HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: NHS Financial Management and Sustainability, HC 344

Friday 22 May 2020

Ordered by the House of Commons to be published on 22 May 2020.

Watch the meeting

Members present: Meg Hillier (Chair); Olivia Blake; Mr Richard Holden; Gagan Mohindra; Sarah Olney; James Wild.

Liaison Committee member also present: Sir Bernard Jenkin (Chair).

Gareth Davies, Comptroller and Auditor General, Robert White, NAO Director, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-82

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department for Health and Social Care; Sir Simon Stevens, Chief Executive, NHS England and NHS Improvement; David Williams, Director-General, Finance, Department for Health and Social Care; Julian Kelly, Chief Finance Officer, NHS England and NHS Improvement; Steve Powis, National Medical Director, NHS England.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General
NHS Financial Management and Sustainability (HC 44)
Review of Capital Expenditure in the NHS (HC 43)

Examination of witnesses

Witnesses: Sir Chris Wormald, Sir Simon Stevens, David Williams, Julian Kelly and Steve Powis.

Chair: Welcome to the Public Accounts Committee on Friday 22 May 2020. We are here today to look at the financial sustainability of the NHS as well as capital expenditure in the NHS. These are two really important issues that we have been looking at as a Committee for some time. In the light of COVID-19, they are even more important, if that is possible. Faced with the huge challenges that COVID-19 has put our health system under, we still need to keep a close eye on that long-term spending, for physical kit and buildings, and for day-to-day expenditure. Today, as well as looking at that, we want to ask some questions about COVID-19.

I would like to welcome our witnesses today. We have Sir Chris Wormald, who is the Permanent Secretary at the Department of Health and Social Care. David Williams is the second Permanent Secretary at the Department of Health and Social Care and has been finance director at the Department for some time. Congratulations to you, Mr Williams, and thank you for stepping up to take on this important role while the Department is very stretched in dealing with the current virus crisis.

We have Sir Simon Stevens, the chief executive of NHS England and NHS Improvement, and his finance officer, Julian Kelly, who is in that post. We have seen both of you before many times. I am pleased to welcome, maybe not for the first time—you have been before I think—Steve Powis, who is the national medical director for NHS England. I think all of them are familiar to many of the people watching the daily press conferences.

Before I start, I want to thank you all for the hard work that you and your teams are putting in, and the long hours you must be working to make sure we protect our NHS and save lives. That is not a glib phrase; it is crucial to the work you are doing to make sure this country can come through this crisis as well as possible. We are going to be asking you some tough questions, nevertheless, because the public and the taxpayer want to know exactly what is happening. At the beginning, I want to ask you some questions about COVID-19. We will try to direct questions to you and are hoping for crisp, clear answers, which I am sure you are very

capable and willing to give.

Q1 **Mr Holden:** Obviously we are facing an unprecedented international crisis, which has hit us here in the UK as well, with the global coronavirus pandemic. For a start, a lot of us are wondering at the moment what you are learning from this. What steps is the NHS taking to tackle it? What is fundamentally changing in the way you are delivering healthcare during this difficult time for so many people?

Sir Simon Stevens: Maybe I, too, can start by thanking all my colleagues across not only the National Health Service but the care services more widely and a lot of the essential public service workers, who have all been part of this extraordinary national mobilisation. If you wind the clock back just a few short weeks, we were at the very beginning of this pandemic. Even from early March through to mid-April, we saw a huge increase in the number of very severely ill people requiring hospitalisation for coronavirus, 19,000 daily at the peak of the first surge in activity.

The NHS has had to move incredibly quickly to make sure that everybody who would benefit from emergency hospital treatment, whether for coronavirus or other conditions, was able to be looked after without the NHS being overtopped. That was the concern, based on what we had seen in northern Italy at the beginning and, indeed, what the modelling scenarios showed could happen in this country. The first thing to say is that the NHS and our partners have had to move incredibly quickly to provide patients with the care they needed.

That has meant huge flexibility on the part of staff, many of whom have taken on additional roles that they would not traditionally have been undertaking. It has meant that we have had to deploy new ways of providing care in a matter of weeks, where previously that might have taken months or years, particularly the move towards safe provision of consultations with GPs and hospital specialists, including for the shielded group in the community, that did not rely on physically going to an appointment at the doctors surgery or the outpatient department. Underpinning all that has been the fact that we have benefited enormously from the support we have had from the armed forces, the voluntary sector, social care, local government and the independent sector. We will want to sustain many of those partnerships and coalitions.

