way they currently operate.

Q158 **Anne Marie Morris:** Okay. Can I just ask Mr Selbie a question? Given that public health is now the responsibility of local government—yes?—I am slightly surprised that the local government Department, which now has this extra housing responsibility, is not somehow in the mix. Mr Selbie, how are they involved if they are responsible for public health?

Duncan Selbie: There is a real opportunity here to engage the directors of public health at a local level much more centrally into whatever the right design is for the next phase. The local director of public health, who has really great expert knowledge about what is going on locally and all the things we have talked about today, is not consistently involved at the moment.

Q159 **Chair:** So it is an opportunity?

Duncan Selbie: Without making it a fourth wing to add to the three that Simon was just describing, the opportunity through Mike's review, which we are talking about, is, "How do we best engage them directly in this, because they've got a lot to contribute?" So I'm thinking about how that is going to be part of this future-proofing for the entire future.

Sir Chris Wormald: Just to be absolutely clear, we fund public health in two ways, with separate responsibilities. A set of resource goes to local government to deliver some specified things, and a set of things are done by the NHS nationally. Screening is on the national side; it is not funded from the local health grant. And while Duncan is exactly right that we want the join-ups, the last thing we want is a fourth player at the table. So I'm sure we will want to keep screening as a nationally set thing—

Q160 **Chair:** There's nothing to stop screening money, for example, going down to public health directors to decide how to target advertising—

Duncan Selbie: I was thinking about the way that Sir Chris was discussing, which is less about how the money moves but about how we engage at the local level the directors of public health, who know a huge amount about how to reach the communities that we are finding hard to reach.

Sir Chris Wormald: To be absolutely clear about where the money goes, this is national taxpayers' money that goes to NHS England and out into the NHS system. It is not locally raised taxation that goes into the public health grant funded by council tax and others, including national money and national—

Q161 **Anne Marie Morris:** Got it, Sir Chris. Sir Mike, are you going to be taking into account what the local government Department could/should do, with or without money?

Professor Sir Mike Richards: I have already been talking to local directors of public health and I wish to talk to more before coming to my conclusions, but I have already spoken to several.

Q162 **Anne Marie Morris:** So your mind is not closed to a fourth pillar?

Professor Sir Mike Richards: No. Again, I think it is about what they can contribute at a local level—their knowledge of what happens locally. They are keen and willing.

Duncan Selbie: Absolutely we don't want a fourth pillar. What we want to do is to engage the people that have the best understanding of what is happening in their area in this review.

Chair: You've said that, yes.

Q163 **Anne Marie Morris:** One of the things that Ms Flint, who is not with us any longer—

Chair: She is with us, I hope, but not here.

Anne Marie Morris: Yes—she's not in the room. Ms Flint raised this issue about understanding a local community. Well, it would seem to me that one of the justifications for moving public health into local government was that there was a greater understanding of the community. So, if you are going to do a better job of analysing, targeting, getting stuff done and marketing, then surely there is more that local government should do. Sir Mike, are you looking at that?

Professor Sir Mike Richards: I am looking at all opportunities to increase uptake in screening and the convenience of screening. That is why I am talking to people at local as well as national level.

Q164 **Anne Marie Morris:** Are you talking to patients?

Professor Sir Mike Richards: Yes. Interestingly, of course I am talking to patients and patient groups, but here we are really talking about the healthy public who we need to get to. That is a whole different segment. I am talking to a variety of different people who are experts in how we might get to people with learning disabilities and other vulnerable groups, where we know the uptake is currently low. That is an important part of what I will be doing.

Sir Chris Wormald: It illustrates some of the challenges; this is a classic public policy challenge, because there are a whole set of things where, in line with Mr Rowley's questions, you want to do them once and do them nationally and get those economies of scale, and then there are a whole series of things that are intensely local. The challenge here is to design a system where you get that control at national level of the things it is better to do at that level, but still leaves the space for the people who really understand the community in Tower Hamlets or Devon or wherever it is, to be able to adapt the system.

