

Public Accounts Committee

Oral evidence: DHSC Annual Report and Accounts 2022-23, HC 459

Wednesday 13 March 2024

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Members present: Dame Meg Hillier (Chair); Sir Geoffrey Clifton-Brown; Mr Jonathan Djanogly; Sarah Owen.

Gareth Davies, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, Peter Morland, Director, and Anna Kinghan, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1 - 117

Witnesses

I: Sir Chris Wormald KCB, Permanent Secretary; Shona Dunn, Second Permanent Secretary; and Andy Brittain, Director General, Finance, Department of Health and Social Care; Professor Dame Jenny Harries, Chief Executive, UK Health Security Agency; Julian Kelly, Chief Financial Officer and Deputy Chief Executive, NHS England.

Examination of witnesses

Witnesses: Sir Chris Wormald, Shona Dunn, Andy Brittain, Professor Dame Jenny Harries and Julian Kelly.

Q1 Chair: Welcome to the Public Accounts Committee on Wednesday 13 March 2024. We are looking at the Department of Health and Social Care's annual report and accounts, which sounds dry but lays out all the expenditure on health across the year ending '23. In 2023, we reported that the Department had overpaid and overordered £14.9 billion of inventory, with vast unusable quantities of PPE in storage. That was a significant cost to the taxpayer.

We also looked at issues around the UK Health Security Agency, which had been established midway through a financial year. That is why Professor Dame Jenny Harries is with us again today. This year the accounts are late still, partly as a result of the covid challenges, which we recognise, but the Comptroller and Auditor General has been unable to provide an opinion on the accounts of the UK Health Security Agency and has identified concerns elsewhere in the DHSC accounts.

We know that you take these matters seriously, and we do too. We want to get to the bottom of why that is and when things will get regular again, because we want to have the positive confidence that they will. We know it is not a wilful process of yours, but there are concerns that we need to raise today. We want to hear from you about how you will address those concerns, and there are other issues in the accounts that we will touch on as well.

Before we go into the main session, I will introduce our witnesses and then I have some other questions. We have Sir Chris Wormald, the permanent secretary at the Department of Health and Social Care, joined by Shona Dunn, the second permanent secretary at the Department, and Andy Brittain, the director general for finance at the Department, who also oversees the finance side of the UK Health Security Agency. He is not the chief finance officer for the agency, but he has a line management responsibility there directly.

We are also joined by Professor Dame Jenny Harries, the chief executive of the UK Health Security Agency, which was established in September 2021. That was midway through a financial year, which is one of our concerns about how some of the challenges it has faced have come to arise. Finally, we have Julian Kelly representing NHS England, where he is deputy chief executive and chief financial officer. Every time someone appears in front of us, they have a longer title. I am not sure if that is efficiency savings or productivity in the NHS—we live in hope.

I will start with Sir Chris. Back in 2018, this Committee produced a report on continuing healthcare and its funding, at the time when now Lord Stevens was in charge of NHS England—Julian Kelly will no doubt want to come in on this as well. We were very concerned then about how the efficiency savings being earmarked for that were going to actually bite.



HOUSE OF COMMONS

Since then, the BBC has done some research about the eligibility for receiving continuing healthcare. It came up with some quite disturbing figures, including on regional variation in eligibility, which ranged from 50% of adults who applied getting support in some parts of England, to fewer than 10% in other areas. For under-18s, eligibility rates ranged from 14% to 96% in 2022-23. I will not go through all the detail—it was a journalistic bit of work, so it is all available—but some families were denied funding after a medical assessment, and then another panel, without talking to them, refused support.

We know this is an expensive area for the Department and the NHS, but these are very worrying figures coming out of the BBC. I want to hear from you, Sir Chris, on what the plan is for managing continuing healthcare, so that the patients who need it are getting the support they deserve.

Sir Chris Wormald: As you say, this is a shared responsibility between the Department and NHS England, so I will hand over to Julian Kelly in a bit, on the operational side. Essentially, the Department does the policy and the legal framework, and then NHS England does the operations.

This is an incredibly complicated area. When we did this in 2018, I think we had nearly three hours on just this subject, so we can only touch the sides today. As you say, it is both an extremely expensive and growing area of the budget, and extremely important to the individuals concerned. In terms of the policy, the absolute heart of it is individual decision-making about the individual in front. We do not have quotas or regional targets.

Given the different demographics of different places, we would expect quite a divergence in what happens in individual places. Now, whether or not that justifies the numbers you read out, we will need to look into further, but this is categorically not a thing you just roll out equally across the country. As I say, the absolute heart of it has to be individual decision-making based on a clinical diagnosis of the individual.

We set out extensive policy guidance about how those individual decisions should be taken, and then NHS England operationalises those decisions. To get to, “Was an individual treated fairly or unfairly?” you would really have to look at the individual cases, which of course we are happy to do offline, but now is probably not the time. NHS England takes an oversight of how it works out in different places, at which point I hand over to Mr Kelly.

Julian Kelly: I do not know which aspect you would like me to start with, but on eligibility and variation in rates, we do track that. In particular for the adults—I can come to the children briefly in a minute—there is variation, as Chris has said. A major reason for that is different demographic profiles and, to some degree, different services offered elsewhere in the community that would otherwise provide some of this care, including between the NHS and local authorities. We track by



HOUSE OF COMMONS

classifying ICBs into seven categories, depending on their demographic profile—

Chair: ICBs are integrated care boards.

Julian Kelly: My apologies: ICBs are integrated care boards, which are responsible for commissioning the services and making the decisions. As I was saying, when you do that, the variation shrinks. There is variation due to those—

Q2 **Chair:** So you benchmark peers?

Julian Kelly: We do benchmark peers. We spot where the outliers are. We have gone in previously and audited some of the individuals' decision making where we have outliers, at least to confirm that the decision making is robust. Where it is not, we agree improvement plans.

Q3 **Chair:** To be clear, with outliers, is it those who are granting more and less?

Julian Kelly: Yes, both. You may be granting too many or too few. There has been a narrowing in the level of variation since 2018. The commissioning body has changed in that time, but there has been a narrowing in the variation of application rates, which would at least indicate that there is better understanding in populations of what is available. We have seen a narrowing, by less, in variation in what we call the conversion rate—as in, what percentage of applications are accepted. We continue to work with the outliers, and we continue to look at how we can improve the way we audit the decision making where appropriate.

Q4 **Chair:** Do you have enough money for it? We looked at it, and you were going to be making £855 million in efficiencies, which we were worried was going to be causing problems, and now we are seeing challenges.

Julian Kelly: Since about 2018, I think, the amount we spend on all-age continuing care has gone up by about 50%, so it is a major cost pressure. That is a combination of the implications of the fair cost of care policy adopted in social care, as that flows through into NHS continuing healthcare, and the national living wage.

We have definitely seen an increase in the complexity of the cases we are funding. You can particularly see that in the children's side. I think you are seeing very similar issues in local authority children's social services. We certainly have not reduced the amount we are spending in this area. In fact, it has increased substantially. It is a significant cost pressure.

Sir Chris Wormald: We could write to you with an update on that bit. I am stretching my memory for six years, but I think the savings we talked about were against the counterfactual or where the budget was expected to go. They were not about the cash sums in that area.

Chair: Yes, and as Mr Kelly says, the numbers were going up, so we were concerned about that juxtaposition. If you could write to us with an update, we may then pick it up in a future session more specifically,



HOUSE OF COMMONS

because it is hugely important for those who receive it and very challenging if it is reduced when they are expecting it.

There are not many options available unless you have lots of your own private money, which is obviously not the case for most people. Indeed, it is an NHS service, so it should be provided. We will continue to watch this. We are aware of the pressures, but that does not mean that it shouldn't be being provided to people who need it. Thank you very much. Let's go to Sir Geoffrey Clifton-Brown, deputy Chair.

Q5 Sir Geoffrey Clifton-Brown: Good afternoon to our witnesses. Could I come to you, Mr Brittain, and refer to the *Health Service Journal* issue of 27 February, which reports that you have taken a billion pounds out of the capital budget to fund the ongoing industrial action? Is that correct? If so, I have follow-up questions.

Andy Brittain: The industrial action would be for the current financial year rather than the year referred to in these accounts. I would need to check the precise figure, but there is a general principle here, which is that when unexpected costs emerge across the Department and in the NHS, we of course look in our own budgets first to see to what extent we can re-prioritise, and then we enter into discussions with the Treasury. We also look across resource and capital budgets.

Where we forecast underspends in capital budgets because delivery is going more slowly than expected and there is, therefore, some headroom, we do use that. We are absolutely not consciously slowing down programmes or delivery. It is where delivery is slower than expected and money is available that we use that, and on an exceptional, non-recurring basis. When we had the industrial action discussions this year, we went through that reprioritisation process, and we reprioritised an element of capital. I would need to double-check the precise number that you quote.

Q6 Sir Geoffrey Clifton-Brown: Okay, so it is true. Given that the hospital building programme is under such pressure, particularly with things like RAAC, this is surely a very unwelcome development; a billion pounds would build you a new hospital, there or thereabouts. This Committee has railed against raiding the capital budget to pay current expenditure before, so how do you justify that?

Andy Brittain: I do not characterise it as raiding the capital budget. As I said, it is where delivery is slower than expected against plans and there therefore needs to be a reprofiling against delivery and the budget associated with that. Therefore, we put underspends that emerge that will not be used for other purposes towards emerging pressures such as that.

Q7 Sir Geoffrey Clifton-Brown: I hear the gloss, Mr Brittain, but presumably you have a capital budget for a reason.

Andy Brittain: Yes.

Q8 Sir Geoffrey Clifton-Brown: And presumably you plan to spend it.

Andy Brittain: We plan to spend it when it is set, yes.



Q9 Sir Geoffrey Clifton-Brown: Particularly when there is such pressure on the hospital building programme, accentuated by RAAC. What effect will this have on the hospital building programme?

Andy Brittain: I think the Committee recently discussed the hospital building programme, so the detail of that is well-known. Compared with when the profile was set in the spending review, the delivery has needed to be reprofiled against that, and that is where these underspends are emerging.

We are working with the Treasury to reprofile the overall costs of the hospital building programme so that we can work towards the aim of eradicating RAAC by 2030, which is when the hospitals need replacing by. The overall aim remains intact: it is the profile that has changed.

Chair: Thank you. Obviously, we constantly keep an eye on this issue.

Q10 Sarah Owen: Hello to all our witnesses. I want to ask two questions, specifically about changes in guidance and the ability to fund them, and the support given to trusts. They are both close to my heart.

The first is around the NHS's announcement today that guidance will change to give two weeks' bereavement leave to people who suffer miscarriages, which is incredibly welcome to me as one of many campaigners for miscarriage bereavement leave.

As somebody who has suffered multiple miscarriages myself, I cannot tell you how welcome the announcement is, and how important it is that it is the NHS that has done this as one of the largest employers, particularly of a woman workforce. It proves that it is necessary, but also possible; it is that "possible" part that I want to push on now. How is NHS England ensuring that trusts can actually do and fund this and are supported in this change in guidance?

Julian Kelly: When we decided to do this in response to the recommendation from the Government's pregnancy loss review, we looked at the cost. In the grand scheme of the total funding to hospitals, when you calculate it—I forget the precise sum; if you want to know, I can go and find out—it is a de minimis amount of money. In some cases, trusts were already doing this, so it is actually saying, "No, we insist that everyone follows the standard." As I said, in the grand scheme, it is always a tragic situation, but the numbers are quite small; our estimate of the cost is reasonably de minimis and therefore manageable within the total funding envelope.

Q11 Sarah Owen: Fantastic. Would you be able to share those costs with me? I think it would help to show that the NHS is leading on this issue for other employers that might be reluctant or worried about how it would impact them.

My second point is, having been a HCA, I know that the guidance changed in 2021 around the "Agenda for Change" from band 2s to band 3s and the uplift. What has the Department done to ensure that trusts have the resources and funds to support that uplift and the associated back pay?



HOUSE OF COMMONS

Who is best to answer that—Mr Brittain?