Alongside the NHS response, there has been an enormous amount of scientific learning. That has revealed things about the way coronavirus attacks a population, a country, a world. We know an enormous amount now that we did not know in January. Steve Powis may want to say a little more on that point.

Steve Powis: Yes, it is a very good point to start on. We are learning about the science more and more as we go on. It is easy to forget that it is only four months ago or so that we began to learn about this virus. We are learning all the time. I pay tribute, in addition, to all my NHS

colleagues. The scientific community, both here and around the world, has moved at huge pace to try to learn about the virus and to quickly move into possible therapeutics, whether that is drug treatments or vaccines. There are still things that we do not know, and that is always important.

There are a few things I would highlight. We do not know what immunity looks like. We know people develop antibodies after they have had the virus. We will be finding out more about that as our serology tests start to roll out. We do not know whether that confers immunity and, if it does, for how long. We will not know that until this goes for a further period of time and we can do those studies.

We do not know exactly what being asymptomatic but having the virus means. We do not know whether the infection rate is the same in people who do not have symptoms. We do not know whether children, for instance, transmit virus to the same extent as adults. We are learning all the time. One of the things that have impressed me most is our ability to take that science and rapidly deploy it, at a speed we have not seen before, towards our response to the virus.

Q2 **Mr Holden:** I think we all appreciate that this is a huge learning curve for everybody across the world. This is a brand new virus, and I think the entire Committee would like to pay tribute nationally but also locally to their NHS services and care sectors. I take on board the point you are making that we have to take some learnings from this now. Are there not things we could have done better in advance? I am thinking particularly of issues around PPE. This was known in advance, before early March when the virus hit. Are there not lessons that we should have perhaps learnt from other countries in advance of the virus hitting the UK?

Sir Simon Stevens: I am sure the answer to that is definitely yes. I do not think everything has gone perfectly. In a way, how could it? There are clearly things we will want to learn from and do differently in future. This is not just a matter of professionalism of staff across the health service. For most of us in the health service, it is also intensely personal. We have been affected by family and friends, who have been subject to all kinds of problems associated with coronavirus. Many of us have family members or friends who have died. This is felt very personally, as well as professionally. Without doubt, there are things we have to learn from and do differently. On PPE, Chris Wormald may want to comment.

Sir Chris Wormald: I will reiterate the points my colleagues have already made about our thanks to everyone who has worked on this issue, and thanks also to the Committee for your kind words about our response. Yes, there are undoubtedly things we can learn and are learning, both on PPE and more generally from the global response. There is an awful lot in common in the problems that different countries have faced. There is a long list of countries that have had problems with PPE, for example. We have been learning as we have gone along.

We have a completely different approach to sourcing PPE than we had at the beginning of the crisis. We put in a lot of new structures, under the leadership of Paul Deighton. It is, again, a great example of joint working between the Department, Simon's teams at the NHS and the military. In particular, we have learnt a lot about the long and complex supply chains, and international supply chains, that we rely on to deliver PPE, medicines and an awful lot of what we use in the health and care system and beyond. I am sure that, as well as the learning we have done along the way, one of the lessons we will learn nationally is to have a better understanding of the resilience of all those supply chains. They work perfectly well outside crisis times, but they have been put under huge pressure within crisis times. There is a lot in what Mr Holden has said.

Q3 **Mr Holden:** To pick up on that, none of us underestimates the challenge that the Department and the NHS more broadly have been facing. One of the issues a lot of constituency MPs have had is companies getting in touch with them locally to say, "We want to supply PPE. We did not hear anything back for weeks". Some still have not heard anything back from the Department. People talk about lessons being learnt through the process. Have those lessons now been learnt? Are the companies that are reaching out to help, because of exactly the supply chain collapse that everybody knows about, all dealt with?

Sir Chris Wormald: I think so. I will go away and check there are not any still outstanding. That was a huge challenge. We had a lot of offers of help, which was wonderful to see, and it took us a little time to build the systems to deal with those properly. It was one of the reasons why we restructured what we were doing in the way I described. To be honest, I have not seen a report for the last few days on whether we have any outstanding offers of help. I will go and check what the exact position is and come back to the Committee. You are correct to highlight it as an issue, but it is one we got on top of.

