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Committee of Public Accounts

Adult health screening

Ninety-Sixth Report of Session 2017–19

Report, together with formal minutes relating to the report

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The Committee of Public Accounts

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Summary

Health screening is an important way of identifying potentially life-threatening illnesses at an early stage. Yet the Department of Health & Social Care (the Department), NHS England and Public Health England (the national health bodies) are not doing enough to make sure that everyone who is eligible to take part in screening is doing so, and do not know if everyone who should be invited for screening has been. We took evidence on the management of four of the 11 health screening programmes operating in England: bowel, breast and cervical cancers and abdominal aortic aneurism. None of the screening programmes we examined met their targets for ensuring the eligible population was screened in 2017–18. Performance varies drastically across the country and yet the national health bodies still do not know which specific barriers prevent certain groups from attending meaning they cannot effectively target these groups to encourage them to attend.

The IT used to identify the eligible population for screening has been unfit for purpose for screening programmes since 2011, but still has not been replaced. National health bodies therefore run a constant risk of not knowing if all the people who should have been identified for screening have been. At the centre of this, the national oversight of screening programmes has failed patients, resulting in thousands of women not being invited for breast and cervical screenings or waiting too long for their cervical screening results. The national health bodies have been too slow to recognise and respond to the problems caused, including sufficiently holding local screening providers to account for long-term failure.

Introduction

Health screening is an important way of identifying potentially life-threatening illnesses at an early stage. Health screening programmes in England currently cover a range of conditions including different types of cancer, foetal and new-born screening, diabetes and abdominal aortic aneurism. This report focuses on four of the 11 screening programmes operating in England: screening for bowel, breast and cervical cancers and abdominal aortic aneurism. In 2017–18, almost 8 million people were screened for these conditions at a cost of £423 million. The Department is ultimately responsible for the delivery of health screening in England. It has delegated responsibility for health screening to NHS England, via an annual public health functions agreement. NHS England commissions and manages local screening providers; it also manages some of the IT that supports delivery of the programmes. Public Health England supports the Department and NHS England with expert advice, analysing and producing data; managing some of the IT that supports delivery of the programmes; and undertaking quality assurance work on the screening programmes to make sure that certain standards are met.

In May 2018 the then Secretary of State for Health and Social Care announced there had been a failure in the system that invites women for screening, affecting some 450,000 women. This number turned out to be closer to 122,000 but nonetheless raised concerns about health screening programmes. In October 2018, NHS England became aware of a similar issue on the cervical screening programme, with 43,220 women not receiving letters inviting them for a cervical cancer screening and a further 4,508 not being sent their results letters.

Conclusions and recommendations

1. **The Department, NHS England and Public Health England are consistently failing to meet their targets for the number of people who should be screened and have no clear plan on how to reduce the alarming health inequalities that exist.** Just 71.7% of the eligible population, or 3.2 million women, were screened for cervical cancer in 2017–18, which represents a 21-year low. We are extremely concerned about the massive disparity around the country with some areas in the North East consistently reaching more of their eligible populations than areas of London. On the cervical screening programme just one out of 207 CCG areas succeeded in meeting the target of screening 80% of its eligible population. There is also an overwhelming lack of understanding about local variation: the national health bodies do not know and could not tell us why performance is good in some areas and so poor in others. It is unacceptable that those in charge cannot pinpoint which economic, social or demographic factors prevent specific groups from attending appointments. The wealth of insight and knowledge local authorities hold about the specific barriers that prevent groups within their areas from attending screening appointments seems to have been completely ignored. Without this detailed understanding, the national bodies will not be able to address the health inequalities that exist.