Q165 **Anne Marie Morris:** I am fascinated, because as we move into a world of trying to integrate health and social care and say, "Let's not worry so much about the budget; let's just get the job done," you are continuing to tell me about the money. It seems to me that, from everything I have spoken to Mr Stevens about historically, he has said that clearly the money is important, but that we need to remove the barriers and ensure we work together in the legislative chain. Therefore, it seems to me that Sir Mike ought to be looking quite deeply at this, including, conceivably, suggesting a change in how the money is allocated.

Sir Chris Wormald: Sorry, I was merely giving you a technical description of how it works.

Q166 **Anne Marie Morris:** Okay. I've got the technical description.

Sir Chris Wormald: Sir Mike will recommend whatever he believes to be correct. Personally, I would be surprised of one of his conclusions is that there are not enough parts of Government involved in the decision making and there need to be more. I suspect that the threshold would be the other way and that, as I think someone said, we need to simplify some of the decision making in this area. That is the balance we will make. On the question of how we involve local government, and indeed lots of other people who understand local communities and different parts of those communities, in how we get people to participate in the programmes, I am completely with you.

Q167 **Anne Marie Morris:** I am very pleased to hear that, Sir Chris. Mr Stevens, if you are looking to simplify, you have an unenviable challenge. What I am hearing is about complexity, but I agree that simplification would be the right answer. How, then, are you going to take what Sir Mike gives you, simplify it—because ultimately it will be your decision with the Department of Health and Social Care—and come up with something that works, and fast?

Simon Stevens: Obviously that depends on what Mike actually says, but as we have talked about, a technology spine that is shared across screening programmes will help. The way these have originated has been through individual screening opportunities arising for particular diseases, the National Screening Committee looking at them and their being layered in over a period of some decades. What we now have to do is to think holistically: for you as a person, what are the combination of risks that you are experiencing, and what do we know about how you are most likely to want to get the relevant screening and, potentially, downstream tests? It is moving away from a series of stand-alone verticals to something that can be more personalised to you. That is a huge shift, and that is what Mike has to chart us the route map for.

Q168 **Anne Marie Morris:** Does the fact that you have now identified your nine centres lead us to draw any conclusions on how your thinking is developing?

Simon Stevens: You are talking now about the cervical screening centres?

Anne Marie Morris: Yes.

Simon Stevens: No, because at the moment mammography will still be delivered in many more locations than that—in fact, we probably want more flexible and portable screening units and so forth to increase access. Some of those screening modalities will move to your being able to do it at home, which we talked about possibly with HPV but certainly with the new FIT test for colorectal, where you will get the little dipstick for your poo, and you have to do that once rather than three times. That has been

shown in the early data to increase uptake by 7%, and hopefully we can do better than that as well. I think the actual modalities are going to be driven by how the technology shifts, and then we will have to make decisions that, hopefully, will be invisible to the naked eye as far as the public are concerned—the patients—about what the right delivery chain is for those different modalities.

Q169 **Anne Marie Morris:** With the current system, are you able to prioritise and identify those individuals with a positive test result, so that that can be acted on sooner?

Simon Stevens: Yes, in some respects, but if you take, say, bowel cancer, we think there is an opportunity to move to much greater stratification of the call-recall offer for patients, based on what we increasingly see from their own genetic dispositions, and therefore the familial consequences of that. That is quite a fundamental change from the one-size-fits-all call-recall screening, which has worked well and saves nearly 9,000 lives a year but is probably not what the future will look like in five or 10 years' time.

Q170 **Anne Marie Morris:** So you take that approach across the board?

Simon Stevens: I wouldn't be surprised if that is what Sir Mike recommended, but I defer to what he has to say.

Q171 **Anne Marie Morris:** Sir Mike, are you going to give us any clues?

Professor Sir Mike Richards: As others have said, in the delivery, yes, we know there will be probably nine different laboratories for cervical screening, but for breast screening there are 79 different centres and for bowel screening there are 65, and that may be entirely appropriate. The question to me is how we commission those services, at what level we commission those services, and how the contributions of Public Health England, NHS England and indeed the Department of Health and Social Care are themselves integrated. So that is what I am looking at.

Q172 **Anne Marie Morris:** What about the accountability piece? Are you looking at that as well?

Professor Sir Mike Richards: Absolutely.