Q4 **Mr Holden:** In my constituency, I was at Glenroyd House in Consett the other day, seeing members of the public making scrubs for hospitals. I spoke to my local hospital trust and it said there is no immediate issue now with PPE, although things had been very tight at certain points over the last few weeks. Are we still relying on the public and goodwill to fulfil the needs of the NHS at this point?

Sir Chris Wormald: No. To be clear, scrubs are not PPE. They are used in hospitals, but they are not personal protective equipment. There has been no point during the crisis at which we have nationally run out of any type of PPE. There have been two issues. First, it has been rather more just-in-time than for any of our comfort. One thing we want to do is move from a situation where we are meeting need day by day to having security of supply over some months. Although we have nationally never topped out, it has not been as stable as we would like.

Secondly, there is distribution. Although we have never run out of any key item nationally, there have been a lot of challenges locally and it has

been a huge logistical challenge. This was best put by the Chief of the Defence Staff, who has been helping us with the logistics. He described it on 22 April as the biggest logistical challenge he had seen in his 40 years of military service. We were moving from supplying basically 240 customers—the trusts—to trying to supply 50,000 customers across health and care. It has been an enormous challenge. Where we have seen difficulties of the type you describe, it has more been in the logistics of getting the right thing to the right place than the national supply issue. I pointed to the things we have learned as we have gone on. We have completely redesigned how all that logistical system works.

Q5 **Chair:** Sir Chris, I am going to jump in here. In the last Parliament, when we were looking at preparations for Brexit, one of the questions we asked you about the social care sector was how supplies would reach that sector. We were not entirely happy with the response then. The Department was thinking about that logistical supply chain in that context, for medicines and equipment. Where was the problem with having to deal with that in the light of COVID-19? We get the volume and the pace, but does it not perhaps point to the fact that there was not a good system to supply what is largely a private sector and multifaceted business through the care sector?

Sir Chris Wormald: To be clear, in normal times the state does not have a role in supplying PPE to private social care.

Q6 **Chair:** That is right. Maybe I did not make myself clear. It is not in supplying it directly, but you are the Department of Health and Social Care. Part of your responsibility is to make sure you are managing the social care sector and are aware of issues in that market. We discussed, in this very Committee, the issues around getting the right things, letting the social care sector have access to supply chains if necessary, but making sure it was covered and there were not going to be gaps in the light of perhaps a no-deal Brexit. That is a different type of crisis, but it was a crisis you were preparing for.

Sir Chris Wormald: You are correct, but the issue is completely different. For our Brexit preparations, the issue was how you got stuff into the country, not how it was distributed once it was in the country. We were looking at scenarios where usage of equipment was at normal levels. The issue we were facing in coronavirus, in both the health sector and the care sector, was a massively expanded demand, rightly, for particular items of PPE. In no-deal preparation, the point was the existing methods of supply chains, in which, in the case of social care, it buys direct from wholesalers and is delivered by the commercial market.

Here, the state has stepped in to supply elements of PPE alongside what social care sources itself directly. There was not a pre-existing system for this and it was not a system we would have needed in any of the Brexit scenarios. That is the giant logistical challenge the Chief of the Defence Staff was pointing to.

Chair: There are certainly some parallels, but I hear what you say.

Q7 **Mr Holden:** There has been a big debate about NHS versus social care. Are you saying that you think the Government's and the Department's response on social care was particularly slow off the mark in ensuring that supply was there? Let me rephrase it. Although the NHS never topped out in terms of PPE supply, are you saying the same for social care?

Sir Chris Wormald: I am saying that nationally we never topped out. I fully accept there were lots of issues within health, because we were doing this in community care as well as acute care, where PPE is normally most used, in the scaling up of both the volume and the types of delivery we had to do, going from 240 to 50,000 customers. I do not accept that it was slow off the mark. I would say the much clearer and more established system we have for the National Health Service meant we could scale up what we were doing much more easily. In the much more diffuse and varied social care system, it was much, much, much more difficult.

I agree with the thrust of your questions. Those are issues we have debated with the Committee before and we have all recognised the challenges that the nature of the social care market gives us in delivering in that sector. I think there is a common view across the whole political spectrum about the need for reform. I am not trying to underplay the challenges in social care at all, but they are to do with the nature of the system.