Julian Kelly: I am happy to start. The position did not actually change in 2021; what happened was that we clarified what should have been happening with the actual rules and the terms on which we should have been evaluating job roles. At that point, this does cause a cost pressure, because clearly now trusts have had to look at where they have banded people at 2 rather than 3 and where they are doing a job that should be at 3. Those discussions between unions and individual trusts are ongoing.

We and trusts are having to manage that cost, both the non-recurrent element and the recurrent impact, on an ongoing basis. That is one of the financial challenges that we are and have been grappling with.

Q12 **Sarah Owen:** Just to be very clear, is additional funding being made available to the trusts that are really struggling with this, and if not why not?

Julian Kelly: There has not been specific additional funding, in part because they as employers are responsible for the way they employ their staff, so this was a clarification of what should have been happening. Therefore, we haven't taken money off other people in order to fund specific trusts that have had to adjust what they are doing with staff.

None the less, it does create a pressure, and as we are discussing with individual hospital providers and the systems of which they are a part, we are having to discuss what that means for both what they can deliver and the funding they need in any given year.

In part, the rate at which trusts are sorting this out is also differential, so it is not as if there has been a single rule as to what individual trusts have to do, because they all find themselves in different situations. It really is an employer-by-employer with-their-staff issue.

Q13 **Sarah Owen:** Isn't there a sense of duty and responsibility from the NHS overall to some of the lowest paid members of staff, who have been, for a number of years now in different areas and in different trusts, doing more than they have actually been paid for? Albeit that you have said that the individual trusts are the employers, isn't there a sense of responsibility and duty here from for the NHS?

Julian Kelly: It is the responsibility of the employer to sort those issues out with their staff. They are supported by NHS Employers; indeed, I have been in some conversations with trusts only in the last few days on this very subject.

Q14 **Chair:** I think what Ms Owen is driving at is that if you are healthcare assistant and that is your title, your job is a certain job and that is something that the NHS overall would agree.

Julian Kelly: Yes, and the guidance, as you say, was clarified in 2021 for exactly this reason. It is the job of the employer to make sure that they are employing people on the right basis.



HOUSE OF COMMONS

Q15 Sarah Owen: But if the guidance wasn't clear in the first place, surely there is a responsibility on yourselves for having unclear guidance for a number of years and allowing this ambiguity to arise.

Julian Kelly: As I said, I don't commission NHS Employers, but they clarified the guidance in 2021, which I think was just to make it absolutely clear to employers that no one could hide behind it.

Chair: Thank you very much for that. We will now move on to our main session, which is to examine at least a portion of the Department of Health and Social Care annual report and accounts. It is a large document; I will just make it clear that we won't cover every inch of it. I am sure that witnesses will be relieved to hear that; otherwise, we would be here forever. We will try to pick out the edited highlights. Sir Geoffrey Clifton-Brown, the deputy Chair of the Committee, will kick us off.

Q16 Sir Geoffrey Clifton-Brown: I think these are probably questions for either you, Sir Chris, or maybe Andy Brittain.

I will take you to page 223 in the middle of the report, which says under the heading, "Management of Personal protective equipment inventory": "As part of its response to the COVID-19 pandemic, the Department procured £13.6 billion of personal protective equipment...the Department has written down the value of its PPE inventory by £9.9 billion". That is a staggering amount that you have written off.

I will ask a few questions about that, if I may. In deciding to dispose of these huge inventories, what consideration was given to giving some of this equipment to other needy people, like those in the third world? For example, I am sure that some of the people in Gaza could well have used some of those stocks.

Sir Chris Wormald: I will ask Andy to go through the detail, but just as a matter of fact, of course the £9.9 billion referred to here is the write-down since 2021. Indeed, I think that the amount of the write-down in this year's annual report is—

Andy Brittain: £240 million.

Sir Chris Wormald: It is very low indeed. Of course, we have debated that write-down at length with this Committee. As you know, a large amount of it is simply the change in the asset price from what we bought at a very high level in the middle of the pandemic, and we all know why—

Chair: That is well rehearsed.

Sir Geoffrey Clifton-Brown: Yes, we know all that.

Sir Chris Wormald: Yes. I am merely clarifying your initial statement, Sir Geoffrey. On the specifics—

Q17 Sir Geoffrey Clifton-Brown: On the very specific point, what consideration have you given to giving this equipment away, particularly to needy people, maybe in the third world?



Andy Brittain: Of course, we keep under regular review what we are doing with the stockpile, and we manage it in accordance with the Government's waste recycling hierarchy, which looks first at reusing it—so sales or donation. Well, first, it is using it in the NHS and in health and social care settings, and then the next step down is looking at sales and donations. We have had an extensive international engagement programme to see to what extent other countries would like to use and take hold of our PPE. The next step down is recovery, which is energy from waste, and the final one, which we seek to avoid, is landfill. We continually review the stockpile through the lens of that hierarchy. To the extent that countries are willing to take it, that has been looked at.

Q18 Sir Geoffrey Clifton-Brown: I hear that answer, Mr Brittain, but if you go over the page to 224, in paragraph 5 it says: "In 2022-23 the Department did not perform full and complete stock counts on its PPE inventory, including that held in containers. The Department has said that a full stock-count would cost £70 million". Yet £70 million in terms of the amount you have written off—£9.9 billion over the last couple of years—is small beer. If you do not do that stocktake, how do you know what is useable and not useable, what could be given away and what could be sold?

Andy Brittain: We know what PPE inventory we have and where it is. The subtlety here is that we were unable to gain access to it ourselves and we were unable to give the NAO access to do an audit to physically count it because it was in containers, stacked up.

Chair: Which we know.

Andy Brittain: That is why we were unable to do that. On the £70 million, because we were working our way to reducing the stockpile, we took the view that spending £70 million to count all this would not be value for money and, in fact, it would have delayed the plans to dispose of the stockpile by quite a significant extent. In fact, we have managed to accelerate it and save a further £130 million against our costs. For that reason, we took the view that it was not worth counting the inventory in sufficient detail to provide it up to audit evidence quality.

Q19 Sir Geoffrey Clifton-Brown: I hear that answer too, but given that there were a large number of unopened pallets, I simply do not know how you can know whether they were either fit for use or fit for resale. But you have answered that question.

Let us move on to the future, and the strategic reserve. I am concerned that you have disposed of this large amount of equipment and it is going to take at least a year for the covid inquiry to establish the causes of and the preparedness for the last pandemic. Given that we are likely to get another pandemic, how are you considering getting rid of all this stuff, compared with keeping it in a strategic reserve in case you need it for the next pandemic?

Andy Brittain: The stockpile we have at the moment is not of the right sort, so it is expiring. Some of it is not fit for use in health and social care



HOUSE OF COMMONS

settings, so we are getting rid of what we do not need. Separately, we are working to identify what a sufficient pandemic stockpile would be.

Q20 Sir Geoffrey Clifton-Brown: But you got rid of it all before you worked through what it should be.

Sir Chris Wormald: No, Mr Brittain's point is the stuff that is being disposed of is the stuff that we can never need.

Andy Brittain: Yes.

Sir Chris Wormald: Normally because it is going out of date, as it were, so there are no circumstances in which it could be used for a long-term stockpile.

Q21 Sir Geoffrey Clifton-Brown: Thank you for that. I interrupted you mid-flow, Mr Brittain.

Andy Brittain: For future stockpiles, we will base the size of the stockpile on the reasonable worst-case scenario for pandemic and emergency disease risks, and that work is in hand now to work out what that is and make sure we have a stockpile of sufficient size for that.

Q22 Sir Geoffrey Clifton-Brown: On the recommendation of the Treasury minute, you committed to doing a regular update to Parliament. When will you be making the next update to Parliament?

Andy Brittain: An update to Parliament on what, sorry?

Sir Geoffrey Clifton-Brown: On this whole subject: PPE inventory and disposal.

Andy Brittain: The last update we provided to you was in November 2023 and I think that was the last one we committed to providing. We are currently thinking about what future updates we should give, whether annual or not.

Chair: Perhaps we can discuss that offline.

Andy Brittain: Of course. I am very happy to do that.

Chair: We want to make sure it is useful information in real time, but on the other hand, if six months becomes too frequent, we might negotiate to help on that one.

Q23 Sir Geoffrey Clifton-Brown: This is the final question from me on this area for the two of you. Going back to the strategic reserve, you said you were working through what you need for a future pandemic. When will those deliberations be complete?

Andy Brittain: As I said, we are deciding what stockpiles we need in the light of the reasonable worst-case scenario for pandemic and emerging risks. We will also take note of what the covid enquiry decides and update our plans in response to that.



Sir Chris Wormald: I think you said a year previously, but I do not think that is the inquiry's plan. I think their plan for module 1, which is on pandemic prep, is to report as soon as they can. As I expect you know, they are trying to do it module by module, rather than a grand report right at the end. We are still in the wind-down period of the stockpile, so we are pretty confident that we still have more PPE than we would ever want to retain for a future pandemic. As we come out of that wind-down, you are correct, we will have to take decisions about exactly what we want to keep long term. As Andy said, we will want to take account of what the inquiry says in taking that decision.

Sir Geoffrey Clifton-Brown: Thank you.

Q24 **Sarah Owen:** To follow on from Sir Geoffrey's points, the covid-19 procurement was not just about PPE; it was also about other pieces of equipment. I want to focus on ventilators: £569 million was spent on 20,900 individual ventilators. Mr Brittain, can you explain why such large volumes of ventilators have been scrapped, rather than being donated or sold, perhaps, as Sir Geoffrey said, to developing nations that might need them or best use them? Why were they not sold in the first place?

Andy Brittain: Yes, we did have a covid ICU reserve, which includes the ventilators you have just described. A strategic decision was taken to close that in February 2024, so we are now working through precisely how we will dispose of those. That is being worked through in a slightly different hierarchy, called the value retention activity model. That looks first to try to donate ventilators into the NHS. If that is not possible, it looks to return them to suppliers for buy-back. If that is not possible, we look to international humanitarian donation. We will check which other nations want them. If that is not possible, we look to auction on the open market. Finally, we look to disassemble and recycle them. We have a zero waste to landfill policy for this particular item of equipment. We go through that hierarchy to make sure that we get the absolute best value for money out of the equipment that is available.

Sir Chris Wormald: The only thing I would add, and I expect you know this from your professional background, is that ventilators are much more difficult to donate into the third world because they rely on quite sophisticated hospital oxygen systems to make them work. Indeed, the limiting factor to how many ventilators you can run is very frequently the pipework of a hospital, not how many individual ventilators you have. Therefore, they can normally be used only by people who already have a sophisticated hospital position. That does not mean we do not try, but it is more difficult than with some other medical equipment to find people who can actually use them.

Q25 **Sarah Owen:** I completely understand that. I have a follow-up question on some of the options you said you would work through. Have you made an estimate of how much of that £569 million you will get back, the likelihood that ventilators could be used elsewhere, and what you would get in return for the buy-back scheme from manufacturers?



Andy Brittain: We have not yet, because it is a work in progress. It is a dynamic position at the moment. The work is only really just happening at the moment, so I do not have an estimate at the moment.

Q26 **Sarah Owen:** When do you think that work will be completed?

Andy Brittain: It will be ongoing until we have worked through the amount of equipment we have. I am very happy to give you an update on the position as it is at the moment, if that would help.

Q27 **Sarah Owen:** Is there a pause on the NHS buying ventilators, given that you have 20,000 available?

Andy Brittain: I will have to ask Mr Kelly to answer that one. I am not sighted on that. I am not sure if Mr Kelly is either.

Julian Kelly: I am not sighted on the specifics, but it is as with PPE: we have used the first port of call for the stocks we already have.

Sarah Owen: It would be really useful to know.

Julian Kelly: I do not know specifically whether anyone has gone and bought—

Sarah Owen: It just would seem a little bit ludicrous to be purchasing ventilators.

Sir Chris Wormald: We will go and check. I suspect you are right. The only caveat would be where people are buying very specialist equipment that we do not have in store. We will go and check the exact position, but as we are making it available to the NHS first, it would be slightly surprising if anyone were buying new ones.

Sarah Owen: Surprising but not impossible.

Sir Chris Wormald: As I say, there may be very specific reasons why a particular type of ventilator is needed in a particular type of environment, but we will go and check.