   Recommendation: ***By the summer recess, the Department of Health and Social Care, NHS England and Public Health England needs to set out the specific steps they are going to take to understand why performance is so poor in some areas and then publish a plan, with timeframes for action, that explains how they intend to address these inequalities.***

2. **It is unacceptable that NHS England has continually failed to hold local screening providers to account for their poor performance.** NHS England is responsible for commissioning local screening providers and then managing their performance against the agreed targets and standards. Women attending cervical screening appointments are being continually failed by screening providers, with just 55% of women receiving their test results within the expected 14-day period. Targets are being set but not met: this delay is unacceptable and the impact of the undue stress and worry for women must be recognised. What is more, the Department told us that the 14-day target is a customer service ambition and not actually based on any essential clinical need. We are therefore concerned that this lack of clinical significance is not being communicated to women waiting for their screening results, especially when they are delayed. NHS England told us that some local providers currently have staff shortages, but as this target has not been met since November 2015, it is clear to us that NHS England is not managing local providers effectively.

   Recommendations:

   By the summer recess, the NHS England must write to the Committee to set out how it is going to hold local screening providers to account against their agreed targets and standards. It should also set out its targets for improving the performance of local providers over the next 12 months.

NHS England has a duty to make the public aware that the 14-day target is not based on clinical need. In the same letter, it should outline to the Committee how it intends to raise awareness.

3. **It is unacceptable that the national oversight of screening programmes has failed, with the Department, NHS England and Public Health England all being too slow to recognise and respond to the problems this has caused.** The existing arrangements for oversight and monitoring of screening programmes failed to identify that thousands of women had not been invited for breast and cervical screenings. In the case of breast screening, the failure went undetected for more than half a decade. The division of roles and responsibilities between the national bodies, between individual programmes, and between national and local bodies causes us concern, and the national bodies accept that there is "fragmentation" in the system. Public Health England is responsible for quality assuring the screening activities that take place, for example, visiting local providers to make sure they are conducting screening in the way set out in the national guidance, yet it has not got the power to enforce any changes it deems necessary. The national health bodies seem overly complacent in their approach to understanding the specific challenges facing health screening. They are heavily relying on Professor Sir Mike Richards' review to solve a host of problems, some of which have been evident for some time. It is also worrying that the review is not focused on speaking to people undergoing screening or to local authorities—who would both have clear ideas about what needs to change to deliver the screening services that we all expect.
Recommendation: ***Professor Sir Mike Richard's review into screening programmes should scrutinise oversight arrangements, the division of roles and responsibilities and the quality assurance arrangements. It should also include evidence that the conclusions are informed not just by central government bodies, but also by people who actually undergo screening and local authorities.***

4. **The woeful inadequacy of the IT supporting breast screening has played a fundamental role in the failure of the screening programme.** All of the screening programmes rely on a single IT system, known as NHAIS, to identify the eligible population for screening. Without NHAIS, the individual programmes cannot send invites for screenings. The Department of Health & Social Care accepted that NHAIS was "not fit for purpose" for health screening in 2011. NHS England has now committed to replacing NHAIS during 2020. However, this is three years later than planned, with the delay costing the taxpayer £14 million. NHS England has decided that it can no longer work with Capita, its original partner, on this project, so NHS Digital will take on responsibility for replacing NHAIS. Until NHAIS is replaced, there remains a risk that more people will not be invited for screening when they should be. After those eligible for screening have been identified using NHAIS, each screening programme has its own IT system to send invites, reminders and test results. Public Health England acknowledges that the IT supporting some individual screening programmes is "hopeless". The IT supporting the breast screening programme causes us particular concern. Public Health England put in place a new, single system in 2016 to assist the 78 separate systems that had previously been propping up the programme. The national health bodies, by not undertaking this reform sooner, undoubtedly contributed to the ambiguity around

what women could expect from the breast screening programme; and, ultimately, to the national incident in May 2018 when the then Secretary of State was forced to announce some 450,000 women were affected by a failure in the system that invites women for screening, albeit that the actual number turned out to be closer to 122,000.

