

Health and Social Care Committee

Oral evidence: Work of NHS England and NHS Improvement, HC 430

Tuesday 25 June 2019

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Andrew Selous; Dr Paul Williams.

Questions 138 - 314

Witness

[I](#): Simon Stevens, Chief Executive, NHS England.

Examination of witness

Witness: Simon Stevens.

Q138 **Chair:** Welcome to the Health and Social Care Select Committee, Simon Stevens, chief executive of NHS England—and possibly soon of NHSI as well.

Simon Stevens: On 1 July.

Q139 **Chair:** Thank you very much. We have a number of areas that we would like to cover today, but could I start by asking you to update us on the NHS financial position, particularly around deficits?

Simon Stevens: Yes. The NHS ended the last financial year, 2018-19, in a break-even position on revenue, actually a £90 million underspend, but that was comprised of an overspend of around £830 million in the trust sector and a £920 million offsetting underspend in the commissioner sector.

Q140 **Chair:** In the NAO report from 18 January, Amyas Morse says that bringing stability to the system would require £1.85 billion to eliminate the underlying deficits. Of course, those fall overwhelmingly in the acute sector. Is there a risk that further transfers will make it very difficult to achieve what you are hoping to achieve in terms of £4.5 billion shifting into primary and community care? We know that over many years, with all good intentions to see shifts into primary care, mental health and the community, what has happened is that it ends up being sucked into the acute sector. Is that a concern?

Simon Stevens: We had the benefit of knowing what the five-year funding settlement would be and what the 2018-19 financial position was at the point when we published the long-term plan on 7 January, so we incorporated for the current year we are now in—2019-20—an additional £1 billion put in to support trust deficits and control totals. We were able to factor that in and make the commitments that mental health services would grow faster than the overall NHS budget, worth at least £2.3 billion a year extra by 2023-24, and that for the first time in NHS history, primary, medical and community health services would grow faster than the overall NHS budget, worth £4.5 billion extra in real terms by 2023-24. We knew the position that Amyas describes when we set those commitments.

Q141 **Chair:** Do you feel you are still on target for achieving those goals?

Simon Stevens: As we sit here today, yes.

Q142 **Chair:** Overarching all that is the fact that we are now not going to get a spending review in the autumn, so we do not know what is going to be there for Health Education England, for social care, for public health and for capital. How concerned are you and what impact do you anticipate that will have on the ability to develop detailed local plans?



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Simon Stevens: We think there would be a strong case, almost regardless of what happens with the rest of the medium-term decisions on public spending, for being able to give the NHS certainty on its five-year outlook for capital spending and for education and training budgets, as well as the other matters around social care and the public health elements of local government; they do not substitute for it but they complement the five-year revenue settlement that the NHS has.

When, last June, the five-year NHS revenue settlement was set out, we were able to develop the long-term plan in anticipation of there being a five-year funding settlement for those other services as well. Whatever the other considerations are, there will be great benefit in being able to ensure that NHS delivery is on track in setting five-year budgets for the other services later this year.

Q143 **Chair:** How can you plan NHS delivery, for workforce, for example, which underpins everything else, if you do not know what your HEE settlement is going to be? Surely, you cannot make plans for that.

Simon Stevens: The bulk of the additional funding that will be paying staff across the national health service is in our revenue settlement, which we already have, so the question is about the number of nurse places, where we are going to need a big increase, the debate around student finance, possibly more medical school places and the need to reinstate continuing professional development funds for nurses.

Yes, all of those have to be addressed as part of the spending review, so later this week, when we set out the planning process that we are going to ask the NHS locally to use to do their long-term plan implementation for the autumn, there will obviously be some uncertainties against which people will have to have scenarios between now and the autumn.

Q144 **Chair:** Isn't that an understatement?

Simon Stevens: I do not have an answer for that as yet. That is just the reality we face.

Q145 **Chair:** When you say "some uncertainties", it implies that it is a minor detail. This is major uncertainty, isn't it?

Simon Stevens: It is a relevant uncertainty, but the fact is that this is only the second time in the NHS's 71-year history when we have had a multi-year revenue funding settlement, and it is the first time that we have had it during a time of economic pressure. We do not look a gift horse in the mouth; we realise that we are in a privileged position, relative to other public services, and we can get on with the bulk of what we need to do.

Q146 **Chair:** Isn't there a danger in that statement, in that when we come to the spending review everyone will say, "Well, the NHS has had its fair share and it is job done on the NHS"? Surely, you must recognise it is not job done on the NHS, because if we do not get a reasonable settlement



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for social care, for capital and all the other things I have just referred to, it will seriously impact what happens to the wider NHS.

Simon Stevens: Of course I recognise that. It is an argument that we have been making for some time. On capital investment in particular, there is a need now to see a gear change in the level of public capital investment in the NHS. That is required not just to deal with the £2 billion increase in backlog maintenance we have seen over the last several years, but to deal with the need to modernise mental health in-patient facilities, to modernise our diagnostic equipment and, frankly, to restart the major hospital building programme we are going to need across England.

When the country's attention turns to infrastructure, I think the infrastructure questions in the NHS, which have not yet been addressed through the five-year funding settlement, need to be an important part of the dialogue.

Q147 **Chair:** The figure we have is that there is now over £6 billion in backlog of maintenance, and of that over £3 billion is high and significant risk. That is extraordinary, isn't it, yet we have continued to see capital-to-revenue transfers to prop up deficits in the acute sector? How are you going to turn that around? Presumably, you cannot start building the shiny new hospitals until you have dealt with the high and significant risk. I have seen that in my local area with the impact of our hospital closures.

Simon Stevens: Absolutely. I think people understand that over the last five or eight years public investment has been constrained, and that is going to stand in the way of some of the quality and productivity improvements that we want to see in the NHS if we do not get that right. The capital, the equipment and the facilities available per staff member in the NHS have decreased in value by 17% since 2010, and most other sectors of the economy that are driving productivity and improvement would be increasing the capital available to their staff. We completely see that. Given as well that PFI is dead, and many would say rightly so, and given that the Treasury has declared that PF2 is not a funding route, frankly, it will have to be public investment if other routes all score against the public capital limit.

Q148 **Chair:** It is not only not increasing; capital investment has actually fallen by 7% since 2010, hasn't it?

Simon Stevens: Per staff member it has fallen by 17%, I think, yes.

Q149 **Chair:** Overall, it is a very significant fall.

Simon Stevens: It is and, as we have discussed before, and we have discussed with the Public Accounts Committee as well, we have had to make some difficult choices around using some of that future investment for day-to-day running costs to keep services going, but that is not the right answer for the next five years.



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Q150 Chair: No, so you are quite clear that you need to see that go up. One area where I wonder whether you have some control is sales of NHS capital. We have seen £4 million of sales in 2017-18 compared with £175 million in 2010-11, and that is meant to be reinvested in other capital projects. In fact, that has not been the case, and significant amounts of it are just going into revenue. Is that something you can have some control over to make sure where it is going? At least where we are making sales, you would expect that to go back into capital.

Simon Stevens: Over the last several years, hospitals and the trusts involved have needed that revenue, so I in no way want to criticise what has happened over the last several years. Looking forward, yes, we would want to find a way, where we have unused older land and buildings, that that can be recycled into investing in new facilities, of course.

Q151 Chair: Is there anything else you want to say about capital at this point?

Simon Stevens: No. The wider debate is now turning to questions of infrastructure. As it happens, public borrowing costs are very low by historical standards, so there have been suggestions of an NHS Government bond, for example, that could kick-start some of those programmes, but these are all matters for the next Administration.

Chair: Thank you. Diana, do you have anything you want to ask about capital?

Q152 Diana Johnson: Very briefly. I want to ask about diagnostic equipment, because you talked about that. The need for investing in diagnostic equipment is vital to deliver the long-term plan, isn't it? In the priorities for capital investment, where would you see diagnostic equipment sitting on the list?

Simon Stevens: Quite high, because, as you say, we have seen a big increase in the number of tests and scans. Our availability of MRI and CT is pretty constrained by international standards. We explicitly put in the long-term plan a chart, at figure 28, showing the proportion of our national income that was being invested in capital, and a separate chart looking at the availability of CT and MRI scans. It is a key part of being able to expand early diagnosis for cancer services, for example.

We have seen a doubling in the number of urgent cancer checks since 2010, so the diagnostic capacity piece is one of the areas that has a workforce constraint that we are looking at as well. We think there are new and better ways of doing that, and in particular we are looking at whether we can use artificial intelligence for doing some of the scans that at the moment require people, and we can use some of the scanning equipment we have got more intensively. We need new equipment, but we can also do things differently, and we can drive productivity and diagnostics as well.

Chair: Can we come on to primary care?



Q153 **Andrew Selous:** Where did it all go wrong with the general practice forward view of April 2016?

Simon Stevens: Do you want to get your follow-up in first to further defend your accusation?

Q154 **Andrew Selous:** I just want it to be a friendly, helpful exchange. There are some serious points. I am not here to score points, because we all care deeply about general practice; it is the front door to the NHS, isn't it?

Simon Stevens: Absolutely.

Q155 **Andrew Selous:** I guess this is slightly where I am coming from. Your April 2016 document is a great read, isn't it? I have the front page of chapter 2 on workforce here. It all looks excellent: 5,000 extra doctors, 5,000 extra staff. We are going to have those in by 2020, and you list a series of bullet points on how you are going to achieve it.

I then come to the long-term plan—lots of good stuff. You have dropped a date; you still want the 5,000 but there is no date as to when they are going to be there. Actually, the figures are pretty awful, aren't they? The figures I have are September 2015, 29,229 GPs; March 2019, 27,381. That is a fall of 1,848, and I think that is full-time equivalents.

On supply and demand, I do not know whether you track how many people are using GP services, but the data I have from the Office for National Statistics show that there were 1.5 million additional new migrants from overseas—GP registrations—in England and Wales alone between 2015 and 2017, so you have a workforce going one way and demand going another way. I am sure you did this document with the best of intent, but why should I not be sceptical about it? How is it going to be different? I guess that is the heart of my question.

Simon Stevens: First, I am afraid I disagree with the premise of your first question. It clearly is right that GP numbers have not gone up in the way we wanted them to, so that is true, but overall primary care services have received additional investment and there are more non-GP staff working across primary care.

Q156 **Andrew Selous:** I am talking specifically about GPs. I get the point about clinical pharmacists and practice nurses, but you cannot run primary care without GPs and we have growing populations using those services.

Simon Stevens: In that case, your question is not, "Where did the GP forward view go wrong?", because I do not think it did, but, "Why do we not have 5,000 more GPs?"

Andrew Selous: Yes, it is.