Q28 **Chair:** Not every member of the Committee was on the Committee when we looked at the ventilators, but when we looked at this issue, we recognised that it was an expensive programme to deliver. At the time, of course, everyone thought that we needed ventilators, so it is not entirely a surprise that we have a lot of ventilators that we do not need. It was the right decision to do it, even though it was costly, but we now have this problem of trying to wrench value for money out of the decision, even at this late stage.

Sir Chris Wormald: It is important that even if it was the right thing to do at the time, we get best value for the stocks we have, so I do not think there is any difference between us and the Committee on the objective here.

Q29 **Sarah Owen:** Absolutely. That leads on nicely to my next question, which is on the Nightingale hospitals. They were absolutely the right thing to do



HOUSE OF COMMONS

at the time, but obviously trying to get best value for money post that is really important. How is it going recovering costs for the Nightingale hospitals, which were not really needed to the extent that they were expected to be? That is probably to you, Mr Brittain.

Andy Brittain: The seven Nightingales were set up to provide surge capacity at the start of the pandemic. All were decommissioned in 2021. Of those seven, there is no impact on this year's accounts, and all the costs have already been incorporated in previous sets of accounts. There were separate surge hubs set up during omicron but—I am looking to Mr Kelly—I believe they have been closed down now as well.

Julian Kelly: Yes.

Q30 **Sarah Owen:** I was asking specifically about your progress on recouping some of those costs because the NHS lost £13 million in unused beds alone, and it has been reported that they are being sold for as little as £6 when they cost £2,500 in the first place. Surely we could have found better use for those beds or got more money for them, many of which were unused.

Andy Brittain: The same principles apply as to ventilators. Where there was spare equipment from the Nightingale hospitals, we will have first looked to provide it to other NHS trusts. If they did not want it, we would work down the hierarchy to get the best value for money out of it. I cannot comment on the specific figures you have just quoted, but that is the general approach we will have taken.

Q31 **Sarah Owen:** Would you have looked just to keep them in the NHS, or would you have looked at the care system as well and to share that resource?

Andy Brittain: Again, the principle is that we would look across the health and social care system. We have definitely done that with PPE, for example. We look across the system.

Q32 **Sarah Owen:** You say this work is ongoing.

Andy Brittain: Not for Nightingale.

Sarah Owen: Not for Nightingale, okay. How is it that there have been reports that beds have been sold for £6?

Andy Brittain: That may be possible. As I said—

Sarah Owen: How?

Andy Brittain: Because if the decision is taken to sell equipment on the open market, it will sell at the market price. I cannot comment on the specific figures, as I say.

Sarah Owen: Despite them being bought for £2,500.



HOUSE OF COMMONS

Andy Brittain: Again, I am not able to comment on the specific figures you are quoting, but, in principle, if items of equipment are not required for the NHS or other settings, they will be sold.

Q33 **Chair:** Are you doing anything to ensure that you are not flooding the market? If there are a lot of hospital beds all for sale at the same time, maybe they do go cheap.

Andy Brittain: Again, we will go away and check this. Since they were closed in 2021, I do not believe there is any equipment from Nightingales still left to be disposed of, but I will go away and check that.

Q34 **Chair:** Yes, just check. Presumably there was a plan to sell it into the market at a reasonable pace.

Andy Brittain: Of course.

Shona Dunn: I believe all the stock was disposed of by July 2023, and it was disposed of through auction, donation and disposal. On the specifics you mentioned, without knowing the precise bit of equipment, the condition it was in, its uses and so on, of course that is perfectly possible but unlikely, and I am sure it would have only occurred in a few circumstances. Through those different routes, we definitely will have generated the best value we could. Of course, we were also trying to make sure that we were not incurring significant ongoing costs to the taxpayer for storage. Clearing the decks, if you like, would have been a priority at that time.

Q35 **Sarah Owen:** My final question is about PPE and equipment overall from covid-19. Is there any ongoing work to extend the life of the inventory that you have, and its possible uses?

Andy Brittain: Yes. We do that across all our inventory. Whether it is PPE, vaccines or antivirals, that is one of the key things we look at: extending the shelf life as long as possible, while retaining health and safety concerns.

Chair: We have touched repeatedly on the fraud issues. Ms Dunn, are you the one who has been leading on this?

Shona Dunn: I am more than happy to answer, Chair.

Q36 **Chair:** I just want to make sure who I am directing questions to. We have previously looked at the number of contracts that are still in dispute. Can you give us an update on what number we are at on that? That is obviously not all fraud or crime, but what number are we at now?

Shona Dunn: The dissolution team is the team that does this, as you know; we have discussed this with you before. The number referred to in the accounts for March 2023 was 45 contracts that were still under review. That number has come down substantially: I think it is now under 20, but I will not comment on the precise details, because we are always quite careful about that.

Chair: We have not got the exact figures, but because these accounts are



HOUSE OF COMMONS

delayed it is helpful to know what the trajectory is.

Shona Dunn: Indeed. That work has continued at pace. The accounts refer to the sums of money that both avoided fraud and were recovered. We have continued to work through contracts. As you know, they are mostly not at issue for fear of fraud, but there is some level of dissatisfaction with the contracts as a consequence of our review of the materials.

Q37 **Chair:** How would you describe in simple terms how that is going? Are people saying, "Yeah, we gave you the wrong stuff. We are now going to give you the right stuff"? There are two layers to this: there is getting the public money sorted and the deal for the taxpayer, but there are also lessons to be learned and driven home where people did the wrong thing during the pandemic. Where are you drawing that line? How are you finding the negotiations?

Shona Dunn: As you would expect, it is a mixed picture. I go through this in some detail with the dissolution team from time to time, and have done so very recently. It is fair to say that in most cases what we are now talking about are materials that were not quite up to the standard we expected or that were, for some technical reason, missing information, documentation and so on. But where we identify that people were effectively attempting to profit at the expense of the taxpayer, we take a very, very firm hand and we pursue that as far as we can.

Q38 **Chair:** How many are you pursuing on fraud? Even if you cannot be specific, can you give us a ballpark figure?

Shona Dunn: I am reluctant to give you specific numbers, because a lot of these cases are very live.

Chair: So a small sample could be identifiable.

Shona Dunn: Absolutely.

Q39 **Chair:** We will continue to pursue this in public as much as we can. Can we have a private briefing?

Sir Chris Wormald: Yes, why don't we provide you with a private briefing specifically on the fraud, as we have done previously?

Chair: We want to shine sunlight on this in the public domain, but I think the public would want to know that someone is looking at what is going on. Notwithstanding the fact that you are doing your best to get this back and take on the fraudsters, a bit of scrutiny of that doesn't hurt. That is what we are here for.

Shona Dunn: Absolutely.

Q40 **Chair:** When will you be in a position to report to Parliament and the public on the level of fraud that has materialised?

Shona Dunn: We will go after every penny we possibly can when we think the taxpayer is being defrauded, certainly, but at some point there



HOUSE OF COMMONS

will be diminishing returns, and the cost of the exercise will be greater than the return. In that case, we will make the decision to close that team.

At the end of that process, we will report to Parliament on the overall out-turn of that effort. I cannot tell you when that will be yet, because we are determined to keep on going after this money.

Q41 **Chair:** Are we talking months or years?

Shona Dunn: I would expect that we are talking months rather than years.

Q42 **Chair:** That is helpful to know. We will keep a beady eye on that.

We have talked about this before, but now that you are at this stage, what lessons do you think you have learned, on both fraud and error, that would be helpful if you were advising someone in a future pandemic? You have trawled through all these contracts to see what has gone wrong.

Shona Dunn: As with some of the other things that we have discussed today, we have spent many hours on this in this Committee, haven't we? And the things that we have discussed—

Chair: Yes, but you are at a stage now where you have a maturity of understanding, because you have gone through everything with a fine-toothed comb, haven't you?

Shona Dunn: To be fair, Chair, I do not think that the work that the team have been doing to go after money that should be returned to the taxpayer has elicited any further lessons other than the ones that we have previously discussed. We know what those are, but those are extensive lessons that have been covered in the Boardman review and elsewhere about how you procure in circumstances like the ones we were in. I don't think that there are any new lessons.

I realise that I did not answer your question a moment ago about the level of overall fraud within our PPE purchase. I don't think that we are seeing anything that is changing our previous assessment that it is at about 1.8%. We will report on that at the end if we have seen any significant difference.

Q43 **Chair:** Mr Brittain, you are the money man: you will collect the money in if it is recovered. Have you anything to add about estimates of what you might be able to collect and what you have collected so far?

Andy Brittain: No, other than to say that of course we pursue—where it is reasonable and the right thing to do—every pound we can to get the money back.

Q44 **Chair:** Is there anything to say about the speed at which it is done? We recognise that a lot of money was spent in fast measure during the pandemic—we have gone through all the rights and wrongs of that—but we know from all our and your work that the longer it takes to chase down money paid, the harder it is to find it, if someone is deliberately trying to defraud the system. Are there any lessons that you have learned about



HOUSE OF COMMONS

the pace at which we should be doing this work?

Andy Brittain: I think that the contracts resolution team has been doing it at a very significant pace; Ms Dunn has set out the extent to which the outstanding contracts have drawn down over time. The ones that are left are probably the more complex cases, as you have described. I think they have done it as quickly as possible, but it is the easier ones that have been resolved first.

Sir Chris Wormald: As you know, Chair, there is a huge balancing act going on here. You are completely right about "The quicker the better," but we want no message out there that people can time the Government out or that all they have to do is add complication. We want the message out there that we will pursue every pound. It is "The quicker the better," but also "As long as it takes," and "You're not going to get away with it simply by delay."

Chair: Yes. My point about "The quicker the better" is that they can disappear into the sands if they really want to.

Sir Chris Wormald: Exactly, and we completely agree with your point, but we need to do the double thing of "The quicker the better," plus "You won't get away with just because you're timing it out."

Q45 **Chair:** I did ask about how many cases you will be taking to court, but I will try to ask it again another way. Mr Dunn or Sir Chris, is there any number that you can give us? We know that there is one high-profile case that we will not discuss here.

Sir Chris Wormald: We will give you a private briefing.

Chair: Okay, let's have a private briefing. We'll start with that, and then I assure the public that we will take as much into the public domain as we possibly can, when we can.

Sir Chris Wormald: Yes. As you have said, we can put a lot more into the public domain in retrospect than we can while these things are in flight, when we have to keep it private.

Q46 **Chair:** And you will pledge to do that, to Parliament?

Sir Chris Wormald: Yes.

Chair: Okay. We will want to talk to you about how you present that as well, because we have things like elections coming and we are already four years on from the start of the pandemic. People forget why we might need to know these things, but we will keep a beady eye as a Committee. I will hand over to Sir Geoffrey, the deputy Chair.

Q47 **Sir Geoffrey Clifton-Brown:** Good afternoon, Dame Jenny. You inherited a poisoned chalice as chief executive and accounting officer for the UK Health Security Agency. Unfortunately, your organisation has had its accounts disclaimed for the second year running. I think that even one disclaimer for any organisation in the public sector has not happened for



HOUSE OF COMMONS

the past 20 years, so this is a highly unusual occurrence. You will forgive me if I ask you—and the man sitting next to you in charge of the numbers, Andy Brittain—some quite searching questions.

The first question goes right to the overall organisation of it all. Is there sufficient organisational understanding and acceptance of the level of cultural change and control improvement required to fix the issues? I shall be going through them in detail in a minute, because they are quite deep-seated and quite serious.

Professor Dame Jenny Harries: “Yes, of course” is the short answer. I would not want to be running an organisation any longer than I could with an accounting position as it is; it is not where we had hoped to be this year.

I would just like to draw a distinction between last year’s disclaimed accounts and this year’s, because they are quite different. You may wish to go into both sides.

Last year, we were a new organisation. As you have alluded to, we inherited a number of issues on coming into being. We came in mid-year, on 1 October 2021. We were given a new accounting system on the first day that we started, which is probably not what you would normally do. We arrived in the middle of a pandemic. Many of the issues we have just been talking about—the various contracts and things that we now control or oversee—were given to us: they were not ones that the organisation itself controlled.