Recommendation: ***Public Health England and NHS England should develop a more integrated approach to its IT systems to make sure that the multiple systems that need to be in place are able to connect and talk to each other to give screening patients the best possible service. This integration should also include a single owner who is responsible for making sure the IT works as intended.***

5. **We are extremely doubtful that NHS England will be able to successfully bring the failing IT system that supports the cervical programme back in-house, remove the backlog of samples that are waiting to be tested, and roll-out a new testing regime in just 6 months' time.** NHS England intends to move to HPV testing on the cervical programme in December 2019 but faces an uphill battle to do so. The incident on the cervical programme in November 2018, when 43,220 women did not receive their invite or reminder letters, was a warning signal that the programme was in turmoil. Capita subsequently accepted full responsibility for the failure. NHS England announced at our evidence session that it is terminating Capita's contract for cervical screening in June 2019. However, our concerns are not alleviated given NHS England's continued reliance on 360 separate IT systems to function, some of which are 30 years old, creating a high risk and far too complex operating environment. While NHS England has committed to creating a "unified cervical screening system" it cannot give a number for the number of systems it is working towards. NHS England is also working through 98,000 samples that are waiting longer than 14 days to be tested. Despite witnesses assuring us that there is no clinical impact from results being delayed, many women will not know this and will suffer undue stress and anxiety whilst waiting longer than expected for their results.

Recommendation: ***NHS England should set out a clear plan for how it intends to deliver this inherently risky project on time without making the service provided to women undergoing screening even worse.***

1 The performance and oversight of national screening programmes

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department), NHS England and Public Health England (collectively referred to as the national health bodies) about the management of health screening programmes in England.[1]

2. Health screening is an important way of identifying potentially life-threatening illnesses at an early stage. The Department is ultimately responsible for the delivery of health screening in England but has delegated its responsibilities to NHS England under the Health and Social Care Act 2012. NHS England is responsible for commissioning and managing the local providers that deliver screening services to members of the public; it also manages some of the IT that supports delivery of the programmes. Public Health England is responsible for providing the Department and NHS England with information and expert advice; producing and analysing data; managing some of the IT that supports delivery of the programmes and undertaking quality assurance work including visiting screening providers to make sure they are delivering screening services to the expected standards and processes. We focused on four of the 11 health screening programmes operating in England: screening for bowel, breast and cervical cancers and abdominal aortic aneurism. In 2017–18, almost 8 million people were screened for these conditions at a cost of £423 million.[2]

The performance of screening programmes

3. The Department measures the success of screening programmes by looking at the proportion of the eligible population that has been screened. Each programme has different targets, but in 2017–18, none of the screening programmes that we took evidence on had met their targets. On the breast and cervical screening programmes, in March 2018 more than a quarter of women who were eligible were not screened (just 72.1% and 71.7% respectively). The breast and cervical screening programmes are considered to be running optimally if they achieve their target of screening 80% of their eligible population. The national health bodies conceded that they were not content with current performance levels and accepted that there were areas in health screening "where we need to do better". The Department told us that the number of people who were undergoing screening had increased but recognised that it had more to do to make best use of modern screening methods, make screening appointments more accessible and encourage uptake.[3]

4. The number of people going to screening appointments varies greatly by area. We were concerned that the disparity in the number of patients being screened effectively created a postcode lottery. In London for example, performance is consistently below expected levels, whereas some areas, such as areas in Yorkshire, South Derbyshire and Hampshire consistently perform well.[4] The national health bodies asserted that the differences across the country in the number of people attending screening appointments are explained by

1 C&AG's Report, *Investigation into the management of health screening*, Session 2018–19, HC 1871, 1 February 2019
2 C&AG's Report, paras 1, 1.1, 1.3 to 1.6
3 Q 2, C&AG's Report, para 2.3 and Figure 5
4 Qq 4, 52, C&AG's Report, para 2.10–2.11

a combination of socio-economic factors including the age of a population, deprivation levels and ethnicity. NHS England told us that it is the responsibility of its local teams to track uptake of health screening and work on approaches that will tackle these health inequalities. Despite this, NHS England, nor the Department or Public Health England could explain to us what was causing the low take up of screening in specific areas, such as London. None of the national health bodies to date have set personal targets for reducing these health inequalities.[5]