Q8 **Mr Holden:** I understand that. I understand the nature of the differences. Local councils will have a good relationship with care providers in their areas and could have been a way of distributing them. You tried to reinvent the wheel in terms of distribution, rather than going through potentially existing support networks. Do you think what you have done was the right approach throughout?

Sir Chris Wormald: This will be common throughout the hearing: we are not defensive or complacent at all about learning and doing things differently as we go along. We took a lot of decisions very quickly, as you would expect. I am sure not all of them were right. Where they have not been right, we will want to put them right or put them right for the future. In this case, our main route to social care and to work with local authorities is via the local resilience forums. Where we have made PPE contributions, for example to social care, we have largely done that through the LRFs, of which local authorities as well as their other statutory partners locally are a key part.

We have been building a system in which care providers can order rather more directly via an internet-based supply system. We have been trying to use all available routes. As I say, our primary way of working with local authorities has been via the local resilience forums.

Q9 **Mr Holden:** Can I open the question up to David Williams and Julian Kelly? One of the issues I have found locally is that the price of certain items, particularly face masks, which my local NHS trust has had to provide, has gone up by at least a factor of 10. The impact of that, particularly on the social care sector as well, which was initially trying to source these from the marketplace, has been huge. Could you give us a bit of an update? Are you worried about price gouging in this market at the moment from certain suppliers trying to profit off coronavirus?

David Williams: You are right to say that we have seen substantial increases in the unit cost of a range of PPE items. It is a feature of the international market, where demand from a whole range of countries is very high and supply is constrained. It is more that, rather than necessarily deliberate price gouging. In terms of our response, we have had very constructive engagement with the Treasury about agreeing financial support for our PPE programme. The NAO report published yesterday indicated where that financial envelope sat when the NAO did its review of our plans. It is partly why we have looked as well at doing purchasing at a national level and then looking at prioritisation at a local level. We are keen to make sure we are not competing with ourselves, as it were, in a market.

Q10 **Mr Holden:** Yes, exactly. Can I pick you up on that? Central purchasing is really important. When did you step in on this central purchasing point? If we have a national system of distribution, surely a national system of purchasing would have been a natural start before that happened.

David Williams: We start from a supply chain company that we established around 18 months or so ago, which has been building up its customer base, primarily within the NHS. Looking at the rapid ramp-up in the requirement for PPE, it was clear that we needed to supplement that with additional capability and capacity, as Sir Chris has already described, looking at resource within the Department, within NHS England, out into Cabinet Office commercial colleagues and, indeed, leaning quite heavily on diplomatic posts and embassies abroad, particularly in China, both to identify opportunities for PPE purchases and to help with the deconfliction of orders from what are, for a lot of our PPE lines, a relatively small number of manufacturers and factories.

Q11 **Mr Holden:** I do not think you have quite answered the question there, to be honest. We knew there was a national issue. We had to get PPE out, across the board, to different parts of the country. As Sir Chris said, we had to supply to a huge amount of new people. When, centrally, did we step in to organise the purchase of PPE equipment?

David Williams: I can check specific dates and get back to you. In practice, our approach from the beginning has been to focus on national purchasing routes. It is just the way in which that national purchasing has been structured and resourced. The scale of that national purchasing effort has grown over the course of the pandemic to reflect the increasing requirements we have been trying to meet.

Q12 **Mr Holden:** I think we all understand that. On this particular thing, something that the Department and NHS England could see together, working with the devolved Administrations, we knew there would be an issue around PPE, particularly purchasing and then distribution of it. We have then seen local health trusts and local providers going outside the system to try to get much-needed supplies. I am trying to drill down. If this was not stepped up as quickly as it could have been, why was it not? Is there now a system in place? Nobody knows what the future is going to hold in terms of COVID-19 or the response that might be required. Is there now a system in place to make this work?

David Williams: Before the coronavirus pandemic, national purchasing of items was running at maybe 35% to 40% of NHS consumable requirements, with other purchasing being done on either a regional or a local basis. That was the backdrop from which we have started. As I say, from the beginning our emphasis has been on building up that national capability. It has been a transition from the early stages of the response to where we are now, where the vast majority of new deals are being done through the national task force, under the direction of Paul Deighton.