Nevertheless, I think what you will see from the NAO Report this year on what we put in place to try to pull ourselves out of those disclaimed accounts last year is that we have made very good progress. I think that that is clear in the board. That does not mean that we are complacent at all; I absolutely recognise that there are cultural issues with all organisations. To flag a few of those issues, one of the difficulties for this year’s accounts was that we came in with very little headroom because of the disclaimed accounts last year. We then had a separate issue with the covid vaccine unit and the model, which we can come on to.

In terms of what we did last year to pull ourselves forward, I chair a finance and control improvement board that has representation from the NAO, the DHSC and the GIAA. We have an ARC in place that was not fully formed at the start—we were in the organisation without all the right parts of the system. All of that has been put in place, and I think you can see that in this year’s accounts.

What has happened this year is a separate issue relating to the covid vaccine unit, which I am very happy to—

Q48 Sir Geoffrey Clifton-Brown: I am going to come on to that.

Sir Chris, given that this was an organisation that was new and that had a new accounting system, and given that it was in the height of the pandemic, why did you add a huge additional responsibility to that organisation by transferring the covid vaccine unit to it on 1 October

2022?

Sir Chris Wormald: I will say a couple of things about UKHSA as well, but I will answer your specific question first.

Our starting point is the health protection function and what makes a successful health protection system. I should put it on record that on that side of UKHSA's operation we were extremely pleased with how the organisation has been established and has gone forward. It did the end of covid, obviously, but it has also done some other very significant health protection work around monkeypox, MMR and measles. That is exactly what you want to see, on the real purpose of the organisation—the science and health protection work. Our starting point is always that.

Let me take the issue of covid and covid vaccines. Vaccination, as you know, is absolutely central to health protection across covid, flu and everything else.

Q49 Sir Geoffrey Clifton-Brown: I don't think anybody doubts that, Sir Chris, but why did you transfer it to an organisation that was new and struggling?

Sir Chris Wormald: Because they are the people who are very good at health protection. Who should be taking the decisions about the deployment of vaccines, how we use them, and how that interrelates with the flu programmes that UKHSA already had? It should be our health protection experts. In terms of getting successful vaccine deployment, it is a complete no-brainer that that should be in UKHSA.

It does leave us with the issue that you are identifying of a new organisation that has quite a lot of systems issues on this side. We always take the view that we are not going to do something sub-optimal on health protection on those grounds. If there is pain to be taken, we take it on how we, the public servants, have to account for it—not on the population and how its health protection is taken.

We took the view that we had to transfer the money and the accounting officer responsibilities at the same time. It is really bad practice to have the operational decisions taken in a separate organisation from the accounting officer. Once we decided that the best operational decisions are those made by UKHSA in line with its other responsibilities, the accounting officer responsibilities and the financial control responsibilities go with that. That is the basis of the decision, and frankly I still think that is the right decision: to start with what makes good health protection and then deal with the other issues. That was the heart of the decision making.

The other general point I want to make about UKHSA—I think we have discussed this, and that the C&AG agrees—is that we have seen significant progress from UKHSA on its base financial systems and its culture. You are not shaking your head at me, Mr Davies, so I think that is fair to say.



HOUSE OF COMMONS

To your very important first question on whether we are creating the right culture to move forward, we think yes, fundamentally. The evidence we have had from the NAO—

Chair: I will just bring in the C&AG on that.

Gareth Davies (Comptroller and Auditor General): Just to respond to that point, I absolutely agree that quite a lot of important governance arrangements were introduced following the first year's accounts, including the operation of the audit committee, which has made a big difference. There has been progress on being able to present a more manageable set of financial data for us to audit. I think there is still a long way to go on that one; although it was better, it was going from an extremely challenging position to a challenging one.

A crucial success factor here is not underestimating what remains to be done, and therefore allocating sufficient resources of the right expertise and so on to continue cleaning up the financial ledger, with the ability to respond promptly to audit queries in a kind of pressurised timetable—all the nuts and bolts of a normal accounting process.

Sir Chris Wormald: Fortunately, you have said exactly what I was going to say in the second part of my answer. That is not the same—

Chair: So you don't need to repeat it, then.

Sir Chris Wormald: No, I'm not going to repeat it. That is not the same, as there isn't still a lot to do and a lot of things to fix. I was answering your very specific and correct point of whether our organisation has the right culture that is seeking to make the necessary improvements, even if it hasn't got all the way there yet, and I think that is where we agree.

Q50 Sir Geoffrey Clifton-Brown: Right. To test both of your answers, Dame Jenny and Sir Chris, I am going to go to the money man—the figures man—and ask him several specific questions. I thank the C&AG for his very helpful intervention there.

Mr Brittain, we talked about the CVU team being transferred to UKHSA, but your finance team also uses the outputs of the CVU demand model within its own accounting model to provide the impairment and provision figures in the annual report and accounts. Given the significance of the model to the accounts—the C&AG identified it as a key audit risk when planning his audit—what have you done to remedy that?

Andy Brittain: You mean to remedy the key audit risk?

Sir Geoffrey Clifton-Brown: Yes.

Andy Brittain: The issue for this account occurred because the UKHSA CVU team switched from their primary model to a back-up model, which had been cross-validated in numbers. The issue is that the NAO couldn't then audit it sufficiently in the time that was left available. This year, to remedy that, we are putting in place a detailed plan that we have agreed with the NAO to go in and audit the covid vaccine unit model much earlier



on in the audit, so that we have assurance that it is auditable and fit for purpose. We are also putting extra resource into UKHSA to enable the information to be there ready when the NAO goes in to audit it.

Professor Dame Jenny Harries: May I build on that a little bit? I am clearly nearer the detail of the organisation, and very much value Andy's oversight of it.

There was a Python model, and, exactly as Andy said, there was a validation model as well. Both were sitting within the same governance structure. The particular point that triggered this issue was the fact that—picking up Sir Chris's point—there was a change in the variant. All of this happened after the end of the financial year. The point here is that it is about the model. The covid vaccine unit switched; they needed to forecast for public health reasons, and they took that action. It was known to our finance team but, exactly as Andy said, the alert to the NAO came in November, which was too late to then go through the assurance process.

However, we have put in place some other actions since, which was the point I wanted to pick up. One is that there is a business-critical model; definition has gone in. We already had an analytical quality assurance framework, but we have gone back over that and completely resourced it. We have a registered analytical pipeline—a RAP plan—that we have implemented as well.

There are a whole host of things, all consistent with the Aqua Book, the Macpherson review and various other things that have all been put in place to make sure that that cannot happen again. It was largely a communications issue, rather than there being, as yet—I realise the NAO will want to quite rightly ensure that this is the case—any suggestion that the actual model has failed us in this case. Indeed, I think we had to change the output again the following month because of the variants.

Q51 Sir Geoffrey Clifton-Brown: Dame Jenny, may I press you a little on this matter? Although you think you have now improved the control improvement considerably, the C&AG reports on your accounts, on page 138: "UKHSA changed the model it was using and key stakeholders, including my audit team, were not informed of this change on a timely basis." Surely, when you make a significant change like that, the first thing you do is tell your own financial team and the external Government auditing team? You did not do that on a timely basis.

Professor Dame Jenny Harries: That is what I was trying to explain. That is absolutely what should happen. We recognise that and we are absolutely committed to ensuring that the model is reviewed and that, as Andy has said, we have a timeframe set out to do that going forward into next year. In this case, we had finance business partners in a governance meeting, which we also asked external DHSC colleagues to review afterwards to check that the process was okay. The communications issue was between the business partners in the meeting and our central controls teams, who did not realise that the change in methodology—or rather the

change in model, given that they were on the same methodology—was a material change. That is where the problem was.

Sir Chris Wormald: To be clear, Sir Geoffrey, no one is denying that this was a mistake. We all agree with the C&AG's words that clearly that should have been notified to the NAO earlier, which would have helped with some of the problem. This is not a pedantic point, although it sounds like one. On your words about what we do, that is the not the first thing we were doing. The first thing we were doing was focusing on getting the right vaccine into the right arms for the variant that we had at the time. We should have done exactly what the C&AG says in the report, and say we agreed it as well. As I say, our first focus was on getting the right vaccines to the right people at the time. But categorically, the C&AG is correct that a mistake was made and this is the result.

Q52 Sir Geoffrey Clifton-Brown: Thank you for that admission, and thank you for the action you are taking. I have no doubt that the C&AG will look at that very carefully when he looks at your next set of accounts.

This question is maybe for you, Mr Brittain. The report says: "Given the extremely large size of the CVU balances in relation to UKHSA as a relatively small organisation, UKHSA will therefore ensure an additional layer of management review is introduced at an earlier stage." How are you doing that?

Andy Brittain: Sorry, I missed the second half of your question.

Sir Geoffrey Clifton-Brown: Given the extremely large size of the CVU balances in relation to UKHSA, as a relatively small organisation, will UKHSA therefore ensure that an additional layer of management review is introduced at an earlier stage?

Andy Brittain: Oh, I see. Yes is the answer. What has happened is that—

Q53 Sir Geoffrey Clifton-Brown: I think that is probably all we need. The report says: "The late post balance sheet events, as described above, and consequent changes to our accounts have resulted in it not being possible to provide required assurance of these balances in advance of the 31st January statutory deadline." Can you give us an assurance that the necessary infrastructure, particularly financial oversight, is in place to ensure that the post balance sheet events do not happen again this year?

Andy Brittain: I cannot guarantee that no post balance sheet event will happen because, as Dame Jenny set out, that sometimes relates to covid variants, which are outwith our control. I can say that we have put in place much more rigorous governance and controls around the accounts, models and the ability of the accounts team and finance team to engage with the business, and we have a detailed audit plan, which we have agreed with the NAO, to get this year's audit done to a good time and flag any issues early. I think we have put in place quite significant improvements, which should mitigate that risk very significantly.

Q54 Sir Geoffrey Clifton-Brown: Can you be more specific on that, particularly on the resources and people required to make sure it does not



HOUSE OF COMMONS

happen again? This is a really serious matter. We do not want it reoccurring. What resources? What people? For example, would a chief finance operator in UKHSA be a useful addition?

Andy Brittain: I would pick up three things. One is that the core UKHSA finance team has been recruiting and building its capability and capacity, and that is coming on well.

The second thing is that, as I said, given the significance of this year's audit and the amount of work we need to do, we have agreed a detailed plan with the NAO and are getting in some external assistance to front-load it and do the really hard work on cleaning up the information so that we are able to provide it to the NAO in a decent state.

Thirdly, as you alluded to at the beginning, we have codified my role in UKHSA, which is to work with Dame Jenny and ensure that the finance team and the governance controls are of the right standard. I can go into any of that in more detail if that would be helpful.

Q55 Sir Geoffrey Clifton-Brown: I accept that, but it is not quite the same thing as having a high-powered chief finance officer within the organisation who can nip all these problems in the bud, rather than you, sitting in the Department, looking at them from the outside.

Andy Brittain: UKHSA does have its own chief finance officer and a finance director.

Q56 Chair: But I think Sir Geoffrey is saying it is sub-optimal. We have seen situations like this before where there is oversight. It does happen. When do you expect UKHSA to be stand-alone? Dame Jenny, when will you have the support? Do you need any other executive roles, such as a chief operating officer, underneath you? You are the expert, but they run the organisation.

Professor Dame Jenny Harries: Absolutely, and I recognise that. I see Andy and the Department as an additional layer of support, critique and challenge to what we are doing internally.

Q57 Chair: How long do you expect it to continue?

Professor Dame Jenny Harries: I will go back a bit. At the start of this year, our whole workforce was very unstable. Going back to the start of the financial year, 30% of our workforce—

Chair: Just to be clear, this is 2022-23.

Professor Dame Jenny Harries: Yes, the accounting year we are considering. We had only 30% of our workforce stable. Andy talked about building a new team, and we are now up to about 83%, I think, which improves the whole culture and system of the organisation. Just putting in place a stable workforce moves us forward into the position you would expect the organisation to be operating in.

We do have our own chief financial officer, and we also have our workforce rated not only within the financial control and improvement plan but on a



HOUSE OF COMMONS

strategic risk register to make sure it is prioritised. We are talking about the basics here. We have spoken about the model, but the absolute basics, which I think are what the C&AG is referencing in how we move forward, are things like getting our workforce data right—that is progressing phase 2 of MaPS—and getting our purchasing processing right. We are very much focused on those things.