5. We asked the national health bodies how they shared good practice between the best and worst performing areas, and to encourage specific groups who are less likely to attend screening to take part. NHS England told us that it had introduced 'some fairly straightforward' activities, such as text reminders and personalised letters from GPs, that it asserted have been shown to increase uptake. However, these approaches are not new and we were concerned that they would not be sufficient to encourage some groups to take part. NHS England also told us it had recently met with its Muslim health network to increase understanding and the acceptability of cervical and breast screening invites because areas with a large Muslim population, such as Leicester and Bradford, have low take up rates.[6]

6. Attendance at cervical screening appointments is at a 21-year low, with just 3.2 million women screened in 2017–18. Only one Clinical Commissioning Group area met its target of screening 80% or more of its eligible population in 2017–18; and in a further 143 out of 207 Clinical Commissioning Group areas at least 25% of the eligible population were not screened in the same period. The national health bodies admitted that they do not understand why so few areas met their targets or why performance is so different across the country. None of the national health bodies had engaged with women to understand why they do not attend cervical screenings; instead they offered generalities including women having "busier lives" as reasons for the decline in attendance.[7] Public Health England launched the first national campaign to encourage women to attend cervical screenings in early 2019. We welcomed this campaign, but we questioned how well it will be able to target specific groups of women and convince them to attend a screening appointment when the national health bodies do not fully understand why women are not attending in the first place.[8]

7. The national health bodies recognised that more needs to be done to make cervical screening less frightening and invasive and more accessible to women. Yet, they fell short of providing us with concrete plans to do this. Public Health England told us about a pilot that is underway to allow women to complete the test at home which we welcome. All of the witnesses were reliant on the review of screening, currently being conducted by Professor Sir Mike Richards, to come up with specific recommendations about how to improve in this area.[9]

8. NHS England is responsible for managing the performance of local screening providers and has delegated this responsibility to its local commissioning teams. We were concerned that local screening providers are supposed to deliver cervical screening results to 98% of women within 14 days of their screening appointment; yet in December 2018,

5 Qq 4, 7, 14
6 Qq 6–8
7 Qq 25–27, C&AG's Report para 1.2, Figure 1
8 Qq 16, 24, 31–34
9 Qq 6–8, 19–22, 32

they were delivering this level of service to just 55% of women. Public Health England admitted that the proportion of women who receive their results letter within 14 days varies considerably across the country.[10] In Southern Derbyshire, only 2.1% of women received their results letter within 14 days.[11] NHS England told us that there was no clinical reason why results needed to be sent to women within this timeframe, describing the rationale for setting the target at 14-days as a 'public service reason'. We were nonetheless concerned that women could endure unnecessary stress and worry if they are forced to wait longer for their results.[12]

9. We asked about the breast screening programme, where in 2017–18, 8% of women were not being invited for a repeat screening within the required 36 months window.[13] NHS England told us that problems, such as a lack of staff in hospitals in the Portsmouth and Brighton areas, had hindered performance across screening programmes. But, it was unable to tell us how it is tackling this poor performance beyond theoretically needing to balance local problems with being "quite hard-nosed" about provider performance.[14] Whilst NHS England's local teams can apply financial penalties for poor performance, and as a last resort, terminate a contract, NHS England admitted it is difficult to enforce this because of market conditions.[15]