Simon Stevens: There are three parts to the answer. The first is that the early retirement rate has gone up. Secondly, the part-time working rate of GPs in their 30s and 40s has continued to increase. The average



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GP non-partner in their 30s or 40s is doing core general practice about three and a half days a week; some of the rest of the week they may be doing other clinical activities, valuable activities, for the NHS, but not core general practice.

Those two have been the outflows, and they have not been sufficiently offset by the new inflows, which nevertheless are good, because for the last two years we have had the highest number ever of young doctors choosing to train to become future GPs. That is the future promise, but we have to do something about increasing the participation rate among our part-time, younger GPs, and dealing with the early retirement rate on the part of GPs in their late 50s and 60s.

Q157 Andrew Selous: I completely agree, so can you give us some detail on what you are going to do on those two issues?

Simon Stevens: Sure. On the early retirement rate for GPs, there are three things that keep coming up in what GPs tell us. One was the burden associated with the indemnity arrangements, whereby individual practices were on the hook for rising costs for their medical negligence liability, unlike hospital doctors. From April this year, for the first time since the health service was set up, that liability has been removed from the shoulders of individual practices and practitioners and that, I think, has been regarded by the profession as a big plus. Secondly, there is obviously an ongoing question about pensions costs, and we—and indeed the Department of Health—have been advocating changes to the way the pensions policy works to try to offset some of those pressures.

Thirdly, there has been a question about the workload pressures on GPs and whether they can see a realistic prospect of them being relieved. On that front, we have been doing intensive work with individual practices on changing the way the appointment system works, and on the role of practice nurses and other health professionals in primary care, and two years ahead of time, per the goal in the GP forward view, we have increased the number of other staff working in general practice by more than 5,000. We are up to over 7,000 whole-time equivalents now, with another 22,000 to come. That, I think, is the unvarnished answer to your question.

Q158 Andrew Selous: The three things you are doing all seem to be absolutely in the right space. I think you are also looking to recruit from overseas in addition.

Simon Stevens: Yes.

Q159 Andrew Selous: Given those good things, I am curious as to why you have not put a date in the long-term plan. In April 2016, you were prepared to commit to a date. It is a slightly scary thing to do; it means you can be held to account in sessions like this and we say, "Why didn't you meet it?" I get the reluctance, but if you have confidence in what you are doing, and if this really matters, why won't you give us a date for the



extra 5,000 GPs?

Simon Stevens: Because the NHS nationally does not control the retirement decisions of individual GPs or the part-time working decisions of GPs mid-career.

Q160 **Andrew Selous:** That was no different in April 2016, was it?

Simon Stevens: What we have seen since then is that those have become a bigger factor. We want 5,000 more GPs net, and we want to get them as fast as we possibly can, but we also want to be as objective as we can about setting timelines, and not making dates that we cannot be clear about.

Q161 **Andrew Selous:** Okay. It is good to hear you re-state that commitment: 5,000 net more GPs as soon as possible, 100% committed to that.

Simon Stevens: Yes. Absolutely.

Q162 **Andrew Selous:** Can I ask you what you are looking to do, if anything, or if it is even on your radar screen, when individual GP practices are struggling or failing? When I look across public services generally, if a school is in extreme difficulties, the local authority can send in school improvement officers, and we have Ofsted and it can be put in special measures if necessary. It is the same thing for a local authority; the Government could ultimately send commissioners from London. They rarely do that but they do it from time to time.

If a GP practice is seriously struggling, given that this is probably the frontline public service that our constituents care most about, when I have looked into it, I have been truly shocked at how few levers there are to do something about it. The sort of comments that come back are, "We'd better not push them too far, or they'll hand the contract back." Nowhere else in the public sector would that be an acceptable reply, given that public money is being spent. Also, are you not concerned about the lack of visibility of the finances of some of these practices, given again that it is public money?

Simon Stevens: You are saying that you think the practices are not being pushed hard enough.

Q163 **Andrew Selous:** What I am concerned about is that where a practice is not giving an adequate service, when I have looked into it in considerable detail with NHS England, with the clinical commissioning group and with the Care Quality Commission, the levers to do anything about it are few and far between. I think that is a big worry, because, as I say, probably all of us here would say this is at least one of the public services—being able to get in to see a GP—that our constituents care most about. Is it an outdated model? Do you need more powers?

I am truly shocked, as a Member of Parliament, at how little we can do about it when a GP practice is really struggling. It may well need help. It may need guidance. You may need to clear out a managing partner who



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cannot lead, cannot keep their staff or does not look after them, but there is no ability to do that in the way you have structured the contract. Is that on your radar screen, because it is a big concern to me at the moment?

Simon Stevens: Yes. I suppose the first thing to say is that over the last several years, for the first time, GP practices have been subject to independent inspection, which has not been hugely popular across general practice, I think it would be fair to say. Nevertheless, there is now that external view of what individual practices are doing, and we have published data on the back of that.

Secondly, we have seen some individual practices, several hundred individual practices, stop, probably for some of the reasons you describe, and that often generates an equal and opposite issue, which is, how come we are seeing some of these smaller practices cease and the patient list being taken over by other—

Q164 **Andrew Selous:** It can actually be practices with over 20,000 patients that are in that situation; it is not just the small ones.

Simon Stevens: The third thing is that, as part of the new GP contract we have just agreed for the next five years, we have, in effect, mutual support through the primary care networks that have now been established in every area.

Q165 **Andrew Selous:** With respect, mutual support does not quite cut it if a practice is manifestly failing. Maybe they are resistant to support. Maybe they just brush it aside and sit there, and people cannot get in to see a doctor and there is very poor service. I think it is almost unique in the public sector, in that we are able to do very little about it, and that worries me greatly.

Simon Stevens: I would be happy to get together and hear more about some of the particular cases you are referring to.

Q166 **Andrew Selous:** I have tried to keep it general rather than specific.

Simon Stevens: Under the terms of the GP contract, there is a set of terms of service set out and they have to be met, but we have two GPs on the Committee, and I do not know—

Q167 **Andrew Selous:** That is fine. May I finish briefly? If I may, I will come back to you offline on that particular issue.

Finally, I want to come on to the issue of RightCare and Getting It Right First Time. I asked for some follow-up information from, I think, Ian Dalton at one of his previous appearances on this Committee. You are starting the general practice roll-out of Getting It Right First Time.

Simon Stevens: Yes.

Q168 **Andrew Selous:** I believe Professor Helen Stokes-Lampard has agreed the proof of concept for that, but I was slightly curious that there was a



comment in Ian Dalton's letter to me that RightCare was collecting the data, but my understanding is that it is at CCG level, not at individual practice level. I wanted to make sure that there was not any resistance.

Simon Stevens: All of these programmes have been brought together into a combined improvement function, as NHS England and NHS Improvement come together, because, frankly, one of the criticisms that I would say has been directed at the national bodies by some of the frontline NHS is that there have been too many different teams turning up to help, and what people need is a shared holistic view.

The work that has been done on general practice improvement, the methodologies that GIRFT applies, and the RightCare look at who is doing what across a geography all has to be brought together, and we have appointed a new national director for improvement who is doing that.

Q169 **Andrew Selous:** I am just checking. I spent nine years trying to get the NHS to adopt GIRFT. You now have it in 32 specialisms and I think it is on track to save you billions. I hear it is doing good things, so we will wait for the independent evaluation.

Simon Stevens: It is doing good things, but one of the challenges for GIRFT is that it has to go deep as well as broad. What we do not want in general practice is duplicative effort. We have to sync it all up with the other change programmes that are happening in primary care.

Q170 **Andrew Selous:** But you would see RightCare and GIRFT working together, hopefully.

Simon Stevens: I would, and with some of the other primary care improvement programmes as well.

Andrew Selous: Excellent. Thank you.

Q171 **Dr Williams:** One of the things that my constituents contact me most about is access to GPs. They see that in some practices access is absolutely superb, with people able to see a GP on the day they want, at their convenience, book online, sometimes using electronic consultations and telephone consultations—really responsive, and not just with doctors but other practitioners as well. But they see in other practices lack of responsiveness and having to telephone hundreds of times before they get through at half-past 8 in the morning. Do you think primary care networks might change that?

Simon Stevens: I think that will be one of the litmus tests as to whether they have been successful, yes. The point is that, by having practices across a neighbourhood or a town working together, it should be possible to divide some of the specialist support so that some of the routine consultations can be done more quickly. It frees up doctor time to have longer appointments for the patients who would most benefit.

There is also, in a number of parts of the country, the move towards offering not only phone appointments but, potentially, digital



appointments as well, where that means that part-time GPs can do extra sessions from home rather than having to come into the surgery. It is possible that that would be one route for expanding the overall supply of GPs in the way I was just talking about with Mr Selous. We have to look at that as part of the answer as well.

Q172 Dr Williams: Are you confident that the configuration of primary care networks will deliver that?

Simon Stevens: With the exception of a couple of dozen practices, I think the whole country has now agreed its primary care network configuration. Primary care networks are not new organisations; they are not little mini-commissioning organisations. They are kind of what it says on the tin. Are those the practices in each network? Will they, in all likelihood, evolve over time? Yes, but it is pretty remarkable that between 1 April and the end of June, in the course of three months, all practices across the country, bar a couple of handfuls, have figured out how to work on that network basis.

Q173 Dr Williams: My question is around oversight. I am a bit concerned that some practices have worked with other practices that might better meet the practices' way of working rather than necessarily meeting the needs of the population.

For example, there are two practices in my constituency that actually share the same building and serve the same communities, yet they have decided to go into separate networks, potentially losing some of the advantages of working with the voluntary and community sector, community services and social care. There has not been oversight of that to tell them, no, the interest of patients is that they work together, and to help them to facilitate any barriers to perhaps working together. Have you seen that?

Simon Stevens: I think CCGs have had the opportunity to be in the mix in those conversations, and in some parts of the country there has been a bit of to-ing and fro-ing between practices and CCGs on those questions, but I would be happy to look into the situation in your area.

Q174 Dr Williams: You also said that you might meet or talk to Andrew Selous about improving access to general practice. Could I join those conversations as well, please?

Andrew Selous: You are very welcome.

Simon Stevens: Absolutely. We are gate-crashing Andrew's party, but with Andrew's permission, yes.

Q175 Diana Johnson: Access to GPs is the big issue that I get. Unfortunately, I have not been as lucky as Paul to hear from my constituents that there are practices in Hull North where people are able to access appointments on the day. What I get is that they are waiting at least three weeks for an appointment. Of course, we used to have targets, didn't we, around how



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quickly you could get to see a GP? When do you think we will get to the point where you will be able to say there is a target that you can see a GP within 48 hours? I think that used to be the target, didn't it?

Simon Stevens: It did, but it produced some unintended consequences, which is that a lot of patients found it hard to actually book a convenient appointment with their practice. You might say, okay, today is Tuesday, I could come and see you on Friday, and the practice would say, no, you have to phone on the morning rather than having a bookable appointment. That was part of what patients were saying then.