There has been a challenge around workforce capacity. I think we are now up to roughly the right numbers, but that was not the case when we were stabilising the organisation. There was huge churn.

Sir Chris Wormald: I will add two things that are pertinent to your question. First, as the vaccines unit demonstrates, there is quite a lot of traffic between the Department and the agency, and therefore having a single person who oversees all that has positive advantages. In an ideal world—we are not quite there yet—oversight from the Department will never stop, but it will be more like the relationship that we have with the Treasury, so it is genuine oversight, rather than being in there doing the work. There is no circumstance in which that oversight will stop, because of course the external oversight is useful to the process, in exactly the same way as Treasury oversight of us is useful to the process. That is the end state. We are not quite there yet, but that is the role we will play.

Chair: So there is always oversight, but this is a bit more day to day.

Sir Chris Wormald: Yes.

Q58 **Sir Geoffrey Clifton-Brown:** Sir Chris, your Department would not normally have this degree of oversight over one of your non-departmental organisations.

Sir Chris Wormald: Well—

Sir Geoffrey Clifton-Brown: You wouldn't. You wouldn't have your chief finance officer sitting on the top of it in the way that he is.

Sir Chris Wormald: It is very important, of course, to note that this is an executive agency of the Department. These are other civil servants, and it is formally part of the Department, so it is not like our relationship with NHS England, which is a separate statutory body.

In its set-up phase, no, it is not that unusual. It is a thing Departments do when we are still in the set-up phase of a very complicated organisation. I agree with your fundamental point: if we are still in this situation in two or three years' time, something will have gone badly wrong because we would expect UKHSA to be doing all these things for itself. But in this circumstance, where you have a new and complicated organisation that is a merger of three very complicated organisations, and has very complex day-to-day health protection responsibilities, I think it is fair enough that we are giving UKHSA extra assistance as it gets through that phase. As long as that is a phase thing, I am happy with the situation, but I do not think Jenny or I would be happy if that were still the situation when we are



HOUSE OF COMMONS

coming out of the set-up phase and into it being an established organisation with its own systems.

Q59 Sir Geoffrey Clifton-Brown: I hear that argument, Sir Chris. This part of your organisation has had an effect on the qualification of your overall departmental accounts, which cannot be a good thing. It has had two years to sort itself out, and you talked about another two years.

Sir Chris Wormald: No, I was talking about the oversight and the extensiveness of the oversight.

Sir Geoffrey Clifton-Brown: Well, let me rephrase the question: are you confident that, in the next financial audit, the accounts for this organisation will not be qualified?

Andy Brittain: They absolutely will be qualified. I think the question is whether there will be another disclaimed opinion. We are working extremely hard to avoid that circumstance. What I would add to Sir Chris's and Dame Jenny's points is that the first one was largely related to financial controls and governance, which have largely been rectified.

Sir Geoffrey Clifton-Brown: That fed over into the second one.

Andy Brittain: It reduced the amount of headroom we had to avoid a disclaimer, and it is unfortunate that this covid vaccine unit issue emerged later—late in the financial year. We are working as hard as we can to rectify that. I hope and anticipate that we will be able to avoid another disclaimer. I cannot guarantee that at the moment, because we have 10 months of work to do with the NAO to get through the audit.

Q60 Sir Geoffrey Clifton-Brown: Ten months is quite a long time. A qualification is one thing; a disclaimer is a totally different thing.

Andy Brittain: Yes, I know.

Sir Geoffrey Clifton-Brown: Surely within the next 10 months you ought to be able to work this through, so that at least you have a reasonably reliable set of accounts for the C&AG.

Andy Brittain: Indeed. We are throwing absolutely everything we have at this. As I said, we are getting in a team of external assistants to scrub the data, clean it, and make sure it is of such a standard that the NAO can go in and audit it first time. That is what we are talking about with the core financial information.

We are getting in some separate people to ensure that the covid vaccine unit model is able to be audited cleanly and quickly when the NAO goes in. However, it remains the case that, given the history of the organisation and the history of the covid transactions going through it, it is far more complicated than any other ALB would be.

Sir Chris Wormald: To be absolutely clear, we never guarantee in advance. It is a decision for the C&AG. For obvious reasons, the C&AG



HOUSE OF COMMONS

does not commit himself in advance, and we do not second-guess the C&AG's opinion.

Chair: But you are doing your best.

Sir Chris Wormald: As Andy says, we have to throw everything we can at it. The answer to your question goes our friends' way at the end of the year, and we do not try to second-guess that opinion in advance, for obvious reasons.

Q61 **Chair:** Dame Jenny, you took this on midway through a financial year. You are an expert in the medical field. Looking back, do you wish you had asked for certain other support or help? What would you do differently now, if you were asked to take on a body like the UKHSA? What would your advice be to anyone doing the same thing?

Professor Dame Jenny Harries: For the very reasons that Sir Chris has given, I would take it on in exactly the same way, because we are trying to provide the right health protection for the population, and I think what we have described here is a very unusual set of circumstances arising from the pandemic. Clearly, there are management control issues, and I hope we have described those satisfactorily.

Q62 **Chair:** What would your advice be if one of us was offered a job like this in a new organisation that had been set up? What would be your top tips for someone coming in, with professional medical expertise, who was taking on a new body with all its complications?

Professor Dame Jenny Harries: I do not think one should assume that because you have medical skills you do not have management skills.

Chair: Sorry, I did not mean to put it across that way at all. What I mean is that you were brought in mainly because of your medical expertise, I imagine. Obviously, running an organisation is not new to you, but this was a very complex organisation that was set up at pace, and your priority was protecting the health of the nation, as you say. But there is an awful lot of stuff behind that.

Professor Dame Jenny Harries: But it was also to build a stable organisation with opportunity. The answer to your question is, first, ensure that the ground bits are in place as early as possible. Not all of that is within the organisation's control; it is quite complex to set these things up and get all the right boards and people appointed, even though that was thought of early. Do everything as early as possible, but also articulate some of the potential issues ahead. To pick up Sir Chris's point, when I was here last year I said that this was going to be at least a two-year journey, and it has been two to three years with the point we have just been discussing.

I would also like to flag that if there is another big health protection issue, or, for example, if we are doing what it says on the tin for the UK Health Security Agency, which is working with pharmaceutical companies and building new opportunities in the life science agenda, that may in due

course—and it all needs to be governed properly—put an organisation in a different position. There is a balance point about recognising exactly what we must do in terms of financial governance and control, and flagging some of the potential problems that may come ahead.

Sir Chris Wormald: Exactly; that would be my advice too. We were not really thinking about it because we were at the beginning of the pandemic, but in retrospect, if we were doing it again, we should have been much clearer at the outset about the pain to come, and much more explicit that we were going to take health protection decisions first and then do our best about the rest.

Chair: We appreciate your candour. I think Ms Owen will want to probe a bit of it.

Sir Chris Wormald: That is what we did. We could have been very explicit about that right at the beginning. As I say, it is not surprising that we weren't because, bluntly, that was not what we were thinking about when we set up the organisation. But I think that is the learning point.

Q63 **Sarah Owen:** I want to pick up on some of Sir Geoffrey's points and some of your responses, Mr Brittain. You talked about rigorous models of accounts, a detailed audit plan and significant improvements. Specifically on tackling optimism bias, what are some of those significant improvements?

Andy Brittain: For this year, in establishing the audit plan, we have worked much harder and much more comprehensively up front with the NAO to agree what we both consider to be a realistic audit plan. That includes elements of contingency in case things go on longer than we would hope. That is the fundamental thing, because last year we had a plan, but then it was a bit of a voyage of discovery as we went through the year, particularly given the covid issues.

This year, we know what the issues are, so we have a plan in place that is more credible early on. As I said, we have thrown extra resources at it. In the Department, I have a monthly board with the NAO, where we jointly take stock of progress against the overall Department's group audit and the component bodies audit, which is the NHS particularly and the UKHSA. I think we have a better plan and better governance in place this year to enable a better chance of success.

Q64 **Sarah Owen:** Great. Is that part of the culture change that Sir Chris was alluding to? Is there much more challenge within the Department itself?

Andy Brittain: I think there is more realism. As Sir Chris mentioned, last year and certainly the previous year, the consuming focus was the response to covid. Of course, we knew that we needed to improve controls and governance very quickly coming out of that, and we have previously talked about the finance reset programme that went on in the Department. As we go through that, you see increasing levels of realism and improving governance controls. Where issues continue to emerge, we take quick action.



Q65 Sarah Owen: Would you accept that there isn't any other kind of organisation or department that would be able to operate properly without that degree of realism? Is it not a bit of a shame that it has taken this long to realise that that realism is needed to plan for the future?

Andy Brittain: Again, I would not characterise it in that way, because for the last two years we have been primarily responding to covid. I would contend that that was such an uncertain and volatile disease that I certainly didn't know how to be realistic about the course of it and the impact on the organisation, because it was just evolving and emerging.

Sir Chris Wormald: I do not know what Jenny thinks, but I am not sure that optimism bias was the heart of the problem. I think people knew how tough it was; it is the absolute challenge of getting it over the line that has been the difficulty. I certainly haven't detected people being over-optimistic. It is about the level of the challenge.

Professor Dame Jenny Harries: To add to that, I hope what you hear is an absolute recognition of what we need to be doing as an organisation. The challenge was about what else we were having to do with a new organisation and an unstable workforce. I think we started the conversation with culture. Actually, you need people to be on board, which is a critical component of effective governance systems. That takes a while to bed in and progress, but I think it is moving in the right direction.

Q66 Sarah Owen: Dame Jenny, you made the point that the workforce was unstable and transitional at the start of 2022-23. How much of your executive team are permanent UKHSA staff members, rather than secondees and people on temporary contracts?

Professor Dame Jenny Harries: The executive team are effectively all permanent but, just to qualify that, there are a few on long-term secondments, because we are based on technical expertise. For example, we have an academic executive on a long-term secondment, and a clinician on a long-term secondment, but these are three to five-year appointments, so effectively they are permanent.

Q67 Sarah Owen: Is that a small or significant percentage of your team?

Professor Dame Jenny Harries: It is a minority percentage. As with other Government organisations, we are trying to be efficient. We are slightly top-heavy as we come out of the pandemic, so we are looking at how we can make our spans and controls a little bit tighter, but still remain effective.

Sir Chris Wormald: The small percentage is a good thing, not a bad thing. We do this in the Department as well. Particularly when taking on scientific staff, we are very frequently taking secondments from universities or from the NHS itself. That is a very positive thing, as long as it is long term.

Professor Dame Jenny Harries: Throughout our workforce, we have what we call double-hatters. With academia, I think we have a couple of hundred double-hatters—people who are working half in the organisation



and half in academia. That is beneficial, because it helps work with industry and academia to progress innovation.

- Q68 **Sarah Owen:** Thank you. Sir Chris and Dame Jenny, you have talked about a culture of trying to move forward, and about workforce. One of the rigorous and significant improvements is around diversifying the workforce and the experience within it. I would say that it is not just about experience and skills—when it comes to something like covid-19 and the health inequalities this country is facing, ethnic minorities and low-paid members of communities will increasingly be particularly vulnerable. What are you doing to ensure that that expertise and real-life experience is accounted for? Are there any moves within the Department to see much more diversity within the top levels of your teams?

Professor Dame Jenny Harries: I will answer for UKHSA. I absolutely recognise that. I take the view that unless we have diverse decision-making and all the right inputs, we will make the wrong decisions. That is particularly important if we are trying to design services or support services. We have a strategy around health inequalities, where we challenge ourselves to deliver on all the work we do. We are gradually trying to increase data flow so that we can evidence that. Importantly, when it comes to workforce, we have a group looking at health inequalities. For example, it looks at infectious disease in prisons or among homeless people.

It is important to ensure that we have representative people at senior level. I have put in lots of particular process issues around recruitment. We are not very representative at exco, but as you go down one layer to senior directors, we have an accelerate programme, which pulls through good individuals particularly from ethnic minority or disadvantaged backgrounds, so that we can promote and support them into roles of leadership within the organisation.