The oversight of national screening programmes

10. We were concerned that the oversight arrangements in place for the breast and cervical screening programmes had failed to identify major issues in the programmes over a number of years. In May 2018, the then Secretary of State for Health and Social Care announced that there was a failure in the system that selects women for breast screening, affecting some 450,000 women. This figure was later revised down to 122,000 when a full analysis was completed but nonetheless raised concerns about the programme. This confusion began when a change was made to the programme's national specification in 2013 to try to remove ambiguity around the definition of age for breast screening. The national specifications set out who to invite for screening; how often to invite them; and how the screening is to be conducted. The Independent Review of Breast Screening subsequently found that the change was too late and, although not put into practice, was incorrect. The change to the national specification went unnoticed for more than half a decade. It only came to light through a data analysis exercise conducted for another purpose.[16] The independent review also concluded that once the issue was identified, Public Health England was slow to develop a clear understanding of the incident and its causes.[17] A similar incident on the cervical programme in October 2018 was identified by a hospital manager who was concerned that women were not being invited for screening when they should have been. The subsequent review found 43,220 women did not receive invitation or reminder letters for a cervical cancer screening and a further 4,508 were not sent letters containing their results.[18]

10 Q 17, C&AG's Report paras 7, 2.14–2.16
11 Q52
12 Qq 19–22
13 C&AG Report, para 2.12
14 Qq 4–5, 174
15 C&AG's Report, para 3.4
16 C&AG's Report, paras 1.9, 3.9–3.10
17 Qq 102–103
18 C&AG's Report, para 3.9

11. In light of these incidents, the national health bodies accepted that the division of roles and responsibilities was not working as it should be. The Department accepted that the governance of the screening programmes "looked quite good on paper but did not work as they should do in practice".[19] NHS England similarly told us that the governance arrangements were overly complex, describing the situation as a "triple fragmentation" between: the national health bodies; the individual screening programmes; and, within the delivery chain.[20] We were concerned that Public Health England is responsible for conducting quality assurance checks on local screening providers, yet it has no power to enforce the changes it deems necessary. Public Health England must rely on local screening providers themselves and NHS England to address its recommendations and take appropriate action.[21] Aside from suggesting that simplification is required, none of the national health bodies were able to tell us what specific actions should be taken to improve the governance arrangements, choosing to rely on Professor Sir Mike Richard's review to furnish them with answers.[22]

12. Professor Sir Mike Richard's was commissioned by NHS England to undertake a review of all national cancer screening programmes in November 2018, following the incident in the cervical screening programme. NHS England told us that it expects the review to be completed by Summer 2019.[23] However, we were concerned about the review's ability to cover the length and breadth of screening, including encouraging people to attend, reducing health inequalities, performance targets, governance arrangements and technology, in such a short timeframe. All of the health bodies deferred to Professor Sir Mike Richard's review during our questioning. While witnesses recognised a wide range of issues that needed to be addressed, they told us that their response would be dependent on the results of the review.[24] NHS England told us that it expected Professor Sir Mike Richard's review to result in a "huge shift" in how it worked, which the review would provide a route map for. It told us that this relied on the review providing recommendations that had "built-in proposed phasing and timescales for pragmatically and practically what could get done, so that we could then work off that". NHS England similarly told us that while it would make a range of changes to health screening programmes over the next 12–24 months, it relied on the review to "practically sequence that for us and to set us a road map that can be delivered, taking account of the staffing constraints and all the rest of it".[25] Professor Sir Mike Richard's told us that he had been talking to local authorities, through the Directors of Public Health as part of his review. He committed to speaking to more of this cohort to help inform his review.[26]

19 Q 150
20 Qq 150, 156–157
21 Q 173 and C&AG's Report, para 8
22 Qq 150, 166–167
23 Q 153
24 Qq 2, 14, 65, 157–159, 166–167, 170
25 Qq 167, 191–192
26 Q 161

2 Managing future changes and the IT that supports the delivery of screening programmes

13. All of the screening programmes rely on an IT system, known as NHAIS, to identify who is eligible for screening. NHAIS consists of 83 separate databases that contain the details of patients who have registered with a GP practice. NHS England is responsible for ensuring NHAIS operates as it should.[27] Each screening programme also has its own separate IT systems that are used to send invites, reminders and test results to patients. Public Health England is responsible for the IT systems that support the breast, bowel and abdominal aortic aneurism screening programmes, whilst NHS England is responsible for the IT systems on the cervical screening programme.[28]