Q176 **Diana Johnson:** If we can put a man on the moon, we can sort that out, can't we?

Simon Stevens: With enough GPs and new ways of interacting with primary care, yes, we can.

Q177 **Diana Johnson:** When, do you think? In your tenure?

Simon Stevens: In fairness to GPs, I go back to where Andrew began: the fact is that the burdens on GPs have been rising markedly over the course of the last decade, and, unlike the welcome increase we have seen in the number of hospital consultants, we have not seen that increase in GP numbers. With 307 million patient visits a year to general practice, GPs have a point when they talk about their workloads.

Q178 **Diana Johnson:** When do you think we will get to the point where you can access a GP and not have to wait three weeks?

Simon Stevens: It will be a combination of how quickly we can get the 5,000 extra GPs, how quickly we can get the 22,000 other staff, which will be over the next five years, to help.

Q179 **Diana Johnson:** But do you have an idea in your head?

Simon Stevens: Yes, over the next five years.

Q180 **Diana Johnson:** Over the next five years.

Simon Stevens: But exactly what that will look like will depend on the availability of services, which is not even across the country, and that is another issue, of course.

Q181 **Diana Johnson:** Can I ask one other thing? It relates to GP practices that are perhaps not performing well, but they are practices where they decide that they just do not have the GP staff to carry on.

I have an example in my constituency, where Modality run a practice. They say that they cannot recruit and they are going to close it. When I tried to find out about the process for that, the role of the CCG seems to be that it is able to check that a consultation has been carried out, but it cannot actually stop the practice closing, so we are going to lose that practice. My constituents say to me, "Why is it that in Hull, when we have a medical school where we are supposed to grow our own doctors, we are



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faced with the position that practices are closing and you have to wait three weeks to get to see a GP?"

Simon Stevens: I am very sympathetic to the point that your constituents are making, but obviously those new doctors from the Hull medical school have not yet come through training and started work in the NHS. That is the reason for having five new medical schools that come online this September. It is the reason for the 25% increase in medical undergraduate places.

I was in Lincolnshire a few weeks ago, at the University of Lincoln, one of the other new medical schools, and I said to them, in terms, "Your success or otherwise will be judged based on whether doctors who come through your training programmes want to work in Lincolnshire and help deal with some of the staffing pressures." We have to create good training experiences, and it is not just the universities; it is the NHS as partners as well. I think that is a very fair point.

The location for some of the five new medical schools was influenced by the evidence that doctors tend to work in areas where they have previously trained, provided that the experiences in the round have been good. Whether it be Kent, Lancashire, Hull or Lincolnshire, that is what we want to see.

Q182 **Diana Johnson:** The CCG cannot stop a practice closing. Do you think they need different powers to be able to do that?

Simon Stevens: Ultimately, we do not have conscription—I am not being glib—so, if a GP is not going to work at a practice, then a CCG cannot, by legal power, make that happen.

Diana Johnson: Thank you.

Q183 **Rosie Cooper:** Simon, I absolutely understand the concept of independent contractors, but, seriously, what levers do you have to deal with not necessarily disastrous failing practices but practices that cause concern? For example, in my constituency, the CCG chair's practice requires improvement—a bit of a worry, I would have thought. I do not understand, and I have tried quite a few times, how the levers are applied, notwithstanding that we have the CQC giving them a rating.

Develop that into CCGs. Do they have a future, and, if they do, why is Ian Dodge recommending that they provide or set up commissioning teams, and almost have the resources directly given to them, if CCGs are here to stay? Then I am confused that everybody says place is so important, yet there is so much top-down: the urgent care strategy, transformation funds for mental health and crisis services to be bid for via STPs. Why not give the CCGs the resources, make sure they are operating correctly, put the input there and get them to do what is right for the locality, for the place?



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Simon Stevens: If I can, I will take that in two parts. On the first part, around the future role of CCGs, our expectation is that CCGs will continue to be the legal, statutory commissioners in the NHS, subject, of course, to any changes that Parliament might bring about. In your helpful report earlier in the week on the legislative proposals, the Committee took the view that pragmatically, rather than throwing it all up in the air, we would still, in all likelihood, have CCGs and NHS publicly accountable trusts.

Under those circumstances, the question is, how do the CCGs work with the trusts? We think there will be less transactional annual contracting in the system and more focus on the care improvements we want to see for a given population. A lot of the counting of clicks of the turnstile activity will either go away or will be part of what the integrated providers are doing. I think that is what was being referenced in your first point.

On your second point, I think that is actually the approach we are now going to take, for the most part, to the funding that is in the long-term plan. We have allocated the bulk of the £20.5 billion to individual places, and later this week, on Thursday, we have a public NHS England board meeting and we are going to show the additional funding. The presumption will be that each area will get their fair share, provided that, come late autumn, they can show how they are going to use it to drive those improvements rather than the bidding process for most of it.

Q184 **Rosie Cooper:** Do I understand that to mean that then the CCGs will just become a legal shell?

Simon Stevens: No. It means they will be the legal entity that, as now, is responsible for entering into contracts.

Q185 **Rosie Cooper:** Do they have the power?

Simon Stevens: Their statutory powers, obviously as we speak, are unchanged and under the proposals we discussed would still be unchanged.

Q186 **Chair:** Can I come on to Babylon GP at Hand? We have already discussed the fact that primary care is in quite a fragile state, and into that, in London, you have thrown quite a disruptive organisation. How well have you assessed the evaluation of that before deciding to roll it out to Birmingham?

Simon Stevens: To remind everybody, GPs at the moment have a contractual right to subcontract, to establish branch practices, and that is the arrangement that the practice in Hammersmith and Fulham entered into.

Q187 **Chair:** It is a pretty large practice.

Simon Stevens: The legal basis under which NHS England can stop that is very circumscribed, so the particular reason that was set out last year was around ensuring that the syncing between the GP services and the screening services was in place, and we now have assurance that that is



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the case. With that issue off the table, that practice, just like every other practice, has a contractual right to subcontract. What we are going to propose for consultation later this week is that, where practices do that, they should be required to create new local practices, if it is far-flung, so that you can connect the new local practice with other practices in an area, rather than having a national practice operating out of Hammersmith and Fulham. I think that would deal with a lot of the concerns.

Q188 Chair: You are saying you had no powers to stop them rolling out to Birmingham. Is that what you are saying?

Simon Stevens: Correct. The powers that we had were in respect of the screening and a limited number of safety matters, and we will be putting this all out in a public consultation on Thursday.

Q189 Chair: There is a great deal of concern. I have been looking at the evaluation. Isn't it just creating extra demand, driving new demand? When you look at the demographic of the people who tend to use the service, they are younger, they tend to be more affluent and they are using the service more than you would now expect, given their background profile. In other words, in terms of health inequalities, if you have any kind of serious long-term condition, you do not have the choice to use it anyway. You need access to a smartphone, so it is driving increasing health inequalities, and it is not answering the problems that the NHS has in terms of long-term conditions and deprivation. It is just providing a very expensive service for people who use it more than they need to, isn't it?

Simon Stevens: Any practice like that has to offer its services within the same financial envelope that any other practice would receive. There is a question as to whether there are elements in the way the so-called Carr-Hill formula that pays GPs has worked historically that fairly reflect the different workload you would expect in different types of practice. We have already made some adjustments to that, and, without pre-empting what we do on Thursday, we are going to consult on further adjustments in the fair funding formula in general practice to deal with some of those issues.

Q190 Chair: Indeed. I am very glad to hear you are looking at that, because Andy Slaughter, the MP for Hammersmith and Fulham, has written to me and he says that it has had the impact of an extra cost of £26 million. When you say you are adjusting the formula, can you please assure me that you are not going to be giving even more to these disruptive practices? Are you going to be giving them even more or will you be giving them less, because, of course, GPs in other practices are being left with the patients who actually require much more support?

Simon Stevens: Let us distinguish between the funding that is going to the general practice versus the funding that is going to the CCG to support the non-GP services that patients in that practice require. The



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first of those is the proposal we will be consulting on later this week. On the second, how to deal with the fact that the Hammersmith and Fulham CCG has patients on the list of a practice there who might not be resident in Hammersmith and Fulham, again—

Q191 **Chair:** But it just drives a coach and horses through the idea of place.

Simon Stevens: Understood. Again, we will be making two very specific proposals to resolve that point in our public consultation on Thursday.

Q192 **Chair:** But if resolving it means that you are just disrupting the whole system, the idea that you do not even need place-based commissioning—

Simon Stevens: No, it will not mean that. The money will follow the patient and there will be regular adjustments to make sure that the funding fairly represents the patients who are attributable to a particular geography.

Q193 **Chair:** I find it extraordinary that you do not have any control, if it turns out that this is a disruptive kind of mechanism—an Uber GP model that we are developing—and that we are not actually focusing on continuity of care, and not focusing on place-based models.

Simon Stevens: We have proposals, again on Thursday, specifically to reconnect distant practice populations with their local place, and I am already in danger; you know what I mean. We will publicly be consulting on this on Thursday.

Q194 **Chair:** Okay. We will be looking at that on Thursday, but these kinds of issues are all going to be addressed, are they?

Simon Stevens: Yes.

Chair: They are of grave concern when you have a fragile model.

Q195 **Dr Williams:** I want to push you on that slightly more. The issue that Sarah described was adverse selection. There is one population of people with low need, or perhaps high demand, and a provider is getting paid a lot of money for them, which of course leaves other providers that get the people with high need, and often high demand, and the overall sum of money that is left available to them is reduced. Without disclosing the details of the consultation, will your proposals look at dealing with that adverse selection substantially?

Simon Stevens: We are seeking to do that, and we will listen to the feedback we get as to whether the view is that they have done so adequately. We have addressed already the rurality question. There is a question about patient churn and new patient entitlement, and we have a proposal on that for consultation. There is a question about the demographics of the patients who are on one of these new practice lists and we have proposals on that as well, but these are genuinely for consultation.

Q196 **Chair:** Simon, if it turns out that this is just pouring money into an area



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where it is causing disruption, and it is undermining other practices and not addressing health inequalities, are you saying to this Committee that you have no levers open to you to stop it—to say, “Actually, we are not going to fund this”?

Simon Stevens: We have the levers to adjust the funds flow and the payment rates in the way I have just described, which I think will help, and we also have a particular proposal around ensuring that these models are used particularly to address the inverse care law in general practice by trying to concentrate additional primary care in parts of the country that are most under-doctored.

Chair: We look forward to seeing that.

Q197 **Dr Williams:** We all want to see innovation, but tackling health inequalities and the inverse care law are paramount as well. I just want your assurance that, if you need more tools to be able to achieve those objectives, you would ask for them.