Q173 **Anne Marie Morris:** In which case, with regard to the accountability piece, the fact that Public Health England can identify things that are wrong but have no power to enforce, is that something that you will be looking at changing?

Professor Sir Mike Richards: I have been talking to people who work nearer to ground level, if you like, on this one. I think it is important to stress that the people who work in quality assurance, who are technically part of Public Health England, work very closely with the NHS England staff who are the commissioners. So they do talk to each other a lot and they tell people where they have found problems, so that then the commissioners can take the performance management action that is needed.

Q174 **Anne Marie Morris:** What about the challenge that we have with the providers? Maybe I should put this to Mr Stevens. Capita—I think we are probably all relieved that you are bringing that back in-house, but did you have all the levers you needed to manage that contract, and what about other providers? I suspect that you do not necessarily see all the data that would enable you to hold them to account.

Simon Stevens: The way the delivery chain currently works, that is a different answer for breast screening units than for the requirements in the GP contract around cervical screening. We have this thing called the quality and outcomes framework in the GP contract that has got specific targets for improvement around cervical screening for GPs, which is separate from the route for the procurement we have just done for bowel cancer. So at the moment you have to answer it in each area.

As to the conversation we were having earlier, the question is how do you get the balance right between understanding the pressures that local screening services might be under, particularly around staffing—we talked about Portsmouth and Brighton, and we are going to investigate what the story has been on Derbyshire, per the earlier conversation—versus actually being quite hard-nosed about it? You have to make a judgment, really, about what is in the gift of local areas, and if you need an alternative, how you go about structuring that.

Q175 **Anne Marie Morris:** You have got 11 programmes altogether. That is not hundreds: it is 11. You have said yourself you want simplification, so presumably between you and Sir Mike you are going to come up with a process that actually ensures you know what is going on and, if something is not working, you are going to know about it before something really dire—as we have seen—happens.

Simon Stevens: Correct.

Q176 **Anne Marie Morris:** Good. I am very pleased to hear that. What about Capita, though? Are they paying anything, or are you paying them anything, with regard to their mistakes? You would think they might be fined for that, at the very least. If you are ending the contract early, presumably there might be a question mark about whether you are having to pay some sort of compensation for what is happening.

Simon Stevens: No. To be clear, this is a contract for this aspect of their service, not the totality of everything they are doing. Independent of that, we have obviously been having a continuing discussion with them around service credits linked to non-performance, and the position is as the Committee has heard direct from the chief executive of Capita.

Q177 **Chair:** So the answer is you are not paying them any money; you are doing it through service credits?

Simon Stevens: Well, that was in connection with penalties for performance per se. Yes, those are—

Q178 **Chair:** What about taking it in-house? Are you paying them any money for taking it?

Simon Stevens: No. I don't believe so.

Q179 **Chair:** So you are not paying them any compensation at all for taking it off them?

Simon Stevens: No.

Q180 **Chair:** They are glad to get rid of it?

Simon Stevens: I would not speak for Capita, but I think they will work with us constructively on this transition.

Q181 **Chair:** Well, congratulations on not losing taxpayers' money on that bit of it, anyway.

Simon Stevens: Nor indeed on any bit of it, just to be clear. To remind ourselves of our previous dialogue, we have saved taxpayers tens of millions of pounds.

Chair: Yes, I know—£4.7 million a year. For a rubbish service, but anyway, we won't go back over that.[2]

Q182 **Anne Marie Morris:** To that point, Mr Stevens, although this was not a value for money report, clearly one needs continually to measure how much you are spending on screening and how many people's lives are being saved. Can you give us an update on where you are with that? I presume there is something in place for all 11 projects.

Simon Stevens: Yes. The National Screening Committee obviously makes the judgment as to whether a particular screening programme should be introduced. In doing that, it puts into the equation a whole range of criteria, which were first set out in 1968, one of which, obviously, is whether you can identify patients for whom there is an actionable intervention that will make a big enough difference to their subsequent illness or health. That has to be weighed against the cost of the programme.

Q183 **Anne Marie Morris:** But does somebody measure the savings from all those people who got tested early and therefore did not go into hospital?

Simon Stevens: Yes, and when the National Screening Committee make their recommendations, they factor in the ratio between the false positives and the downstream consequences.