14. NHS England told us that a key weakness within its screening services is the reliance on NHAIS.[29] The Department of Health & Social Care concluded in 2011 that NHAIS "was not fit for purpose" for screening programmes because it was hard to track a person's screening history if they moved across geographical boundaries.[30] This meant that the national health bodies cannot be certain that everyone who is eligible for screening is being identified. NHAIS was due to be replaced in 2017 by a new IT system with Capita contracted to undertake the work. However, NHS England admitted that it had put the project on hold because it did not have confidence in Capita's ability to deliver the change safely. NHS England has since decided to bring the new IT system back-in house and told us that it expected to replace NHAIS during 2020.[31] NHS England would not tell us how much introducing the new system would cost, but confirmed that the cost of maintaining NHAIS during this delay is estimated to be £14 million.[32]

15. Public Health England admitted to us that the "IT was hopeless".[33] Public Health England inherited the IT system that supports the breast screening programme in 2013. Public Health England told us that it updated the breast screening IT system in 2015 and introduced a new system, Breast Screening Select, in 2016. The breast screening programme relies on 79 individual local IT systems that do not talk to each other. Public Health England told us it had made some improvements to these 79 systems in 2015.[34] It also asserted that introducing Breast Screening Select in 2016 had improved its ability to conduct analysis on the breast screening programme. Public Health England told us that the new system allowed it to see for the first time that there were women in their 70th year who were not being called for a screen. However, Public Health England accepted that it did not have a sufficient understanding of the programme's data as even with this improved IT, it still took four months to understand the failure on the programme that emerged in 2018.[35] Subsequently, the then Secretary of State for Health & Social Care made

27 C&AG's Report, para 1.10
28 Q 81
29 Q 127
30 C&AG's Report, para 1.11
31 Qq 128–29, 141
32 Qq 132, 139–144
33 Qq 74, 81, 83
34 Qq 84–86, 94, 103
35 Qq 102–103

a statement to the House of Commons about a serious failure involving 450,000 women who may have missed a breast screening appointment, when in fact the true number was closer to 122,000.[36]

16. NHS England is currently undertaking major changes to the cervical screening programme whilst also trying to manage significant levels of poor performance as the programmes have not met their targets since 2015. Capita is responsible for sending invites, reminders and test result letters to women on the cervical screening programme. Capita took full responsibility for the serious incident in November 2018 when it became clear that 43,220 women had not received their invitations or reminders to attend a screening, and a further 4,508 women did not receive their results.[37] NHS England told us that it was not satisfied with Capita's performance on the programme and would terminate Capita's contract for the cervical screening programme in June 2019, with a phased transition of the service to bring it back 'in-house' throughout the rest of the year.[38]

17. NHS England is preparing the cervical screening programme to switch to primary HPV test by December 2019. The HPV virus is present in 99.7% of cervical cancers. This change to how analysis is conducted will mean that women will be tested for the HPV virus first to identify those women whose samples would benefit from further testing.[39] The change to HPV represents a significant change to how the cervical screening programme is run. NHS England described it as a "dramatic and fast" change to how it manged the programme and told us that it expected the change to result in around an 85 per cent reduction in the workload at the laboratories that analyse the screening samples. It expects this to mean that fewer staff will be needed and the process should be more efficient. Given that this change was announced in 2016 but is not expected to come into effect until December 2019, laboratory staff have "voted with their feet".[40] As a result it has become increasingly difficult for NHS England to recruit and retain staff leading to the difficulties in getting results to women within 14 days.[41] NHS England confirmed that it was currently dealing with 98,000 samples that are waiting to be tested, but asserted that samples could be kept for six weeks before being tested, and preserved for longer with the addition of extra chemicals.[42] We asked whether this number was likely to increase if the recent national campaign to encourage women to attend cervical screenings succeeds. Public Health England told us that the advertising campaign had been running for three weeks and was expected to run for a further five weeks and it was expecting a 5 per cent increase in the number of women attending a screening appointment as a result of the campaign.[43]