Simon Stevens: Yes. I am not sure who can give them to us, but yes.

Q198 **Dr Williams:** Changes to regulations.

Simon Stevens: Potentially, yes.

Chair: We will be having some of those changes coming up.

Q199 **Rosie Cooper:** This is a very short question. This conversation reminded me that you did not quite answer the first question I asked. If you want, you can even write to me. What levers do you have over general practice? What levers does the centre have to effect change when things are not working—direct levers?

Simon Stevens: We have the national GP contract that sets a somewhat high-level set of requirements on individual practices, so a practice that is in breach of its terms of service can then be subject to enforcement action and, ultimately, closure. Secondly, individual GPs are subject to assessment and revalidation processes as part of their ongoing professional development.

Thirdly, as we have talked about, they are subject to CQC review. Fourthly, we can structure the financial incentives. Obviously, since 2004, British general practitioners have been part of the world’s biggest pay-for-performance scheme, in the form of the quality and outcomes framework. Those are our four principal levers.

Q200 **Rosie Cooper:** Who would exercise your first lever? How would you evaluate it—not the CQC, but you? How does NHSE evaluate it? Then I will stop.

Simon Stevens: One of the paradoxes of the 2012 Act was that contract oversight was pulled away from local areas and became a national responsibility, which is obviously quite hard to do nationally for 7,000 individual practices in your part of the country or elsewhere. That is the



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reason why we asked CCGs to take on that responsibility, and the vast majority of them have, but I am not going to suggest that it works perfectly everywhere.

Rosie Cooper: Okay, I will write to you, thank you very much.

Chair: We come now to Brexit with Ben.

Q201 **Mr Bradshaw:** Before we do, I have a couple of questions about waiting times. Simon, who should be held to account when fewer than half of NHS trusts are meeting their 18-week target?

Simon Stevens: NHS trusts are working incredibly hard under the extra patient treatments that are expected of the NHS relative to the funding and staffing pressures they have. Everybody wants short waits for routine care. The median wait for routine care is just over seven weeks at the moment. We have managed to more than halve the number of very long-waiters over the course of the last year, but the fact is that the waiting list overall has been growing for a number of years, and that has been the situation not just in England but across the UK.

Q202 **Mr Bradshaw:** You will have read the Public Accounts Committee's pretty scathing report suggesting that you, as in you at NHS England, are not being held sufficiently to account for your failure to tackle growing waiting times.

Simon Stevens: A lot of the reaction in the NHS to that statement was that it kind of rather ignored the reality, which is that actually we have pressures on hospital beds, on surgeons and on general practice, as we have just been hearing. There are some more fundamental factors at work, and that is true, as I say, across the UK, not just in England.

Q203 **Mr Bradshaw:** They also said, and I quote, that you appear "to lack curiosity" regarding the impact of longer waiting times on patient outcomes and on patient harm. That is quite a strong accusation to make.

Simon Stevens: Yes. We think they were wrong about that and said so in the hearing.

Q204 **Mr Bradshaw:** Would you care to tell us why you think they are wrong now, in front of the Health Committee?

Simon Stevens: What the health service has been having to do over the last three or four years is balance the need for additional emergency services in hospital; the extra investment we want in primary care; for the first time in 15 years, beginning to seriously tackle some of the long-standing issues in mental health; driving improvement in cancer, with cancer outcomes continuing to improve; and ensure that long waits for routine surgery continue to be tackled. Last year, we funded 34,000 more cataract operations on the NHS, for example, so we are continuing to expand the availability of planned care. But that is not the only thing the NHS has to do.



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Perfectly understandably, here we are, an hour into this discussion, and we are coming on to that topic, but, quite rightly, we were talking about lots of other things as well. The NHS, both locally and nationally, is having to balance all those things.

Q205 Mr Bradshaw: Wouldn't it help you make the argument with the Treasury and with Government Ministers for more funding if you were curious about the impact of longer waiting times on patient outcomes and patient harm? The accusation is that you were not even curious about that.

Simon Stevens: That is why it is such a misplaced statement. The fact is that the November before last I explicitly said that, if the NHS did not get an improvement in its five-year funding situation, we would see continuing pressures and deterioration across a range of services, including waiting lists at 5 million, so I have been perfectly frank and outspoken about the need to tackle those pressures.

Q206 Mr Bradshaw: Do you know where the social care Green Paper is?

Simon Stevens: I believe it is in the Department of Health and Social Care.

Q207 Mr Bradshaw: What is it doing there?

Simon Stevens: Gestating.

Q208 Mr Bradshaw: Do you know why it has not been published? We have been promised it six times. Have you asked, and have you been given an answer?

Simon Stevens: That is a matter for the Government, obviously.

Q209 Mr Bradshaw: You have not asked and you have not been told. Do you not want it? Would it not be helpful?

Simon Stevens: Having had the benefit of reading it, the reality is that a Green Paper will advance the debate on a sustainable solution for social care. A Green Paper by itself is not actually going to resolve the operational and funding pressures facing us all this year, next year, the year after and so forth. Regardless of Green Papers, White Papers, legislation that Parliament might bring about, cross-party agreement or not, the fact is that there is a set of things that have to be got right on social care in the here and now and for the next three to five years.

When you talk to most directors of adult social care and children's social care, and most of my colleagues across the NHS, that is what people are kind of focused on in the here and now. Would it be good to be able to crystallise a national consensus on a way forward on social care? Absolutely. But, given the other things that have to happen subsequent to the publication of the Green Paper, that is not going to be the decisive factor over the next several years.

Q210 Mr Bradshaw: The *Daily Express* had a very striking statistic on its front



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page today, which is that 77 people a day over 65 have been dying while waiting for social care since the Government promised the Green Paper—64,000 in all. Do you think that is likely to be an accurate figure, given what you know about the state of social care?

Simon Stevens: There has been a reduction of more than 400,000 people getting publicly funded social care. I think that argument has been understood in Government. The Prime Minister, at the time the long-term plan was launched in January, and indeed last June, was clear that we could plan on the basis that social care would be resourced such as not to put additional pressure on the NHS or our patients over the next five years, and that is a commitment that will be important to hold on to.

I also think, quite frankly, that a lot of the discussion about social care understandably concentrates on long-term care for old people, but we must not forget that actually about half of social care costs are for people with learning disabilities and/or autism, mental health problems, physical disabilities and so forth. That has to be part of the broader picture for social care support over the next five to 10 years.

Q211 **Mr Bradshaw:** If you had £9 billion to spend, would you spend it on a tax cut for the richest 8%, or would you spend half of that amount on filling the social care gap that this Committee has identified?

Simon Stevens: I can often be led in directions of the Committee's choosing, but on this occasion I am not going to be.

Q212 **Mr Bradshaw:** Are you surprised that your Secretary of State has hitched himself to the bandwagon of the man who is proposing such a policy?

Simon Stevens: I think that is a question for your fellow Members of Parliament rather than for me.

Q213 **Mr Bradshaw:** You make representations, I assume, to Health Ministers about tax and spending priorities constantly.

Simon Stevens: Of course we discuss the funding needs of the NHS and social care, and I must say that, generally speaking, Health Ministers are highly sympathetic to those arguments and help advance our cause.

Q214 **Mr Bradshaw:** How is the Brexit no-deal contingency planning going?

Simon Stevens: The NHS had put an enormous amount of work into mobilising for the possibility of no deal on 29 March and then the 12 April date. On 26 April, those arrangements were put on hold. That was a decision that was taken across Government and the public sector.

Our view is that if the country wants to be ready for the possibility, however remote, of no deal on 31 October, it is critical that the transport logistics links are reactivated very quickly. The NHS is completely dependent on the additional dedicated ferry capacity that will be procured by other parts of Government, and, if that is to be available in time for 31



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October, the Government have to push the button on those additional contracts very, very soon.

Q215 **Mr Bradshaw:** What is your definition of very, very soon?

Simon Stevens: Within the next several days or weeks.

Q216 **Mr Bradshaw:** We have to wait another month until we know who the new Prime Minister is. Does it have to happen before then, in your view, to hit the October deadline?

Simon Stevens: Our view is that, to reduce the risks of supply disruption, it is sensible to ensure that the additional ferry capacity dedicated to high priority NHS goods is coming on stream. That means decisions need to be made in the next several weeks at the latest.

Q217 **Mr Bradshaw:** It would be too late for a new Prime Minister after 23 July to activate those plans and be able to meet the 31 October deadline, even if he had parliamentary consent for it, and to ensure those supply chains, in your view.

Simon Stevens: I am not saying it would be too late, but I am saying it would be advisable to make a decision as to how to get that capacity sooner rather than later.

Q218 **Mr Bradshaw:** But there is no prospect that a decision is going to be made on no deal until after any new Prime Minister has started to try—

Simon Stevens: I am not saying make a decision on no deal. I am saying make a decision on the contingency planning to re-ramp up the cross-channel or other ferry dedicated capacity for health supplies.

Q219 **Mr Bradshaw:** How long did it take you last time to ramp those plans up?

Simon Stevens: If you remember, they were undertaken by the Department for Transport, and it was done in quite a concerted timescale with various of the issues that arose as a result.

Q220 **Mr Bradshaw:** How much did it cost?

Simon Stevens: That would be a matter for the Department for Transport to answer for you.

Q221 **Mr Bradshaw:** What sort of impacts are we talking about in terms of the supplies of medicine?

Simon Stevens: By the time we got to 29 March, we had about 400 NHS organisations that were either green or amber with a clear plan to get to green, so we were feeling pretty confident about the NHS elements of the preparations, but, as I said, we were reliant on the dedicated shipping capability and the dedicated air freight capability that was in place, and we need those same two channels to be available for us for 31 October if the possibility is a no deal.



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Q222 **Mr Bradshaw:** What have all those fridges that the Secretary of State was very proud of having procured been doing for the last few months?

Simon Stevens: We are not talking about the fridges; we are talking about the additional freight capacity.

Q223 **Mr Bradshaw:** I know, but the fridges were also part of the no-deal contingency planning, weren't they?

Simon Stevens: There was that. There was also the request of the pharmaceutical companies, the medical devices suppliers and so on, for six weeks' worth of stockpiling. Those need to be reactivated. In addition, the warehousing capacity available in the run-up to the Christmas period is obviously different than it is in the run-up to an Easter period, so the simple point I am making is that, if we want to be ready for the possibility, it would be good to see some of the contingencies activated soon.

Q224 **Mr Bradshaw:** What has happened to the stockpiles in those warehouses and fridges?

Simon Stevens: Many of the companies have been using and replenishing, but, again, that is why a clear signal to restock stockpiles will be important, so that they are able to do that.

Q225 **Mr Bradshaw:** Some of this stuff has quite a short shelf life, doesn't it?

Simon Stevens: Yes. They have been using it and, in many cases, replenishing.