- Q69 **Chair:** Could you explain the acceleration programme? How long will people have to come in for?

Professor Dame Jenny Harries: Broadly, it is a year-long programme, as it stands. There are variations of it.

Chair: So a bit like secondees, for a year?

Professor Dame Jenny Harries: Exactly. People will be attached to one of the director generals, for example. They will get exposure to senior decision-making so they can see from a different perspective. They are supported on an individual basis to ensure that they are comfortable in that role and have all the support they need. It has been hugely successful so far. Our exco level is not quite so good, but we have very good representation—above population average—across our staff, as you come down the system.

- Q70 **Sarah Owen:** In that secondment process, coming down a level, does that level where you see an increase in diversity feel comfortable in challenging up?

Professor Dame Jenny Harries: I hope so. We are still quite a new organisation. We have the senior leadership team; we are trying to start to delegate more responsibility down. We also have values for the organisation around being insightful, impactful, and inclusive. We found that when people came in to present papers, for example, at the executive meetings, there was some suggestion that people did not feel comfortable, so we have put in a process to encourage them to anonymously feed that back in and then we do a stocktake each time to review that feedback.

Sarah Owen: So you are asking for feedback from staff on how—

Professor Dame Jenny Harries: We ask the people who come in whether we are welcoming. Are there problems? Does it feel like a hostile environment? Do they feel able to put their case?

Sir Chris Wormald: In the Department we do well on our diversity indicators, but not well enough. We do very well indeed on gender, where we are 50:50 pretty much across the organisation, including at the top. We do less well on ethnic minorities, although, because we draw on the fantastically diverse NHS, we have some of the most significant thinkers on this subject. You mentioned the covid experience. We have a lot of the most important thinking from Professor Kevin Fenton and his report and Professor Van-Tam and his work on vaccines, both of which make your point, but it does mean we have some of the most significant figures in the country working with us.

What we do not have is the breadth. We do worst on disability, and that is something we really do need to work on. We tend to be at the top of the Government benchmarks on pretty much everything, which we should be given the sectors we draw on and the type of Department, but it is mixed across the protected characteristics.

Shona Dunn: From my point of view, going into the senior civil service, our succession planning and our pipeline into the senior civil service is something we are really focused on across all those characteristics, as Sir Chris has said. We are also really interested in geographical and socioeconomic diversity as well, so our focus on developing Leeds as our second headquarters and making sure that we have good coverage across the country is important to us, too.

Q71 **Chair:** Cat Little has just been appointed the latest permanent secretary. On our reckoning she is the 57th woman ever to be a permanent secretary. That is not a great record, so let's not overblow it—and that is just men and women, let alone other diversities.

Sir Chris Wormald: The numbers are even more extraordinary when you look at them. I think there are about 20 who are permanent secretaries at the moment and 57 in total, which demonstrates a lot of things about the journey.

Q72 **Chair:** Let's not dance a jig just yet on how well things are going. On the overall issue around the accounts and the UKHSA, it is pretty obvious from our questioning that we challenged this last year as well. On setting up a



HOUSE OF COMMONS

new body, there were all the challenges of mid-year, and we know about the pandemic, but that is still not an excuse not to have proper financial controls. This is just the bread and butter of what Whitehall and accounting officers should be doing, making sure that organisations are set up with the proper arrangements.

We have made our point on that, and the C&AG will make his own point. Sir Chris, you must acknowledge it was thrown together. Proper controls were not in place and that is partly why we are where we are. You cannot just blame the pandemic.

Sir Chris Wormald: No, and I am not going to. I completely defend the decisions we took organisationally based on health protection. I also hope—it was certainly our intention coming here—that we have been blunt about what went well, what did not go well and where we have made mistakes. We go into this with that philosophy, and I hope that is what has come over at this hearing. But we do think we have done the health protection bit very well. We think we have made progress, but we also recognise everything the C&AG says about progress. That still needs to be made, and I hope we have been blunt about all that.

Chair: As accounting officer, you are accountable, as is Jenny, to this Committee and to Parliament, so it is important that we get those financial basics right. We know what happens when those controls go awry, and we then revisit all of that. Jonathan Djanogly is next.

Q73 **Mr Djanogly:** I want to talk about suspension payments. I am looking at the accounts, which state: “Under certain qualifying circumstances NHS England can make suspension payments to medical practitioners who have been suspended as set out in relevant statutory regulations.” It goes on to say: “NHS England has not recovered most of the ineligible suspension payments it made. Ineligible suspension payments made to two of the 12 medical practitioners have been recovered in full by NHS England. These recoveries amount to £32,747. The remaining £1,302,879 has not been recovered. NHS England is taking legal advice regarding recovery.” Mr Kelly, why do you not have adequate financial control over those ineligible payments?

Julian Kelly: In late 2022, when the NAO were doing the audit of the previous accounts, it identified two cases where payments should have been suspended and they had not been. I then commissioned an internal audit review of all the people who are on the suspended list and still being paid, to ensure that there were no other cases. In that review we identified 12 other cases. Those are the cases that are in these accounts; those have all been sorted and we have not found any others.

We are going back through the list again, and we have changed our control regime. It was being done by seven different regional teams. These are relatively rare cases and some of the caselaw is quite complex, so we have decided to create a single national team, so it is the same team doing it all the time. That way we have better oversight; we can make sure that it is being done properly and that there are better controls so that we do not find ourselves in this position again.



HOUSE OF COMMONS

As you flagged, we are still seeking to recover more of the overpayment. I don't think we will recover it all, but we are still seeking to recover more.

Q74 Mr Djanogly: I am pleased that you have clarified that, because the accounts do not that say that. The accounts say that you are "taking legal advice regarding recovery." Are you confirming that you are going to pursue recovery?

Julian Kelly: We are making sure that we are on legally sound ground to pursue recovery.

Q75 Mr Djanogly: Are you pursuing recovery?

Julian Kelly: Yes.

Mr Djanogly: In all cases?

Julian Kelly: There are one or two cases where we are just confirming and it is possible that we will not be able to, because of things said and done in the past. That is where the legal advice is being pursued, to ensure that we are on legally sound ground to pursue.

Q76 Mr Djanogly: Are you putting procedural measures in place so that that does not happen again?

Julian Kelly: As I said, we have reviewed the whole caseload once. We are currently in the process of reviewing it again to ensure that we have not missed anything. We are creating a single national team who will now do this, as opposed to its being dispersed through seven other teams.

Q77 Mr Djanogly: And that will stop the problem?

Julian Kelly: Yes, I am hoping it will stop the problem, because we will have one group of people who are doing it the whole time. We can ensure that nationally we check every single month, and we streamline the process.

Q78 Chair: Can you talk through what will happen? You have one team, but you still have all the different trusts, so it could be that people are spread very wide.

Julian Kelly: No, it is largely to do with GPs—it can be to do with dentists as well, but in this particular instance it is GPs. In essence, there is a process where you have to check almost every month whether those who have been suspended are still employed.

Chair: Exactly. So that is what this central team will do differently: they will ring up the GP practice or the individual and check.

Julian Kelly: Yes, or they will review where they are in the process with the General Medical Council. In some cases, the judgment is reasonably complex, so I just want one group of fully trained people.

Q79 Sir Geoffrey Clifton-Brown: Can I turn to you again, Mr Brittain, as the money man, and raise another serious financial issue with you, which is the lateness of auditing some of your local bodies? In particular, on page



HOUSE OF COMMONS

130 of your annual report and accounts, in paragraph 540, it says, "This small but significant number of CCG and ICB audited accounts that were significantly late has delayed the preparation of these consolidated accounts."

There are two bits to the auditing of the local accounts: there is the internal auditing by the organisations themselves, and then there is the external, local auditing. Can we just deal with the internal auditing? What can you do, as you are in charge of finance, to make sure that the local bodies prepare their own accounts on time, ready to be audited?

Andy Brittain: There is a lot of work in hand on this, and Mr Kelly may wish to jump in as well. Essentially, the year we are referring to here was a complicated year, because there were more audits required to be done because of the setting up of ICBs. There were more audits to be done, and there were particular issues in the local audit market, with a small number of firms, one in particular, which—

Sir Geoffrey Clifton-Brown: Hang on to that. I just want the internals first.

Andy Brittain: What can I do about it? We are doing a number of things working with the NHS. We are engaging the market to try to build capacity in the local audit market.

Q80 **Sir Geoffrey Clifton-Brown:** Sorry, it is the internal audits, not the external local auditors. It is your own internal systems preparing those accounts ready to be audited.

Andy Brittain: Oh, I see. I will answer for the Department and then Mr Kelly can answer on what he is doing internally for the NHS. From the Department's perspective, we have brought the Department's core audit forward by two months for the year we are talking about here, which relates to us working through primarily the covid issues that we spoke about earlier. We are in a much better place now to do the Department's core audit. The issue that has emerged in the NHS is local audits, as you say.

Julian Kelly: In terms of the ability of providers and integrated care boards to actually do the preparation of the accounts, clearly, as we came through covid, that was a bit of a shock. We saw last year that the number of providers who were late in completing their accounts was reducing.

The position for integrated care boards was more complicated, for the reason Mr Brittain said, because we were both closing 100-odd clinical commissioning groups and setting up integrated care boards. That is a genuine reason why that was more complicated. Clearly, for this year coming, that was not the case because the integrated care boards are set up, so I am more confident about their ability to do it on time.

I would hope to see continued progress from the individual providers. For those who have been late, we engage with them and check early where they are. That is the kind of ongoing dialogue to ensure that they have



HOUSE OF COMMONS

what they need and that if there are any particular problems or they need to source help, we can help and support them.

Q81 Sir Geoffrey Clifton-Brown: That is a very helpful answer. Mr Brittain, we come to the bit of the problem that you are longing to come to: the local audit itself. What steps are you taking to ensure that there are sufficient numbers of local auditors and sufficient people in the firms to be able to do them? Your annual report on accounts refers to one particular auditing firm that has been a problem. I am not going to name them, for the reasons Sir Chris set out in his written letter to us, but clearly there are problems with this whole local auditing programme. What are you doing to overcome those problems?

Andy Brittain: The first point I would mention is that the Department does not have all the levers under its control on the local audit. The issues in local authorities are particularly well known and have been discussed previously by the Committee, I think. We are doing all we can to ensure that local audit issues, as they refer to the Department and the NHS, are managed and mitigated.

We are taking a number of actions. We are trying to build capacity in the local audit markets. The NHS has engaged with potential new entrant firms, and I think a couple are joining as a result of that. We are performance managing them much better as well. Trusts are performance managing audit firms much better, in the sense that clearer deadlines are being set and they are being held to account for delivery and slippage much more effectively. Audit firms that have not performed in previous years will be getting fewer audits in the future.

We are also engaging across Whitehall and with the Financial Reporting Council to look at things like the largest number of audits that, if they were late, we could rely on alternate procedures for to allow the NAO's audit to go ahead. We are working with the Financial Reporting Council to look at things, such as reducing the threshold at which audits have to be done and the particular bits of the audit that take the most time. We are looking at whether we can finesse the audit requirements to make them less onerous so they can be done more quickly.

Q82 Chair: Can you give us an example?

Andy Brittain: There is a major local audit threshold being considered by the FRC, which, if it were at a certain level, would mean fewer ICBs would be covered by it, so that drives audit requirements. That is a particular example. At the Department level, we are also working with the NHS and trusts to set expectations around issues that have arisen that trusts are responsible for, as well as making sure audits are done on time and, as I said, performance managing them much more effectively this year.

Q83 Sir Geoffrey Clifton-Brown: I thought, Mr Brittain, that you were slightly skating over the problem when you said you did not have the levers under your control.

Andy Brittain: Not all of them for the whole local audit market, no.



Q84 Sir Geoffrey Clifton-Brown: No, I accept not all of them, but you do have a significant number, with these 130-odd trusts now going down to 42 ICBs. It is incredibly important to the Department that these accounts are audited on time, because otherwise they are not consolidated into your main accounts and then they get late and get qualified. What are you doing now, 10 months ahead of the year-end, to make sure there are sufficient auditors who are prepared to do this work with a sufficient number of qualified people? It is the same problem as in local Government. What are you actually doing about that to assure yourselves that, once the accounts are prepared by the internal health audit teams, they go to the local auditors to be audited, they are sent on time and they are audited on time?