Professor Sir Mike Richards: That is effectively part of the cost-effectiveness assessment that they do before deciding that a programme should be introduced.

Q184 **Anne Marie Morris:** Okay, so we have the programme, you have done the calculation and the programme runs for 10 years. I am hoping that you do the same calculation at least every year to make sure you are still

---

[2] "The National Audit Office's investigation into NHS England's management of the primary care support services contract with Capita states that NHS England saved £60m over the first two years of the contract (Paragraph 19)."

saving lives.

Professor Sir Mike Richards: The way you know they save lives is through the original randomised controlled trials, in general. Take bowel cancer, for example. We have very firm evidence from that that bowel cancer screening reduces mortality. I was talking earlier about lung cancer: there is one published study and another one coming that show that mortality is reduced through lung cancer screening. It is based on those trials that we make calculations about the numbers of lives that will be saved, the cost and also, very importantly, how many extra years these patients are likely to live. Obviously, cervical cancer screening is aimed at a younger generation of people than bowel cancer screening, for example, so they have many more extra years to live. I believe it is highly cost-effective.

Chair: Mr Selbie wants to add something.

Duncan Selbie: I just wanted to add that the National Screening Committee formally review each programme every three years, and they have a call for evidence every year. Where there are new technologies or new research, of course they take that into account. Every programme is formally reviewed on a cycle.

Sir Chris Wormald: The only thing I would add is that it is sometimes quite difficult to work out which element causes what. The Milan study published earlier this week, which was widely reported in the media, shows that the UK has, from a quite high base, the fastest falling number of deaths from breast cancer in Europe. It picks out screening as one of the contributory factors, but it does not allocate, "This many was for screening and this many was for the various other things."

Simon Stevens: It is worth underlining that point. As *The Times* reported yesterday, breast cancer deaths are falling faster in Britain than in the rest of Europe, and the death rate this year will be below the EU average after an 18% drop in five years, because of better NHS screening and care, which has paid dividends.

Q185 **Chair:** Mr Stevens, that is a press report.

Simon Stevens: That is the study.

Q186 **Chair:** Yes, but the point is that we can compare internationally, and that is fine up to a point, but there are different health systems so it is difficult to make direct comparisons. The key question is, are we giving people the best system we can? We need to measure against our own high standards, not just rest on our laurels about what might or might not be happening elsewhere.

Sir Chris Wormald: Oh, absolutely. The point I was making was a very specific one. We do all the things that Duncan and Simon and Mike have described about the value for money of screening per se, but, of course, with the ultimate value for money—how many lives we save—you can't say, for example, that that life over there was attributable to that as opposed to better treatment and all the various other things.

Q187 **Chair:** What is surprising—you will have picked this up from some of our questioning—is that we have seen press reports this week about some interventions that can make a significant difference to health outcomes over five or 10 years, yet we are seeing, as Ms Phillipson pointed out, a 21-year low in cervical screening. That will no doubt potentially have an impact on health outcomes. We can measure against other countries, but first we have to measure against our own previous results and our own best successes, and we also have to have an ambition for something better, I would hope.

Sir Chris Wormald: Yes. I don't think we would disagree with any of that. You need to do both. You need to compare against what your aspirations are as a country and your previous performance, and international best practice. That would be true of any piece of policy, in health or elsewhere.

Q188 **Anne Marie Morris:** One last question. One of the key things that you need to get right is clearly the coverage. One of the challenges is that often people are on more than one database—they have moved house and so on. There is also a challenge about the extent to which patient consent has been given for records to be kept. Then you have the private sector, because quite a lot of work goes on in terms of testing in the private sector. I don't think any of those records come into the NHS system. So how do you have any idea what the potential cohort is if you don't have the information that is sitting in the private sector, and that you have the coverage that you want? It seems to me to be a hole in the system. Anecdotally I hear that if you are somebody who does this privately, you are not taken out of the NHS system, and you still keep getting the letters and keep getting chased, even if you send back a letter saying, "By the way, I am doing this privately." That seems a huge waste. How are we going to deal with that?