Q226 **Dr Williams:** Matt Hancock said in December that the NHS had become the world's largest buyer of fridges, so did you buy those fridges in the run-up to December?

Simon Stevens: It was the Department of Health and Social Care rather than the NHS per se, and they had access to some of that refrigerated capability.

Q227 **Dr Williams:** So the NHS did not buy the fridges.

Simon Stevens: Certainly NHS England did not buy the fridges. It might be something the Department wants to come back to you on specifically.

Dr Williams: If it is not your responsibility, that is fine.

Q228 **Chair:** How many drugs have had to be discarded because they have gone off date, or have all of those been sufficiently recycled that they did not need to be wasted before their expiry date?

Simon Stevens: I will have to come back to you on that, Chair. I do not have a number with me on that today. Having spoken to Keith Willett, our Brexit readiness lead, this morning, my understanding is that the majority of that stockpile has been used as you would expect, with no wastage, but I will have to ask him whether he can quantify that for you.



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Q229 Chair: Thank you for that. You touch on a really important point. There is a big difference in the scale of drugs that the NHS uses in the run-up to the winter period and what it uses in the spring, going into summer. Have you made an estimation of whether you are going to have to increase the number of weeks of stockpiled products that you hold to cope with that extra demand?

Simon Stevens: As you say, there are seasonal patterns to the type of medication and other products that we need, so, yes, we have looked at that, and we have refreshed the overall cubic metre assumption as to the volume of goods the NHS needs dedicated supply lines for.

Q230 Chair: Very specifically, we are running into the flu vaccine season as well. We are not into flu vaccine season and there were concerns, weren't there, about the supply of vaccines around a no-deal Brexit cliff edge? Is that something you are actively planning for?

Simon Stevens: There is obviously a whole separate programme around winter vaccine supply. The World Health Organisation, as you know, makes the recommendations on what that should look like, so we have taken account of vaccine supply needs in thinking about the logistical planning.

Q231 Chair: Are there any other concerns that you want to raise with us specifically on the issue of Brexit and no deal, and some of the uncertainties that we are currently facing?

Simon Stevens: No. I was asked the question by Mr Bradshaw.

Q232 Chair: I think it is very important for us to be aware if there are other things that are on your horizon that are concerning you, because it is only when they are flagged up that we have the opportunity to pursue them.

Simon Stevens: I think our principal request is that we get the transport infrastructure back in place.

Chair: That is the key one.

Q233 Mr Bradshaw: Are you making that clear to your Secretary of State, because, again, he has hitched himself to a candidate who positively wants a crash-out no-deal Brexit?

Simon Stevens: I think it is understood in Government and it is now just a question of pushing the button.

Chair: We are probably going beyond our remit. Diana has one point on this and then I am going to come back to Andrew to move on to another subject.

Q234 Diana Johnson: It is about transport. If I recall, with the fiasco over the ferries that did not exist, we had the Secretary of State for Health coming to the House to address the fact that huge amounts of money were having to be paid out in compensation. I want to be clear. Are we able to



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get an update of what arrangements are currently in place, if we crash out at the end of October, in terms of sea freight? Is that possible to know?

Simon Stevens: That is what I am talking about, essentially—kicking off that re-procurement for sea-freight capacity, in line for 31 October.

Q235 **Diana Johnson:** It has not been done yet. The end of October is not very long away, and in Hull, as a port, I am told that most of the spaces are booked well in advance; we are talking six months, nine months or a year. Are you saying that at the moment—

Simon Stevens: The procurement planning, as I understand it, has been done by Government, but the procurement process has not yet been kicked off.

Chair: We are going to move on to an entirely different subject—childhood obesity.

Q236 **Andrew Selous:** A couple of months ago, the head of Public Health England said that men should eat ideally, on average, no more than 2,500 thousand calories a day, and I think the figure for women was 2,000. If it is not an impertinent question, are you aware how many calories you eat each day? Are you able to find that information easily? I personally find it very hard, but maybe you are more successful than me.

Simon Stevens: I am trying to lose weight, so thank you for pointing that out. Yes, in the last several months I have been paying attention again to calorie labelling, such as one can find it, but perhaps the question behind your question is whether there is enough transparency for those of us so interested. I would like to see more.

Q237 **Andrew Selous:** Good. I am glad you would, and that was indeed the sense behind my question. For people like you and me, who are pretty interested in this subject, it is almost impossible to find, so I am not sure how the rest of the population is supposed to do it.

We talked a lot about GPs earlier and I am puzzled why, in general practices, in waiting rooms, we do not have large pictures of the typical meals that British people eat up and down this country, giving an indication of the amount of calories. Don't you think that would be a useful bit of information for us all to absorb as we sit waiting to see our GP? Then perhaps we could go and weigh ourselves on the weighing machine, as quite a few practices now have weighing machines in their waiting rooms, which is a thoroughly good idea.

The serious point is that public information seems to be very scarce out there. It is no good Public Health England telling us two figures, if none of us has a clue or can easily find out the information, is there? What is the point of giving us the information if we cannot do anything with it?

Simon Stevens: I agree with the conclusion of your point. I think home-cooked food is not the principal source of unknown or junk



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calories: it is fast food and it is processed food. Making sure that there is accurate calorie labelling in those settings would make a big difference, as would tackling the number of fast-food joints located close to primary and secondary schools, an easy distance for people or kids to walk in their lunch break or on their way home. I do not see an argument against proper information for us as individuals and as families.

Q238 Andrew Selous: I am told by members of your staff that directors of public health actually have the power to do a little bit more to stop fast-food outlets near schools. If there is a plethora of fast-food outlets in an area generally and there is evidence, directors of public health are supposed to have the power to make sure that planning committees do not add to them and to turn planning applications down. Do you know if that is actually happening anywhere around the country?

Simon Stevens: It has been happening in some places, yes. Paul is volunteering Gateshead, so I definitely take that as a fact. Waltham Forest, I seem to remember, perhaps in the past had been activists in this area. There has been a debate as to whether explicit additional licensing criteria should be added to take it beyond doubt, given that sometimes such decisions are subject to challenge when local authorities undertake them.

Q239 Andrew Selous: Are you satisfied with the efforts across Government to spearhead the issue, because the Department of Health and NHS England cannot do it on their own, can they? It needs serious co-ordinated and, dare I say it, determined effort across Government to get to grips with it. I do not think we quite realise what an outlier we are.

There are four and a half times more obese children in this city than there are in the capital city of France, just over the water: 22% of children in London and only 5% in Paris. That should absolutely shame us, and I have not yet detected urgency or cross-Government reach and action on the issue. Who is having those conversations across Government? Is the Department of Health and Social Care the lead? Are they championing it? Is NHS England really pushing it for the Government?

Simon Stevens: They are in the lead.

Q240 Andrew Selous: I do not see the level of action that the problem requires.

Simon Stevens: The so-called chapter 2 of the childhood obesity strategy represented a significant upgrade relative to chapter 1, and it would be good to see a chapter 3 that now does more of the evidence-based interventions that were talked about but held in abeyance in the second.

Q241 Andrew Selous: Could we not go a bit further than "good to see"? Isn't it a pretty urgent task for the autumn, whoever is sitting in the Department of Health and Social Care at that time?



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Simon Stevens: I agree. It is the right thing for our children. It will have a big benefit in the 13 types of cancer that are partly caused by obesity, as well as all the heart attacks, strokes and preventable type 2 diabetes, and it will save taxpayers billions in future NHS costs. From where I sit, it is a no-brainer.

Q242 **Andrew Selous:** When you look at food manufacturers and supermarkets here in the UK, I do not know if you are aware of a Dutch supermarket called Marqt; it is quite a small one, it only has 16 stores. They say that it is not part of their philosophy to tempt children to use unhealthy products, and it does not fit in with how they want to help their customers. They have a specific policy, and, as far as I am aware, they are a thriving, successful business. Is this something that—

Simon Stevens: I am not aware of them, but from what you have said, they sound as if they have something to commend them, but I do not know about their approach.

Q243 **Andrew Selous:** I know you are NHS England, and that this is Public Health England and the Department of Health. It is cross-Government, so it is perhaps pushing you a bit.

Simon Stevens: In fairness, Andrew, I am strongly committed to trying to take action not only in the NHS but outside, more broadly, on public policy in a way that will improve the health of the nation and drive reductions in inequalities. I have been a strong advocate, and we are putting NHS money behind that, as well as the advocacy the NHS can bring. I am completely aligned with that.

Q244 **Andrew Selous:** I wonder what interaction you are having with the food manufacturing sector specifically. I have seen some initial responses from the Food and Drink Federation, which I find slightly underwhelming, and I wonder where that conversation is going on within Government at the moment, and what part NHS England is playing.

I was absolutely delighted to see prevention at the heart of it. We have needed that for a very long time, so it is very welcome, but I am a bit frustrated that we are not seeing enough—if you will excuse the pun—flesh on the bones, in terms of what we need to do. It is a big, multifaceted issue and it is beyond the scope of NHS England by itself, but I think you need to be a key advocate for engaging with the food sector and the supermarkets.

Simon Stevens: Yes.

Q245 **Andrew Selous:** I wondered what you are doing in that area.

Simon Stevens: One of the things we are doing is trying to ensure that the NHS itself gets its act together and its house in order on junk food.

Q246 **Andrew Selous:** I will come on to the NHS itself in hospitals in a second, if I may, but it is specifically about Tesco, Sainsbury's, Morrisons and Asda, and the food manufacturers. We have talked about the out of



home.

Simon Stevens: In the interactions we have had with the retail sector generally, the retailers for the most part have been quite pro the Government taking a level playing field regulatory approach. Their argument is that, if it is left to voluntary effort, those who do not play by the rules can get away with it.

Q247 **Andrew Selous:** They are looking for a bit of Government push.

Simon Stevens: The British Retail Consortium and others surprised me when I had some of these conversations with them in the past. They said, "Please can Government actually set a level playing field using regulatory or fiscal means that bear on all of us in the same way." I think there is something to build on.

Q248 **Andrew Selous:** What about clear calorie labelling in NHS hospitals? If I go to the canteen, am I going to know, as a visitor, or perhaps a member of staff, what the calories are? Is that going to be clearly and visibly available for me to see? Is it a developing policy in the NHS?

Simon Stevens: In some places. We are going to set new hospital food standards and one of the things that will be included will be calorie labelling.

Q249 **Andrew Selous:** When will that come out? How soon?

Simon Stevens: We would like to be able to get them into the NHS standard contract for April next year. It is linked to some changes for the Government food buying standards, and I would need to check what the timeline is on that, but it is something that the current Health Secretary, Matt Hancock, is also very keen on.

Q250 **Andrew Selous:** Do you share my slight sense of frustration on the issue?

Simon Stevens: I do.