Andy Brittain: I can see that Mr Kelly wants to come in. The points I would make are, first, that when I say that I do not have the levers, I mean that we can do things to incentivise firms to join the market, but we cannot make them. The barriers to them wanting to enter are around fees, which we are looking at, and around complexity and risk, and I have mentioned some of the things around that. I think we are doing what we can to incentivise and encourage firms to join the local audit market. The particular issues we have had are around the number, capacity and capability of the ones this year.

Julian Kelly: We go into completing 2023-24 with every single NHS provider and integrated care board having an auditor appointed for next year. Last year, that was not where we were. My team worked very hard with some of the national firms to make sure they could pick up organisations that did not have auditors, but in some cases those started later, whereas this year we start today with every NHS organisation having an appointed auditor. That just puts us in a much better position and the audit firm with which we have had significant problems—they were auditing about 20 organisations and are now auditing six—where we were most concerned, we have reduced our risk. We will continue to performance manage the position.

Q85 Sir Geoffrey Clifton-Brown: I still do not have the answer to my specific question. It is one thing having an auditor in place; it is another to make sure they have the people to be able to audit them in time, as soon as they are given those—

Julian Kelly: With that experience of last year, 2022-23, with one notable exception, the issue was not significantly audit capacity. We do find, particularly as you hit the summer period, that there are some trade-offs being made in firms between the local authority and NHS market, which is why I think it is going to be hard for us to rapidly move to having completed all audits before the summer recess. The reason we slipped across the calendar year was due to one firm. Basically, the vast majority of audits were completed by September. We go into this year in a much better position.

Sir Geoffrey Clifton-Brown: I am glad to have that very clear answer.



HOUSE OF COMMONS

Q86 Chair: Can I just chip in before Sir Geoffrey continues? When we had the Treasury in, Cat Little was—she still is—the permanent secretary dealing with some of those issues. There was a drive across Government to try and encourage people to go into public audit. Mr Kelly, Sir Chris or Andy Brittain, are you part of that drive to encourage people into that exciting world? We might all think it is exciting, but how do we share that enthusiasm for why it is important and why people going in for qualification should consider that line of work? At the end of the day, what you are doing is quite interesting, but it might not feel like that if you are in a firm and you have private options to go for.

Julian Kelly: I cannot say that we are part of some national campaign to get people to go into the public audit side of the accountancy firms, although we are happy to participate in whatever exercise is done. The thing we are really doing, and Andy referred to it, is to work with other audit providers to see if we can basically increase market capacity. We have three examples of foundation trusts that have taken on auditors who previously were not engaged in this market.

Shona Dunn: The FRC, I think, is working on a local audit workforce strategy as well and the Department is on the steering board for that.

Q87 Chair: Okay, so you are putting your foot in that door.

Shona Dunn: Absolutely.

Q88 Chair: Because it is a way of enticing people in, so that they can see the actual reality of what it means on the ground.

Shona Dunn: To Sir Geoffrey's strategic point about overall capacity in the system, that piece of work is definitely something that—

Chair: We have rehearsed that endlessly with your sister Department, so thank you. Sir Geoffrey.

Q89 Sir Geoffrey Clifton-Brown: Mr Brittain, you referred to fees. The Department for Levelling Up, Housing and Communities has been on this for at least a year and probably longer and they have recognised that fees need to rise in the local government auditing sector. The individual local authorities have now increased their fees considerably, as I know from the complaints from my own council, but that does encourage more firms to come in and enable them to pay their people properly and to train up new people. I don't think the NHS has increased fees to the same level as the local government sector, so what more can you do—

Andy Brittain: I don't know about the direct comparator with local authorities, but I do know that—

Q90 Sir Geoffrey Clifton-Brown: Well, it's similar work, and you expect similar pay for similar work.

Andy Brittain: I do know that, since 2019, fees for local audits that NHS trusts have paid have broadly doubled. I can provide you with some detail on that if that would be helpful.



HOUSE OF COMMONS

Q91 **Chair:** Actually doubled?

Andy Brittain: Yes. But I have spoken to one of the big four audit firms myself and the issue isn't just fees; in fact, that is not one of the primary considerations for them. It is about specialist staff to do local or public sector audits and the level of risk and complexity that they—

Q92 **Sir Geoffrey Clifton-Brown:** One follows the other.

Andy Brittain: It does to an extent, but it's—

Q93 **Sir Geoffrey Clifton-Brown:** If you're paying the right fees, they are able to pay their people properly, which will encourage more people to want to go into the public sector auditing—

Sir Chris Wormald: I might be wrong, and I expect the C&AG knows better, but I think we have always had a very different system from local government. I don't think we have ever set national rates for—

Julian Kelly: No.

Sir Geoffrey Clifton-Brown: No, I'm not suggesting that—

Sir Chris Wormald: That is, it has been more fluid to the state of the market than the system has been in local government, where I think it is set nationally. Is that right, Mr Davies?

Gareth Davies (Comptroller and Auditor General): I think the situation is that audit is purchased in bulk through large framework contracts for local government, so that's where the different approach to fees comes in. Also, the fees dropped in the local government sector in a way they didn't in the NHS. It became intensely competitive for a while and they dropped to an unsustainably low level, which has had to be corrected. I don't think the NHS has had to do that, but it has faced quite steep increases. I know that some NHS trusts have found it difficult to get any bids, from any firm, to do their audit, whatever the fee. So I think it is right to focus on capacity as the key issue, and the risk appetite of the firms to engage in work that historically had been seen as low risk and predictable but became, certainly in a regulatory sense, higher risk for them. That is certainly one of the key issues at the heart of the local government problem. I think that, in essence, the pressure on NHS audit capacity has been the backwash from the big issues in local government audit, because it is in many cases the same teams in the firms who do both types of work.

Chair: As I said, we have rehearsed this quite a lot with the sister Committee. We have been worried about the bleed-across, as Sir Geoffrey has highlighted.

Q94 **Sir Geoffrey Clifton-Brown:** Sir Chris, I want to end on the note that this is a serious problem. Can I have an assurance that you are working within the auditing sector, with both the FRC and the individual firms, to make sure that there is sufficient capacity? I entirely—well, I wouldn't dare disagree with the C&AG that this is all about capacity, as well as



money.

Sir Chris Wormald: We recognise this as a serious issue. As I think you have probably gathered by now, most of the frontline work to actually get this auditor into this trust is done by Mr Kelly and his colleagues at NHS England, and then what we do is the supporting, national stuff we can do over the top of this. But it requires considerable effort by NHS England, doesn't it, to get to the better position that you have described?

Julian Kelly: Yes. As the C&AG said, we have had organisations with no audit firms interested and then we have worked with the audit firms to persuade them that this is worth doing. As I said, we start this year with every organisation having an appointed auditor, and we have managed to minimise the risk on the one firm we have been really, significantly concerned about.

Q95 **Mr Djanogly:** What I am going to say may cross Sir Geoffrey's comments a bit, but the timeliness of filing accounts is of course a very important issue, and group accounts, I believe, have been laid late, in January, for the fourth year in a row, so I think this deserves to be looked at in a bit more detail. I am going to start off with the annual governance statement from the Consolidated NHS provider accounts. Mr Kelly, do you have a copy of that to hand?

Julian Kelly: I actually don't.

Q96 **Mr Djanogly:** Okay; I will read it out.

"NHS England continues to work to improve timeliness in financial reporting including"—there are six important proposals here, which look very good. Basically, I want to see to what extent you are acting on what you said you would act on.

The first is "encouraging auditors to give clear reporting to audit committees where the preparer's quality of draft accounts or working papers needs to improve". Is that happening?

Julian Kelly: Yes, and we have a regular stocktake with all the audit firms to make sure that we are receiving the feedback that they are also giving to the organisations, and my teams review—I forget the acronym—the letters and reports that the external auditors give to each organisation.

Q97 **Mr Djanogly:** Thank you. The next is "working closely with providers to ensure they appoint external auditors in good time, which helps increase the likelihood of deadlines being achieved." Have we covered that one?

Julian Kelly: Yes, I think that is where I said that we go into this year with every organisation with an appointed auditor.

Q98 **Mr Djanogly:** I think you did.

The next is "regular engagement with partners including the Department of Levelling Up, Housing and Communities and the Financial Reporting Council on policy matters affecting the broader local audit system: we believe strongly that firms having sufficient capacity across their wider



HOUSE OF COMMONS

portfolio of work to enable effective interim audits at NHS bodies is important for success”.

Julian Kelly: I think we just covered that.

Mr Djanogly: I think we did.

Julian Kelly: That is where we work with the Department and the cross-Government group.

Q99 **Mr Djanogly:** I agree.

Next: “working with providers where financial reporting issues arise to ensure they are able to address findings effectively”.

Julian Kelly: Yes. I would say that we have had one provider where we had a major issue, University Hospitals of Leicester, who are now close to finally resolving those issues. We have worked very closely with them and given them specific support.

Q100 **Mr Djanogly:** Okay.

Then: “regular engagement with the audit firms and responding to their feedback to continue to strengthen the NHS financial reporting landscape, and working with partners to make sure training and guidance is available for preparers”.

Julian Kelly: We just discussed that we meet regularly with all the audit firms. Maybe one of the advantages we have had is that, as a single team, we act as a single point of advice both to NHS organisations on how to interpret the guidance and to audit firms on how to help them with NHS organisations. I think that is an advantage.

Q101 **Mr Djanogly:** And you have adequate capacity to do that across the course?

Julian Kelly: Yes. We have just gone through a major reorganisation and I have a team who have been under a lot of pressure. We are kind of even right now and are about to start re-recruiting to that team.

Q102 **Mr Djanogly:** Finally: “liaising with broader stakeholders on wider matters that can cause delays in NHS accounts, for example sign offs of local government pension scheme audits, which directly affects a handful of NHS providers with a corresponding impact on these consolidated accounts”.

Julian Kelly: That is clearly less within our control because it depends on the local authority. Again, we work with them to see that we can do everything we can. There are one or two examples that I think are going to remain a problem. Then we work with the National Audit team to make sure we can effectively put in place other means and reassurance processes so that we can materially reassure our consolidated accounts.

Q103 **Mr Djanogly:** Are there problem issues that are going to lead to delays that you see now or that you need to highlight, that are outside of your control?



HOUSE OF COMMONS

Julian Kelly: I don't think there are things now that will lead to the level of delay that we have seen this year. I think there are one or two organisations that will continue to have problems closing out the valuation of their local authority pension schemes. I don't think those will be automatically resolved. That is why we work with our external auditor, to make sure we find other means to provide the reassurance that we need.

Q104 **Mr Djanogly:** Sir Chris, having heard about all of this tremendous work being done, are we going to have the accounts filed at the right time in the future?

Sir Chris Wormald: Well, we did file them at the right time. We hit the statutory deadline. Obviously, we want to do better than that.

There is a colossal challenge here built into the whole system. Basically, we are producing accounts for about 8% of the economy. That is an incredibly difficult thing to do. I have done this for a while now, and every year there is a new challenge or difficulty that we did not predict. I do not throw around guarantees, for reasons you will understand, but I am very confident in the work that has been put in hand by both Mr Kelly's team at NHSE and Andy's team within the Department. I am confident that we are doing all the right things. Andy, are we expecting to be able to do it slightly quicker this year?

Andy Brittain: Yes.

Sir Chris Wormald: But there are a lot of variables, on both our side and the National Audit Office's. You have our assurance that we think we are doing all the right things—again, I will see if the C&AG shakes his head at me. We think working relations with the National Audit Office are absolutely excellent and that we are all on the same page.

Chair: Always wise to praise your auditor.

Sir Chris Wormald: It also happens to be true! This is why I check that he is not shaking his head while I am saying this. We think we have all the right things in place, but with the caveat that this is a huge consolidation. Other than the Treasury on the whole of Government accounts, no one tries to consolidate anything this complicated. That throws up new issues every year. We are expecting a slight advance this year, although not as much as we want.