Professor Sir Mike Richards: There are two elements when you are talking about the private sector here. One is that some of our NHS screening programmes are actually delivered through the private sector. There, of course, we do get the information and that does contribute to the figures. You are right that we don't always get the data from people who choose to go to screening independently.

Q189 **Chair:** Do you know what the percentage that is?

Professor Sir Mike Richards: No, I don't, because we don't have the data, but I have every sense that it is a small proportion. The figures for affluent patients are rather better in the NHS than the figures for deprived patients, and if the affluent were all going for private screening, that would be the reverse. So I don't think it is a major contributor. I wish it was and we could say that our figures were a whole lot of higher because of what the private sector does. I don't believe that to be the case.

Q190 **Anne Marie Morris:** You may well be right, but in terms of the efficacy, there would be some interesting consequences of including that data if you are trying to look at whether this actually saves lives. It is just that the data is elsewhere.

Professor Sir Mike Richards: I can assure you that in my previous job, when I was chief inspector of hospitals, and where I was responsible both for services provided in the NHS and in the private sector, we had a lot of discussions with private providers about their data collection and contributing that and merging it with that of the NHS. I think we made some progress, but there is further work to be done.

Q191 **Anne Marie Morris:** Excellent. So in conclusion, I am expecting from you, Sir Mike, something in the summer and I am expecting from you, Mr Stevens, something quite soon thereafter, because you have agreed that it needs to be simplified. I wonder if Mr Stevens would like to make a final comment to summarise?

Chair: You are in her good books today, Mr Stevens. I'll indulge it.

Simon Stevens: There's going to be a sting in the tail, I know it, so go on.

Anne Marie Morris: When are we going to get this system? When you have got what is coming from Sir Mike, who you are putting under the thumb to do it by the summer, surely you are putting yourself under the thumb—I am sure the Secretary of State will be, if you are not. When are we going to see the results of what Sir Mike has done and your plan as to how to ensure the system works? End of the year?

Simon Stevens: I would hope—if Mike hasn't got this, I will use this public forum to pass the request on to him—that his report makes recommendations that have built-in proposed phasing and timescales for pragmatically and practically what could get done, so that we could then work off that.

Q192 **Anne Marie Morris:** Any clue as to what timeline you are working to? What Sir Mike has written is clear, but you are also under a lot pressure from patients, the public and the Secretary of State to put in place something that works, otherwise we are wasting money.

Simon Stevens: Some things are in the process of changing right now. Over the next 12 to 24 months, we will see big changes, including to the bowel cancer screening programme. One opportunity for us is that, by using this new FIT poo dipstick for symptomatic patients, as against screening the asymptomatic, we think we may be able to reduce the number of colonoscopies and other bowel scoping that is required, which will free up capacity for earlier diagnosis of colorectal cancer and will potentially allow us to change the thresholds for the screening programme. All of that should be layered in over the next 12 to 18 months. That will be a big change.

We have already talked about the big changes that we will see in the cervical screening programme, with introduction of primary HPV over the course of the next nine months or so. We will undoubtedly continue to see opportunities to change the way some of the screening programmes, such as mammography, operate on the back of a set of technology challenges

linked to the better use of machine learning to assist human eye pattern recognition of potentially cancerous lesions.

We will see some big opportunities to shift the way that the screening modalities work over the next 12, 24 and 36 months, rather than the five years-plus that it would take if we depended only on some of the bigger technology shifts.

Anne Marie Morris: Right, so if we said that—

Simon Stevens: However, I am looking to Mike to practically sequence that for us and to set us a road map that can be delivered, taking account of the staffing constraints and all the rest of it.

Q193 **Anne Marie Morris:** So I expect, in two years' time, a system that works and a governance system that works. Given what you said about the current schemes being sorted in nine months, 18 months or two years—

Simon Stevens: I heard the governance bit. What was the first bit?

Q194 **Anne Marie Morris:** The overall screening processes that currently do not work, based on the map that—

Sir Chris Wormald: Well, I think the only thing I can say—

Chair: Sir Chris is about to add a caveat.

Sir Chris Wormald: No, it isn't a caveat, actually. Obviously, Simon will have to have another final word after mine. However, as has been illustrated throughout this hearing, there is a lot that already works in the screening system, so one question, as well as what we should change, is what we should keep.