Q251 **Andrew Selous:** There is a degree of urgency to get on with it.

Simon Stevens: Yes. Actually, the incentive to reformulate sugary drinks that was introduced a couple of years ago will turn out, I believe, to have been a successful public policy, not because of the pricing per se but because of the incentive to reformulate, and we have seen some of the supply responses on the back of that. That could be looked at for other adjacent food and drink categories.

Q252 **Andrew Selous:** I am very pleased you said that, because, if you have established the concept and it is universally thought to have worked, then to me the question is—

Simon Stevens: I am not sure it is universally thought to have worked.

Q253 **Andrew Selous:** I think it is generally thought to have been effective, and there has been significant reformulation, which is good, so are you



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arguing for it to be applied to other aspects of food and drink?

Simon Stevens: Where the Government got to with mark 2 of their childhood obesity strategy was to say that a clear trajectory was needed for childhood obesity reduction, the 20% reduction that was talked about, and, if it turned out that the country was not on track for that, the question would be back in play as to whether a wider range of measures was required.

Q254 **Andrew Selous:** Do you think we need an interim target?

Simon Stevens: Frankly, I would be surprised if wider measures were not required, given the progress that we are otherwise likely to see.

Q255 **Andrew Selous:** Do you not think that reducing childhood obesity by 50% by 2030 is so far out that no Health Minister could do it?

Simon Stevens: They have some intermediate milestones on that as well. PHE were supposed to be tracking annually the reduction in childhood obesity rates, and the commitment was that, if we were not on track for that trajectory, further measures would be brought forward. My prediction is that further measures may well be needed.

Q256 **Andrew Selous:** Do you accept that you yourself as the head of NHS England have a significant advocacy role to speak in the public debate in terms of what we hope and expect to see?

Simon Stevens: I do and I do.

Andrew Selous: Excellent, good. Thank you.

Q257 **Chair:** Can I come now to the issue of specialist commissioning, in particular children's cancer services? You may be aware that there has been a series of articles in the *Health Service Journal* over recent days and weeks looking at the important issue of co-locating intensive care facilities alongside children's cancer services.

A great deal of concern has been expressed about the fact that for many years we have continued to see at the Royal Marsden, the Sutton site, children having to be transferred when they are very sick, sometimes with tragic consequences, yet this has been allowed to continue. A review was commissioned by Professor Mike Stevens and a panel of experts. Can I ask, Simon, who made the decision not to publish their 2015 report?

Simon Stevens: Since this question was raised with us at the back end of last week, we have been looking back. It is four years ago. What we can see is that, after the report was done, the question was taken to our relevant specialised commissioning committee by the deputy national medical director, and, having had a chance to read the report over the past weekend, I can see why there was not a completely black and white question as to what should then follow. That is, first, because the report itself acknowledges: "There are no data which support the influence of centre size (defined as numbers of new patients seen per year) on



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patient outcome assessed as survival.” Often a lot of these changes will be driven by an outcome benefit.

Secondly, the report pointed out that the number of children being looked after at the two London centres was already at the higher end of the centres across the country. Then, thirdly—

Q258 **Chair:** The area of specific concern, though, was around co-location of intensive care facilities.

Simon Stevens: The particular point behind that was the question of safety, so, thirdly, the Care Quality Commission independently inspected the children’s cancer services at the Marsden and determined that they were safe and the quality of care was good.

Having looked at what was in the report, I think it was clear at the time, and again I quote from the report, “that no professional consensus about the future configuration of PTC”—primary treatment centre—“care in London had yet been reached.” Indeed the report itself said that 16 of 22 NHS organisations—three quarters in London—felt that the current number of treatment centres providing care for children with cancer was optimal for the future. Clearly, there were good reasons in favour of what the report said, made in good faith, but there was no consensus across London on that point, hence it was remitted to the independent Cancer Taskforce.

Q259 **Chair:** Can I come back to my original question about who made the decision not to publish? Are you saying it was the deputy medical director, the national medical director at the time, who made that decision not to publish?

Simon Stevens: I am saying, given that this was four years ago, that we have not been able to establish that by looking back through the records we have at our disposal. What we can see is that, properly so, the specialised services committee on 27 June 2016 says in the minutes that the matter was raised by the deputy national medical director, and it was agreed that the review should be considered as part of the wider cancer reform programme set out by the independent Cancer Taskforce because it had implications much wider than just inner London.

Q260 **Chair:** You are saying that it was the whole committee that made that decision.

Simon Stevens: I am just reporting to you. We have gone back through our records and those are the notes we have found of the committee meeting.

Q261 **Chair:** Those are the notes you have. Andy Mitchell, who until 2016 was NHS England’s London medical director, described this as a “bureaucratic burial” of a major review. He is quite scathing about the decision, and the impression we get from a number of people is that a really important report has, as I say, been shelved in a way that has led to very serious



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consequences for children over an issue that has been known about for some time.

Simon Stevens: The Care Quality Commission said that it has not, because it says the quality of care for these children is safe. What Dr Mitchell's boss, Sir Bruce Keogh, said last week on this is, "The suggestion that I was leant on is utterly preposterous. I have a long track record of taking difficult decisions that put patients first." Bruce was at that committee meeting and I place great weight on what Sir Bruce says.

Q262 **Chair:** His record is not in doubt in terms of making difficult decisions. Further to that, there is concern that there has been a watering down in standards more recently, from must to should, when it comes to co-location. We have been told that the data is compelling about the need to co-locate. Is that something you are personally going to look at? A very serious concern has been raised.

Simon Stevens: It absolutely should be looked at. That is why the question is currently out to extensive public consultation. That public consultation is under way. Accepting in good faith that there is expert opinion that strongly takes the view that you have just described, Chair, there are other points of view.

Q263 **Chair:** These are issues that have been raised with us.

Simon Stevens: Indeed. There are other points of view as well. The right way of teasing that out is through public consultation, and I have asked Professor Sir Mike Richards, the former chief inspector of hospitals at the CQC and the former national cancer director, to review the consultation responses independently and to report to the NHS England board in public as to his view on what has come back from the consultation and on the evidence of the correct way forward.

Q264 **Chair:** Will it be the case that the chief executive of the hospital will preclude herself from decisions?

Simon Stevens: She has already said that. That was how she was approaching it, and she said that last week.

Q265 **Chair:** Thank you for that.

Another specific area that has been raised with the Committee is the availability of isotopes for PET scans, in particular the level and extent to which patients are having their scan appointments cancelled, sometimes at very short notice. Can you set out for the Committee how extensive the problem is?

Simon Stevens: I understand that there is a particular issue with one of the PET CT suppliers, Alliance Medical. My understanding is that new regulatory standards for tracer materials were introduced, and they have had to undertake an upgrade programme for their tracer production equipment. They are one of two entities in this country, together with Siemens PETNET, that are the principal suppliers of these tracers. In the



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process of doing the upgrade, at one point, three of their four cyclotron plants needed the upgrade and they had difficulties making the transition, with two of those cyclotrons impaired at one point. I am told that there are still problems at around five of the 31 sites, which NHS England experts, together with the supplier, are working to resolve.

Q266 Chair: We had figures showing that the west midlands had to cancel 10% of its cases. That is a staggering impact on services, considering that these scans are a crucial part of the pathway for investigating cancer.

Simon Stevens: As I say, we are working closely with the tracer supplier in this case, recognising that because these are radioactive products every tracer has a half-life, which limits the maximum travel time between the production facility and the scanning service. In the case of scanning services for some other cancers, such as prostate, we are also deploying Galleon PSMA and F-18 PSMA, and I understand that a licensed product called Axumin will shortly be available in England.

Q267 Chair: Do you think part of the problem underlying this is that they were effectively allowed to be monopoly suppliers? How could it be acceptable that, because one supplier was having difficulties, hospitals were not able to access it from another supplier? Why wasn't flexibility built in so that patients' interests were being put first, rather than the commercial interests of a monopoly supplier?

Simon Stevens: As I understand it, there are two main suppliers.

Q268 Chair: But they weren't allowed to switch.

Simon Stevens: There was an arrangement, so I am told, where AML and Siemens PETNET were able to provide some contingency and back-up supply for each other. That is not always sufficient, partly in overall volume terms and partly because of the point I made earlier about the half-life. If the distances are too great, it can be hard to move the product around the country.

Q269 Chair: We have been told it took 10 months before there was any meaningful intervention in something that was clearly causing major disruption to services and continues to do that. One of the other issues that has been raised with me is that journalists who were trying to investigate this were finding it very difficult to be given the answers they wanted.

Do you think that NHS England is being sufficiently open with those who are trying to highlight problems in the NHS? Are we living the values that we expect from others in terms of transparency and openness? I guess that is my point.

Simon Stevens: We publish more information about the NHS, more performance data, than any other public service in this country. We publish 2,850 different statistical series, which is twice as much as is published on the police, the law and the criminal justice system, and three times as much as on education. We deal with an enormous volume



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of media inquiries. I am sure we don't always get it right, but there were 400 media inquiries in the last fortnight. The NHS has been on the front page of national newspapers 269 times so far this year. We have had 20 TV documentaries on the NHS since the beginning of the year. There is enormous legitimate and beneficial public scrutiny of the NHS.

Q270 **Chair:** Indeed. Sometimes you can lose data; you have so much data you cannot see the important bits. What I am trying to say is that the impression I am getting, sitting in this chair, is that there is sometimes frustration from journalists who are trying to investigate bad news stories. There is plenty of information when it is a good news story, but it is less easy to get information on something they are concerned about. Do you think that is fair?

Simon Stevens: Here are the press cuttings that we have responded to on the NHS for the last two weeks. If there is the idea that there is not enormous transparency about what is happening in the NHS, this rather suggests the opposite.

Q271 **Chair:** If people are coming to this Committee and saying, "I tried very hard to get the information I wanted about this story"—

Simon Stevens: In that particular instance, since you wrote to me, I asked what happened, and I believe an apology has been given to the journalist in question. It was an inquiry that was made both nationally and locally, and there was a disconnect between whether it was responded to in the west midlands, where the journalist originally made the inquiry, and whether it was being responded to nationally. People have now apologised for that.

Q272 **Chair:** Looking more widely at cultures of openness, I understand that it took the Information Commissioner's Office threatening to take NHS England to court in order to publish the internal staff survey. That does not feed into an impression that this is an organisation that wants to be transparent.

Simon Stevens: The Information Commissioner's Office has subsequently written to commend us for our speed and appropriateness in ICO responses. We have definitely ramped up our FOI team so that we can respond more quickly and comprehensively. Last month, we had 188 FOI requests that required a full FOI response. More than four fifths of those were dealt with substantively within 20 working days. People are perfectly entitled to make those requests; it imposes significant work across the NHS, and we do our best and, no doubt, can continue to do better.