Andy Brittain: Both the UKHSA and the NHS accounts have to be substantially complete before we can lay the group accounts. As we discussed earlier, we are working to a November timescale for UKHSA's accounts, and we will aim to lay our accounts then—slightly earlier. Our overall aspiration is to bring it forward by at least a month each year. Moving towards pre-summer recess will require a fairly sizable change in the capacity of the local audit market in particular, but we have discussed that and are working towards it. It is absolutely our aim to keep bringing them forwards.

Q105 **Sir Geoffrey Clifton-Brown:** Chris, I know that the change in discount

has hugely reduced the provision for litigation claims in your accounts. Nevertheless, it remains a very high figure. What actions are you taking to try to reduce that?

Sir Chris Wormald: Is this clinical negligence?

Sir Geoffrey Clifton-Brown: Yes.

Sir Chris Wormald: I will ask Andy about some of the technicals. The single most important thing, which my Secretary of State has been talking about a lot recently, is to reduce the number of incidents that lead to clinical negligence claims. That is indescribably more important than anything—not just because of the financial consequence. As I am sure you will remember from when we did a session on this, a very small number of the total number of claims, particularly in maternity, lead to a very large quantity. Getting maternity safety right, which we have made a whole series of announcements around recently, is absolutely core to it. As I am sure the Committee knows, it is one of the areas where we do not benchmark that well compared with a lot of systems that are similar to us. That is one of the big objectives for us and our NHSE colleagues who work on this more directly. That is probably the biggest thing.

Then there is a whole series of issues about how we manage the clinical negligence system. I think Andy can probably describe better than me how we and NHS Resolution manage claims and deal with the results. However, there is a huge headwind, which is not a bad headwind—because of advances in medical science, a lot of people are living a lot longer after medical accidents. That is an unadulterated good thing, but it does push up our clinical negligence costs, simply because you are paying for more years—which is completely right; it is fantastic that people are living longer. As I say, the real answer here has to be to reduce the number of negligent accidents in the first place. Do you want to say something about the actual management, Andy?

Andy Brittain: Yes, the cash cost of claims has increased over time.

Chair: I think it is actually the biggest liability on the whole of Government accounts, so it is significant.

Andy Brittain: The provision is £70 billion, and it has come down from £130 billion because of the changes to the discount rate. As Sir Chris said—

Q106 **Chair:** I am not sure that we all understand the discount rate—we could explain it. Perhaps you could explain in broad, simple terms what that means for anyone who is under—it is not a cut. Let's just be clear.

Andy Brittain: No, this is an estimate of the total cost we are likely to pay out in the future. That is discounted by an inflationary factor to try to get it into today's prices. As the inflationary factor changes, the sum of the future stream of costs that we are expected to pay out changes too. That is essentially what has happened here.

Q107 **Chair:** Just to be clear, and for anyone who might not follow this detail of



HOUSE OF COMMONS

discount rates, this does not mean that there is less money available for people. It is just as it is recorded in the accounts.

Andy Brittain: No, absolutely not. It is an estimate of the future costs. As Sir Chris said, NHS Resolution processes these claims on our behalf. One of the changes that we will make in 2024 is the introduction of a new system of fixed, recoverable legal costs and claims up to £25,000, which will enable faster processing and lower legal claims costs. We are working to improve the way things are done as well.

Q108 **Chair:** We looked at this before: often there is a lot of blame on lawyers, but actually sometimes the delays have been on the NHS end as well. Is a litigious approach still the right way to do it? You cannot stop someone suing, but has any thought been given to doing it in a different way, like the system of tariffs used by the Criminal Injuries Compensation board? Has anything ever been considered to reduce the costs of managing a process?

Andy Brittain: Not that I am immediately aware of, but I am sure there has been. We can come back to you on that.

Chair: I have been on the Committee for nearly 13 years, and we have been looking at this issue all that time. For the reasons that Sir Chris outlined, it will always be expensive. Some people will just need the care that they need, yet they have to go through a litigious process to prove that. Actually, sometimes it will obviously be the case that someone needs that care. There will always be some cases that go to court. I was just asking the question.

Q109 **Sir Geoffrey Clifton-Brown:** Sir Chris, your detailed answer gave me time to find the right piece of paper—I now have the fixed stake in front of me.

Sir Chris Wormald: That was a mistake!

Chair: Long answers have a benefit—it was a public service.

Sir Chris Wormald: I'll use them more in future, then.

Q110 **Sir Geoffrey Clifton-Brown:** According to NHS Resolution's "Annual report and accounts 2022/23", 41% of the £2.6 billion paid out in clinical negligence payments in 2022-23 related to maternity care—around £1.1 billion. An NHS England board meeting reported that £3 billion was spent on maternity and neonatal services. That would mean that spending on clinical negligence for claims relating to maternity service in 2022-23 was actually a third of that spent on maternity services. You referred to that in your earlier answer—

Sir Chris Wormald: No, absolutely.

Sir Geoffrey Clifton-Brown: I am going to ask you about it again, specifically relating to maternity services. That is a very high figure. I accept that some of the individual claims are a great deal of money, but nevertheless each claim is a tragedy for the person involved. What more



can you do to reduce this?

Sir Chris Wormald: You are absolutely right. Of course, the primary consideration is to prevent the incidents happening in the first place—not for financial reasons but clinical and public interest, and individual safety reasons. It is not unusual at all to see that profile when we look at our international comparators. In the United States, you see exactly the same pattern because of the nature of the service. The NHS—I might hand over to Mr Kelly in a moment—has an extensive programme of how to improve maternity services. As I said, the Secretary of State has made some announcements on this recently.

When we look across the world, there is no silver bullet. It is about every maternity centre in the country doing the basics properly, being properly staffed. Patient voice in this is incredibly important and, as I am sure you know, when we look at the areas we had to do inquiries into, due to the nature of the problems, that has been a huge thing. My Secretary of State is particularly concerned that some of the disparities in this area between particular ethnic minority groups and the white population are just not acceptable and need to be dealt with. There is a very shared understanding across the Department and the NHS and individual trusts that huge improvements need to be made—not just on the figures, not just the ones you have read out, but on the individual cases, which is something we just have to get better at.

It is very hard yards. There isn't a beautiful policy solution. It is about lots of people doing the right thing, every single day, in every maternity service. Julian, do you want to describe what the NHS is doing?

Julian Kelly: Chris has outlined the four key themes. We published a three-year maternity improvement plan—more staff. Even in the last year we have had 1,000 more midwives and over 100 more obstetricians; we have invested £180 million to support trusts so that they can put those staff in place. Listening to women—I forget the precise acronym, I think it is the National Maternity Voices service programme, we have just announced, coming out of the Budget, that we are increasing investment into that to the tune of £3 million a year. Improving culture, now where we identify the trusts with the biggest issues you have a maternity service improvement programme. We are currently working with 33 trusts on how they can get the right processes in place, get the right leadership, get the right culture. Then it is the data. Bill Kirkup's report, coming out of East Kent, said we needed to do improvements there, so we have a whole programme of work, to use his phraseology, so that we can pick the "signals" out of the "noise" and spot the problems early.

In the run-up to the pandemic we were making quite a lot of progress—big improvements in neonatal mortality—birth rate. That has stalled as we have gone through covid, but I think the last data does show some improvements. There is a lot further to go, a lot more work to do. It is a challenging area, but those are the things we are doing.

Q111 **Sir Geoffrey Clifton-Brown:** Mr Kelly, those improvements—you are



HOUSE OF COMMONS

working with trusts, and you are working with my own trust after it has had one or two particularly difficult problems. I think they are putting in some useful improvements, so that answer is hugely appreciated. I suppose, Sir Chris, at the end of the day this is all about people who suffer these problems. So a simple answer: in terms of the NHS as a whole, is the number of litigation claims going up or down?

Sir Chris Wormald: I will check the exact numbers for you and let you know.

Sir Geoffrey Clifton-Brown: That is very kind; thank you.

Q112 **Sarah Owen:** I have some follow-up questions on what you are doing, particularly around workforce, to lower maternity negligence claims. We have often heard a lot about continuity of care being essential through maternity. Where are you with that and the plans for that?

Julian Kelly: The plans are still ongoing. The key thing with continuity of care is making sure that you have sufficient workforce to resource it properly. So, arrangements have been put in place to calibrate the roll-out in individual trusts, depending on having sufficient workforce to do it. As I said, we have significantly increased the number of permanent midwives. We have materially increased the number of obstetricians. We have a programme in place to continue to improve that over the next couple of years.

Q113 **Sarah Owen:** With those improvements to the workforce, are you seeing improvements in continuity of care, or will you have to move to prioritising areas and patients that are particularly vulnerable—such as black women, who are still four to five times more likely to die during childbirth?

Julian Kelly: As I said, I don't have the precise figures on the roll-out of continuity of care at my fingertips here, so we can come back on that and exactly where that is, but as I said, it is calibrating it so that in each individual organisation and unit you have sufficient staff in order to roll it out properly.

Q114 **Sarah Owen:** Are you saying you don't have sufficient staff at the moment?

Julian Kelly: I think that in some places we have not always had sufficient staff to go at the pace we would like, which is why we are increasing the number of midwives and have gone a long way to increase it over the course of the last two years.

Q115 **Chair:** Certainly in my own hospital we have seen a challenge, as a number of midwives left after Brexit. That was a challenge. Some interesting work has also been done to support women in pregnancy and make sure that they are supported, feel more confident about what is being offered and have the chance to ask questions. That will make sure that some of the issues causing the higher number of incidents for black women are being addressed.

Sir Chris Wormald: The only thing I was going to add is that we are very lucky in the Department that our Chief Scientific Adviser, Professor Lucy



HOUSE OF COMMONS

Chappell, has this as her area of professional expertise. She seconded to us and still works in the area as well as being a CSA. She makes two big points. First, focus on a small number of simple things, exactly of the type Ms Owen has been describing. Secondly, the underlying health of people before they become pregnant is vital, too. The health disparities end—who smokes, who drinks, and all the classic things—is one of the things that determines successful outcomes. It is not all about the maternity unit; it is also about health outreach of the type that Ms Owen was describing, but as I say, there is no silver bullet.

Q116 Chair: Maybe it is time for the Public Accounts Committee—perhaps our successor Committee, given that we don't know what will happen next week and in the weeks to come—to look at the whole issue of our abilities. It is many-layered. We do not want to talk about people's lives just in cost terms, but it is also cost-effective for the taxpayer to give people healthier outcomes.

Sir Chris Wormald: Absolutely; this is what I was going to say. We have some very serious experts in the Department, and if the Committee wants to get into that issue, you want a rather different panel.

Q117 Chair: We will decide as a Committee. Given the hour, I want to touch on an important issue about the incidents incurred but not reported, where the NHS relies on the Government Actuary's Department to assess the potential value of those. They are accounting estimates, but they are determined on the basis of information currently available on similar incidents. It is a proxy for what you might have to pay out. Do you have any idea how accurate the actuary's work is and whether it causes any other potential challenges for you? They are pretty good at what they do, but they can only go so far. Do you get any surprises as a result?

Julian Kelly: I am not aware of that work, so I am really happy to take that away and go and look at it.

Chair: Obviously, as Ms Owen has highlighted, it is preventive work. As Sir Geoffrey has said, we have highlighted the big stuff, but we do need to know that there is some approach going on to manage this and understand the potential to see this increase for all the reasons we know. It is a very interesting area. We could go on forever on this and many other issues of the accounts, but I think in this very warm room this afternoon the witnesses will be pleased to know that we have come to the end of our deliberations today. I thank you all for your time, Julian Kelly from NHS England, Professor Dame Jenny Harries, Chief Executive of the UK Health Security Agency, Andy Brittain from the Department of Health and Social Care, Sir Chris Wormald, Permanent Secretary at the Department of Health and Social Care, and Shona Dunn, Second Permanent Secretary at the Department of Health and Social Care.

We will be producing a report on this after the Easter recess, assuming that there is no election called next week. If there is an election called next week, you get away scot-free, unless we can turn a report around in a week. We might try something in that case. There you go; that's a group



HOUSE OF COMMONS

of people now wishing for a general election sooner rather than later, despite their impartiality. Thank you very much for your time. The transcript will be available on the website uncorrected in the next couple of days. Many thanks to our colleagues at *Hansard* for their work.