This is not one of those things. The speed at which technology changes means that there is never a day on which it is fixed. One thing we need is an adaptive system for the kind of technological change that Simon describes, so that we are good at bringing in the next set of easier, more accurate set of tests as they come on stream. As I say, one challenge is that technology moves very fast, and we do not currently know which of those technologies will be groundbreaking.

Q195 **Chair:** That's important, but in terms of the patient process, the test bit is slightly separate, but then they get the letter after the test. A lot of it is administrative.

Sir Chris Wormald: The point I was making is that one of our challenges is to create a system that can be adapted to change, as well as one that fixes the kind of basics that we are talking about here, if you see what I mean. We have that double challenge.

Q196 **Chair:** That's the clinical testing bit. Briefly, before we finish, I will go back to the path labs. There are 48, which is going down to nine. Is that set in stone, or is there any flexibility on that? We have seen, in other bits of Government, large numbers narrowed down to a smaller number, and then a few years later it is realised that there are problems with that.

Is there any wriggle room on that, Simon Stevens?

Simon Stevens: The process for identifying the nine is essentially complete; they will be named shortly. The best advice that we have is that there are minimum volume quality gains and efficiencies, and nine is what we should be doing. However, we should of course keep this under review. To have the adaptive system that Chris just talked about, this is one of those areas where we need to be fleet of foot.

Q197 **Chair:** You can keep it under review, but if hospitals sell off the sites of their path labs or close them to do other things, you will have lost that theatre, potentially.

Simon Stevens: This is a small part of what most of these path labs are doing.

Q198 **Chair:** Let me be clear: is the nine just for screening tests?

Simon Stevens: Yes. It will not be nine path labs across England. It will be nine locations where the cervical cytology—the HPV—aspects will take place.

Q199 **Chair:** So you have the capacity to put that back into other path labs if you find that having nine central locations—

Professor Sir Mike Richards: One important thing to remember is that the number that will need to be looked at under a microscope will go down by 85%. You have got to have a sufficient volume going through an individual lab to maintain the expertise and to have a sufficient number of staff in that centre. That is part of what is driving the number of nine.

Duncan Selbie: On the path, Public Health England did the original option appraisal of how many labs would be needed given the context described, and we reviewed that again with everybody just in this last year. Nine, we think, is the right number, based on the volume. We are not expecting that to change.

Sir Chris Wormald: The other thing, which goes to the example that Simon and I were describing earlier at Leeds, is that once you have digitised a lot of this, a lot of it can be done anywhere. They were quoting the examples of people—the actual production of the sample has to happen in a physical place, but once you have done that, you need the screen and an expert, who could be in their own front room, working from anywhere. That sort of system builds much more flexibility into the decision on whether it is nine, or another number.

Q200 **Chair:** Okay. We are hearing a lot of positive opportunities about the future of technology, but that is about testing. What we are waiting to see is if we can get a system that gets people their letter on time and gets their results back to them on time. From what we have seen in the NAO Report, that is still a big problem. You can race ahead and think it is all going to be fine, but the basics—

Sir Chris Wormald: Yes, you are absolutely right of course. Digitising things also helps with the speed of processing and therefore the speed of getting—

Q201 **Chair:** A shiver goes down my spine every time Simon Stevens mentions that it is all going to be NHS Digital. There have been a lot of challenges with NHS IT programmes,

Sir Chris Wormald: That is why it is important to quote the actual example. The example we have quoted in Leeds, that is happening today, you can go and see it. This is not technology of the future—

Q202 **Chair:** I suspect you will be back in front of us, either telling us it has gone brilliantly, or there may be—but I don't want to predict bad things. I am sure you are keeping a close eye on it, but it seems remarkably quick from when you are taking over the Capita contract to having a better system. We look forward to that success, Mr Stevens; if not, you will be back in front of us—

Simon Stevens: I think that might be true regardless—unless you are giving me two years off, in which case I thank you, Chair.

Chair: Until next time, gentlemen, thank you very much for your time today. The transcript will be up on the website in the next couple of days. Maybe next time it would be a good idea to send a woman to talk about cervical screening. We are always keen to have more female witnesses, so I will perhaps suggest that more firmly next time. Thank you.