Q273 **Chair:** We all understand the impact that emails and inquiries can sometimes have on your ability to get on with other important aspects of your work, but there is a point about the message that goes down throughout organisations. If the message from the top is that we are determined to be transparent and open and people can see that happening, they are perhaps more likely to live those values themselves.



Would you accept that?

Simon Stevens: Absolutely.

Q274 **Rosie Cooper:** I would like to develop that. I understand, Simon, that, if I ask you questions, with your brilliance you will give me a million facts and figures, and you will lose me in the wake of all those. I want to talk about, and explore at a more general, higher level, questions and statements about your view on culture, transparency and your personal commitment to managing people.

Before I ask some of those questions, which, on the face of it could be taken to be critical—I do not mean them to be—I want to encourage you. Frankly, I thank you, because, when the LCH story first broke, you went and met those nurses in Liverpool. Those kinds of things are not forgotten. We have the Bill Kirkup inquiry to come. I am not sure of the exact terms of all of that; it is not clear to me yet, but the general direction is fine.

At a recent hearing of the Select Committee—I wasn't here because I had a broken wrist—it was acknowledged that there was a culture of bullying in the top leadership of the NHS. How much responsibility would you take for that? Do you think your team displays bullying behaviours?

Piggy-backing on Sarah's question, do you agree that the tone and culture of the organisation is set from the top, and how can we honestly expect to see change at local level if we do not see the drive for patient care coming from the top? I still get loads of whistleblowers. It is almost as though you have to get out before you can speak up. How much of that is your responsibility?

Simon Stevens: I definitely have a responsibility to ensure that the culture and approach not only of NHS England and NHS Improvement, but across the leadership of the NHS, is one that will help support frontline staff, will be open to patients and will drive improvement. I absolutely do.

The reality is that there is a circle to be squared with what is often interpreted, understandably, as your desire for strong accountability. You know this yourself, Rosie. You raise questions, perfectly legitimately, about the performance of different parts of the health service and the individuals running it that they experience as bullying and you would, rightly I am sure, describe as accountability. Your own interactions with leaders across the health service have that double lens. The question is, how do we get the best of both?

Q275 **Rosie Cooper:** You tell the truth. We try that. We tell the truth. That is the simple way. You only get to this condition when the truth is not told, when questions are not answered honestly. I talk about Bishop Jones's report, "The patronising disposition of unaccountable power". When things come to NHS England, there is not the automatic view, "Oh my goodness, this is a problem; let's get at it and sort it." The doors are battened down and that sends awful signals. You know that my reach into



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the health service and information is quite deep. There are people who are not happy.

Simon Stevens: I am grateful to you for what you do on that front. We will not always see eye to eye on everything, but often you surface issues that I wish had come to attention beforehand. I regard the work that you do, and the work of colleagues like you, as part of keeping the health service on the straight and narrow. There may be individual instances where we disagree, but the essential thrust of what you are doing is a huge public service.

Q276 **Rosie Cooper:** This is not the question I was going to ask. I often listen to you talking about AI—"Let's get into artificial intelligence"—and I want to wave a flag saying, "How's about human intelligence?" Just listen to us. It took me six years to get the NHS to deal with Liverpool Community Trust. There is Lancashire Care. Mental health problems in Lancashire are severe, and I've been going on about it for three years at least.

Simon Stevens: People sometimes say, "We're getting all these inquiries to deal with," but typically I say to them that nine times out of 10 you get it right, so pay attention.

Q277 **Rosie Cooper:** Absolutely. Turning to Sarah's story about London, we have all been reading those stories. The *HSJ* has it. I do not just read the story; I read the comments underneath. A lot of them may be taken with a pinch of salt, but the whole ongoing cancer services story does not surprise anyone: suppression, message management and collusion.

You said you are the chief spin officer, in addition to being the chief executive officer. That suggests there is a habit of withholding information that is inconvenient. In terms of the data commissioner, I have reported you quite a few times and been upheld. I have waited months, not just 20 days. I have waited six months for a reply and had to go back to the data commissioner, who gives you a chance to answer—not you personally, but NHS England—and NHS England does not answer. Then we get an adjudication. Why do we have to do all that?

Simon Stevens: As I said, I think our handling of FOIs has improved dramatically over the last 12 months, and we have had a commendation from the ICO as a consequence. It is perfectly legitimate for you and others to raise FOIs. What I think you do not necessarily automatically appreciate, and there is no reason why you should, is that a two-line request can take an enormous effort across the totality of the NHS to try to garner the information to be able to respond. We rarely come back and say it is going to take more than X hours, so we are not going to answer, which we could do. We take the time to try to find the answers, if we are able, not necessarily to issue a new data collection request if the information has not been handled.

Q278 **Rosie Cooper:** May I suggest you go back and look at my FOIs? They are not that hard.

Simon Stevens: Well—



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Q279 **Rosie Cooper:** Seriously, when you get them, you should be aware that all I am doing is building the case towards the end. They come in snippets for the most part, regarding fraud or whatever. We have your absolute guarantee here today on transparency, leading from the front and not accepting bullying at any level. I accept there is a difference between accountability and bullying. As we can evidence in LCH, people are going to kill themselves as a result of this stuff. There was the story of the nurse that we heard in the news the other week. That is not acceptable. The NHS will look to you to set the culture.

Simon Stevens: Yes. I think most leaders across the NHS, be it in trusts or CCGs, are highly principled people who have chosen to devote their professional careers to the NHS because they believe in the NHS and what it does. I am afraid I do not accept that there is malign intent or behaviour hardwired into everything that is happening across what people are doing. I accept that there are clear aspects of the way the managerial culture has developed in the NHS that we need to change, and that there are particular circumstances and cases that are completely unacceptable. You and I know many of them.

Q280 **Rosie Cooper:** Have you actually read “The patronising disposition of unaccountable power”?

Simon Stevens: I have read the Gosport report, yes.

Q281 **Rosie Cooper:** No—Bishop Jones’s report.

Simon Stevens: Yes.

Q282 **Rosie Cooper:** That is writ large in most of my contacts. May I move on to another subject?

This Committee has been broadly supportive of the merger with NHSI and the principle of the merger, but we had some concerns about the central control that would result. What steps have you taken to address those? I am talking about transparency and all the rest of it. You are now getting more and more absolute control.

Q283 **Simon Stevens:** The legal framework we are operating under has not changed, so the accountabilities that exist to the boards and to the Government and to Parliament, as well as to the public, in the way we have just been talking about, will continue. Those four accountabilities continue. Once a month, I am here being held accountable before yourselves or some other parliamentary Committee. On average, once a month, I am here personally. My colleagues from NHS England are here answering to yourselves, on average, once a fortnight, so we have that direct parliamentary accountability.

We also, obviously, have accountability to the elected Government of the day, and those arrangements are unchanged as a result of the combining of NHS England and NHS Improvement. If it gets to the point where Parliament chooses to legislate, as you said in your report earlier in the week, there will be a question as to what sort of refreshed accountability



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arrangements Parliament wants to see.

- Q284 **Rosie Cooper:** The merger of NHSE and NHSI was announced by the *HSJ*, and there is a suggestion that it was facilitated in the merged organisations. Was that a major failing or was it planned that way?

Simon Stevens: The idea that NHS England and NHS Improvement should work together has a long genesis and in large part is because the rest of the NHS was saying to the two national bodies, "Please can you practise what you preach? If you are suggesting that locally we should be having more joined-up services and integration rather than the left-hand, right-hand problem, to the extent that you guys are the left hand, right hand, can you please come together?" We responded to that.

- Q285 **Rosie Cooper:** In terms of staff in the merged organisation, when did you last personally address them—not email them or whatever?

Simon Stevens: I have been doing that every week. Within the last three to four weeks, I have personally addressed frontline staff across NHS England and NHS Improvement in Southampton and Derby. I will be in Brighton next week. I was in Liverpool the week before.

- Q286 **Rosie Cooper:** Wasn't that for something else?

Simon Stevens: No, I was talking to our own NHS England and NHS improvement staff. I was in our London office. I am doing an enormous amount of that right now.

- Q287 **Rosie Cooper:** What about your corporate staff here in London?

Simon Stevens: The same.

- Q288 **Rosie Cooper:** What behaviours and ways of working can you adopt to alleviate the issue of over-centralisation, and how will you help the team deliver it? For example, I am interested in the health safety investigation bureau because the next thing I am going to do is complaints. What we find there is a lot of complaints that the chief is committed to the old ways of working, command and control, and there is not a great deal of listening. They are not open to suggestion and do not listen to feedback. Is that inherent in NHSI-E? Is it something you recognise?

Simon Stevens: No, I do not think it is inherent. Come 1 July when I have a wider responsibility, the question on the HSIB is something we will be looking at. It is something that Ian Dalton and Dido Harding have also been paying attention to.

- Q289 **Rosie Cooper:** The next bit is joining it all up together. This week, I had a fair bit to worry about, with Halton and patient choice to pay. I understand the CCG involvement, but the chief executive was the STP lead. That signal undermined the assurances that you and the system have given that the new rules removing the NHS from public contract regulations to create more flexibility to decide who procures what, when, where and how will allow commissioners to award contracts to existing providers and develop new ways of working. In the face of that, the STP



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lead of Cheshire and Mersey says to people that knees, hips, cataracts are all procedures of limited value. I would not be walking without knee operations. Is not walking and seeing absolutely fundamental?

Simon Stevens: I completely get you on that. Those are clearly not procedures of limited clinical value. As I understand it, the trust has withdrawn that, as it was obviously a misguided effort. The law has not changed on the things you have talked about, and the law in respect of self-pay is, essentially, unchanged from, I believe, 2003, and prior to that 1990. The statutory framework they are operating under is the same as it has always been.

Q290 **Rosie Cooper:** The question then is, if the commission has decided that, what are you doing about it?

Simon Stevens: The commissioners decided.

Q291 **Rosie Cooper:** The CCG, sorry.

Simon Stevens: It was the trust, wasn't it?

Q292 **Rosie Cooper:** They have indicated it in the written word. I am waiting for the replies to me, but the written word is that they were following the lead of the commissioners in saying that those procedures were of limited value. Does it not take us back to where we started, which is your powers to deal with this? Yes, they have stopped it, but I have read all the stuff they published, and they said that it was a way for junior doctors to keep their skills up for operations that they indicated they would be doing fewer of because you would have to pay.

Were NHS staff doing it in NHS time? Fine, if you were going to agree to that in the first place, which I do not, and the money was going back in. We talk about hospitals being at capacity and not having the space to do it. This does not ring true as an accident.

Simon Stevens: I don't think it rings true as a sensible thing to do. I would make the distinction between procedures of limited clinical value on which there has been public consultation. Those are things where it is deemed that it is probably not a very good use of NHS money, given all the other competing demands on our funds. That is not the same as hips, knees, cataracts and so forth, which are procedures of high clinical value.