18. The cervical screening programme is also hampered by complicated and old IT systems. The programme relies on around 360 IT systems in total including: the 83 separate databases included in NHAIS which identify who is eligible for screening; and a further 270 IT systems that deal with invites, reminders, analysis and test results. Some of these systems are 30 years old.[44] NHS England accepted that it was not possible for the

36 Q86, C&AG's Report, paras 3.10 and 3.13
37 C&AG's Report, paras 3.13 and 3.14
38 Q 81
39 Qq 19, C&AG's Report, paras 4.5–4.7
40 Qq 19, 54, 56
41 *Letter from Professor Stephen Powis*, NHS England to Chair of Public Accounts Committee, 3 April 2019
42 Qq 64, 65
43 Q 67
44 C&AG's Report, para 1.12

operating model for cervical screening to work effectively with so many IT systems in place. It recognised the need to move to what it described as "a unified cervical screening system". Professor Sir Mike Richards similarly noted that there was an argument for a single end-to-end system for screening programmes. However, NHS England did not know what size of reduction was needed within the IT systems to create a more effective operating model and ultimately make the cervical screening programme less risky.[45]

45 Qq 111–118, 121–127

Formal Minutes

Wednesday 1 May 2019

Members present:

Meg Hillier, in the Chair

Douglas Chapman	Layla Moran
Sir Geoffrey Clifton-Brown	Anne Marie Morris
Caroline Flint	Anne-Marie Trevelyan
Nigel Mills	

Draft Report (*Adult health screening*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 18 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Ninety-sixth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 8 May at 2:00pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 20 March 2019

Sir Chris Wormald, Department of Health and Social Care, **Simon Stevens**, Chief Executive, NHS England, **Professor Sir Mike Richards**, Non-Executive Director at DHSC and Leader of the Independent Review of Cancer Screening Services and Diagnostic Capacity, and **Duncan Selbie**, Chief Executive, Public Health England	Q1–202

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

AHS numbers are generated by the evidence processing system and so may not be complete.

1 Association of Directors of Public Health (AHS0005)

2 Breast Cancer Care and Breast Cancer Now (AHS0006)

3 Jo's Cervical Cancer Trust (AHS0003)

4 Moull, Mr Colin (AHS0002)

5 Moull, Mr Colin (AHS0004)

6 Wigan Council (AHS0001)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Tackling online VAT fraud and error	HC 312 (Cm 9549)
Second Report	Brexit and the future of Customs	HC 401 (Cm 9565)
Third Report	Hinkley Point C	HC 393 (Cm 9565)
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396 (Cm 9575)
Fifth Report	Managing the costs of clinical negligence in hospital trusts	HC 397 (Cm 9575)
Sixth Report	The growing threat of online fraud	HC 399 (Cm 9575)
Seventh Report	Brexit and the UK border	HC 558 (Cm 9575)
Eighth Report	Mental health in prisons	HC 400 (Cm 9575) (Cm 9596)
Ninth Report	Sheffield to Rotherham tram-trains	HC 453 (Cm 9575)
Tenth Report	High Speed 2 Annual Report and Accounts	HC 454 (Cm 9575)
Eleventh Report	Homeless households	HC 462 (Cm 9575) (Cm 9618)
Twelfth Report	HMRC's Performance in 2016–17	HC 456 (Cm 9596)
Thirteenth Report	NHS continuing healthcare funding	HC 455 (Cm 9596)
Fourteenth Report	Delivering Carrier Strike	HC 394 (Cm 9596)
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