Q293 **Rosie Cooper:** The wellbeing of human beings.

Simon Stevens: Exactly. I think there was confusion there.

Q294 **Rosie Cooper:** How do we make sure that does not happen again?

Simon Stevens: I hope that those lessons have been learned, and, if it transpires that they have not been, we will look at whether there are things we can do through the NHS standard contract. That is probably our principal lever, given the statutory framework that NHS providers themselves are otherwise operating under.



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We did it in general practice, for example. I was concerned about GPs beginning to advertise private services in their own surgeries that could have been regarded by patients as a suggestion that they should be paying for something that should be available on the NHS. We put into the GP contract a ban on practices doing that. If the same kinds of questions arise for NHS hospitals, we will have to look at that as well.

Q295 Rosie Cooper: Do you think we need a new STP lead, as they are now, as their legitimacy and their command of the area has now hit the buffers?

Simon Stevens: Juxtapose that question to the conversation we were having earlier. Setting the right culture across the NHS would not be saying, "Okay, because of this, we've got to have a change of personnel."

Q296 Rosie Cooper: You note I did not say chief executive of the hospital. I think there are questions for the chief executive and the board, but that chief executive is also the STP lead for the whole Cheshire and Mersey area. Do you think that the people or the other chief execs would have confidence in going along that route, when somebody's judgment is so flawed that they think this is okay?

Simon Stevens: I am sure it is something that is worth having a look at, but I am not going to shoot from the hip and give you a drive-by answer on that.

Rosie Cooper: It is really scary.

Q297 Dr Williams: I want to explore this a little bit. The trust said it came from something they are now calling criteria-based clinical treatments rather than procedures of limited clinical value, and that the CCG had set certain criteria about when these types of operations could be appropriate and when they were not. Are individual CCGs able to set those criteria or should they be set at national level?

Simon Stevens: In law, individual CCGs are able to set those criteria, since the 2012 Act means that CCGs individually and collectively are accountable for about two thirds of the funds that flow through the NHS. Yes. However, we, with NHS Clinical Commissioners, the group that brings together CCGs, took the view over the last 18 months that for a number of these decisions it would be better if we could have a national public consultation and a set of guidelines that CCGs could then choose to adopt. That is the approach we have taken in two tranches, and on Thursday this week we will be updating what they look like at our public board meeting.

Q298 Dr Williams: Would that include things like cataracts? There is a point, after you have had one cataract done, when having a second cataract is advantageous to people. There is fear among patients that there is a threshold and that, as resources are becoming tighter, the threshold for intervention is not necessarily based on patient experience but is based on affordability.



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Simon Stevens: Ultimately, those are judgments that groups of GPs in CCGs make. In a way, that confirms the situation that has always existed, which is that GPs in our system make the referral decision as to when somebody should have access to secondary care. As it happens, there has been a lively debate on the availability of cataracts. Fortunately, the number of NHS-funded cataracts went up by 34,000 last year, so there is now the highest number of NHS-funded cataracts there has ever been.

The availability of NHS cataract surgery is continuing to go up, but there is obviously a question as to how we can continue to deal with what are going to be further rises in demand for those services. One of the things we have to do across eye health in the round is look at whether we can free up the time of ophthalmologists from some of the other activities they are doing. That is why the big programme to redesign medical ophthalmology out-patients will be so important.

We have 8 million ophthalmology out-patient visits a year, and some of those are for diabetic retinopathy or age-related macular deterioration, or other of the common conditions that it is vitally important to check. We, with the eye specialists, think there are better ways of providing those services, including connecting optometrists in the community with the eye departments in hospital services. All of that will help free up time that can be redeployed for more cataract operations in the future.

Q299 **Dr Williams:** To be clear, you are saying that there is a consultation.

Simon Stevens: Not on cataracts, but on a range of other things. We had the first 17, and there were some others, including recommending that homeopathy, for example, should not be funded on the NHS.

Q300 **Dr Williams:** What we are talking about is people being denied operations based on affordability rather than clear clinical criteria, so sometimes a hip or a knee is not done on somebody over a certain age or because somebody is over a certain BMI.

Simon Stevens: It would not be appropriate to have an age-related rationing culture.

Q301 **Dr Williams:** BMI-related? Whether or not someone smokes?

Simon Stevens: What the orthopaedic surgeons say is that there is an advantage to supporting people to lose weight, if they can, before having major joint replacement surgery, both because their anaesthetic risk is lower and because the success rate for the operation is higher. There may be legitimate reasons for wanting to offer those services.

Q302 **Chair:** If you have time, can I cover one last area?

Simon Stevens: Sure.

Q303 **Chair:** It is the important issue of access to drugs for cystic fibrosis and the state of negotiations with Vertex. You will know that again we appear



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to be in an impasse, and thousands of children and young people are currently being denied access to treatments as a result. Is there anything you can do to update the Committee on further developments?

Simon Stevens: My colleague John Stewart has written to you, Chair, updating in response to your request of a few weeks ago. We made a further offer to Vertex subsequent to the one from last year. At the request of the company, we focused it on the products that are currently licensed. The funding overall for those products, therefore, has improved in price.

In effect, we gave Vertex the benefit of the doubt in terms of the effectiveness of the drugs they want the NHS to fund and said that we would be willing to pay a higher price provided that they agreed to put the real-world data through NICE and, if, down the line, NICE finds that the impact has been as good as Vertex claims, they can keep that higher amount of funding per patient. If, on the other hand, it is not the case, Vertex would owe the NHS a rebate.

We think that is a very sensible approach. The Association of British Pharmaceutical Industries described our most recent offer in these terms, saying that, "it is clear that the structure of the offer from NHS England represents exactly the sort of flexibility industry has been calling for some time—and indeed responds to some of the observations made by the HSC Committee."

Q304 **Chair:** It was clearly an uplift to the offer to have taken the triple therapy out as well. I acknowledge that there has been an improved offer. I am particularly disappointed to hear back from NICE that Vertex have not been engaging with it, although they said in their letter to us that they are. What we hear from NICE is that they are not engaging on the kind of data it needs—the full range of data. Is that something you are in contact with Vertex about, too?

Simon Stevens: We are trying to encourage and beseech them to do so, because, as the ABPI said, "we fundamentally support NICE as the cornerstone of NHS efforts to: ensure the price being charged by a company represents the value being delivered to a patient; maintain a level playing field between companies and to secure value for money in the NHS." The Association of British Pharmaceutical Industries—that is, other companies—would "always encourage companies to fully engage with NICE at all stages of the process." It is therefore incredibly disappointing for our patients that Vertex are not yet doing so.

Q305 **Chair:** Yes, they are not only an outlier—they are an extreme outlier. That is what we are hearing. Is that your impression as well?

Simon Stevens: That is still the case, I'm afraid.

Q306 **Chair:** What the families want to see is a resolution, and you will know that there is now a generic that is available and some families are accessing it through buyers clubs via Argentina. The trouble with that is



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that there is huge inequality involved, because some families can afford it and others clearly cannot. They should not have to be paying for it through buyers clubs, but it seems that these are desperate measures. Is there anything you wish to say about buyers clubs and about Crown use licences? What could be the next steps? Is there anything you would like to share with us?

Simon Stevens: It is entirely understandable that families are exploring all options, including those, but the simple fact of the matter is that the quickest way for patients to get access to these drugs would be for the company, Vertex, to re-engage with NICE and accept the very flexible and generous offer that the NHS and taxpayers in this country have put on the table.

Q307 **Dr Williams:** Would it not be possible for the NHS to use personal health budgets to enable families that want to get these drugs to access them quickly through the buyers club?

Simon Stevens: A number of options have been raised and are worth exploration. The quickest way to resolve this would be for Vertex to engage with the independent objective NICE process, and to accept what would be the most generous offer the NHS has ever made for this type of drug.

Q308 **Dr Williams:** We know that the previous offer was also the most generous offer the NHS had ever made, and when we engaged with Vertex here they told us that they spent so much money on the development of these drugs, hoping that they would end up better than it appears they are, that they want to recoup all the investment they have made.

Simon Stevens: It is hard to see, if you believe in your product, why you would decline to have an independent expert assessment of its value.

Q309 **Dr Williams:** In order to get the drugs for the people who need them, at what point should we start to use alternative possibilities? They say that they have been waiting, waiting and waiting. How much longer should we give it?

Simon Stevens: These are not straightforward alternatives. All the options clearly need exploring, but that is not the most expeditious way of getting patients the treatments that the company wants to sell.

Q310 **Dr Williams:** We have heard that the company has destroyed stocks of the drugs that they have made—that because they have not been able to sell it to the NHS they destroyed the drug. How do you feel about that?

Simon Stevens: I think we benefit greatly from discovery and innovation in the life sciences sector, but it is also incumbent on individual companies to think about their moral compass.

Q311 **Dr Williams:** Do you think we ought to just get the drugs to the patients now and continue negotiations?



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Simon Stevens: That is essentially what we proposed—getting those drugs to patients and then taking time over the next several years to do the independent assessment by NICE, and then adjust the prices based on how well they have done.

Q312 **Dr Williams:** They challenge the NICE threshold of £30,000 per QALY, because they think that is an inappropriate threshold for drugs for rare conditions. What is your response to the company challenging the whole assessment process for these drugs?

Simon Stevens: You have had NICE before you. Sir Andrew Dillon has answered specifically on that question. Tellingly, the drug companies collectively in this country themselves say, “it’s arguably even more important for industry”—for industry—“that all companies are scrutinised in the same way because, if one company is allowed a higher price than its competitors, the rest of the industry would end up paying more through higher payments” under the repayments scheme through the PPRS. The drug companies collectively do not want an individual company to free-ride in the way you are describing.

Q313 **Dr Williams:** Is there a risk that there are wider geopolitical forces because it is an American company, and President Trump has made comments about the NHS underpaying for drugs?

Simon Stevens: The NHS is clearly a better negotiator when it comes to drug prices than the US federal Government. Were we to find ourselves in a situation where we were being asked to pay US prices, it would imply another £10 billion or so from the Treasury just in higher drug prices. I find it inconceivable that any UK Government of any political complexion would want to go down that path.

Q314 **Chair:** That is a very important point in the context of a no-deal Brexit because of any trade negotiation. It has been put to us that the greatest threat is in the potential for increased costs for drugs. That is where you would put the figure, around £10 billion.

Simon Stevens: If we were paying US prices, but I do not think anybody wants to see that. I think we saw a very strong cross-party reaction when that question arose a couple of weeks ago. There are strong moral reasons for our ongoing commitment to a national health service in this country, and there are strong economic reasons as well.

Chair: Thank you very much. We are out of time, but we appreciate you staying on.