Q13 **Mr Holden:** I have two very quick final questions on this issue of PPE. What are the prices we are now purchasing, for example, face masks at? My understanding was that these used to be sold in bulk for around six pence an item, but now NHS trusts are paying between 80 pence and £1. Are you seeing price increases of 10 to 15 times for some of the items you are purchasing?

David Williams: It is a dynamic situation because it depends on how demand and supply vary over time. If I give you a different example, in our reasonable worst-case scenario planning we were concerned about the level of ventilated beds needed in the NHS in a potential peak in mid-April. Our willingness to pay higher than previous prices for mechanical ventilators in the first half of April was considerably greater than it is today, now that that peak has been managed down. Indeed, the market prices, because this is not simply a UK issue, have shown that as well. At any one point, you can see particular line items increasing in price and then the market tailing away. Price increases of the order that you described are not uncommon.

Q14 **Mr Holden:** More broadly, with that level of price increase, a product that was profitable being sold for 6p is now being sold for £1. Do you have concerns? Have you passed any concerns in the Department to the Competition and Markets Authority? You say there is a very limited number of suppliers and commercial distributors. Has there been any move from the Department to look at this or pass those concerns to the relevant authorities?

Sir Chris Wormald: It is a slightly different type of issue, of which we are aware, but a slightly different type of answer. The vast majority of what we are buying is on the international market, so it is not

manufacturers within the UK putting their prices up. We are in the position of buying these things as commodities and paying the price the market accepts.

Q15 **Chair:** You are not able to refer things to the CMA because of the international aspect.

Sir Chris Wormald: Yes, but it is an issue we are concerned about. It is why on a number of items, not just PPE, we have been seeking to develop UK-based production. We cannot depend on it, because obviously we need vast quantities, but it is clear that we need to diversify supply and have more UK-based production for some of the reasons that the questions were implying.

Q16 **Mr Holden:** Finally, given that you recognise the need to diversify supply, can you give us any indication of a timeline, particularly on items that have dramatically increased in price in the international market, in which you will be seeing some of that supply enter the chain, particularly in terms of face masks?

Sir Chris Wormald: We are already seeing supply enter the chain. To be honest, compared to the volumes we are using, it is currently extremely modest. If I may, I will take that question away and ask it to Paul Deighton, who we have put in charge of this area, including the domestic make, and ask for his assessment, which will be considerably more professional than mine would be.

Q17 **Chair:** We can follow that up. I think the core point of what Mr Holden is asking is that we have relied on this international supply chain. In an international crisis, we are not at the front of the queue for that. Will this change for ever the way the Department and NHS England starts procuring its equipment?

Sir Chris Wormald: There are a lot of future decisions to take, which are wider Government decisions as well as DHSC decisions, about the resilience of supply chains. Building up domestic production is but one of the things you can do to make your supply chains more resilient, and I expect we will have to look across the piece. To be clear, in the current crisis, although domestic production will make a contribution, there is no imminent possibility that it will replace what we need to buy on the international markets. There is a much longer-term issue.

Q18 **Mr Holden:** One issue everybody is concerned about is potential second or future spikes at the end of this year and into next year. That gives plenty of time for UK manufacturing to step up to the mark. Is this something you are actively pursuing now? Can you please provide the Committee with some evidence? If there is a second spike, and it will be an international one, we need to know that our supplies will be there for our constituents across the country.

Sir Chris Wormald: I will ask Paul Deighton for an update for the Committee. The only thing I would say is that the supply chain questions

here are intensely complicated right down to where the raw materials come from. Whether you have a domestic factory is not the only consideration in whether you have resilience.

Q19 **Chair:** We know. Our sister Committees are also exploring this and we are liaising with them. If you could get that information to us, we or another Committee will be able to pursue it. I want to move on now briefly. We are going to be quick-fire now, I hope. An extraordinary £13 billion write-off took place in the early stages of this pandemic. It hardly got a headline. It just goes to show the scale of the challenge. That helps with in-year deficits for trusts, but what is the plan long term for those trusts that have structural deficits?

David Williams: As the Committee knows, we have been looking at the question of financial support and debt in the NHS system for a while. The decision to write off that historic level of debt was taken alongside plans agreed between the Department, NHS England and NHS Improvement on developments in both the resource framework and the capital regime. Coronavirus to one side for a moment, the intention is to move to a world in which trusts are routinely generating sufficient income to cover their costs, either through the operating income from the services they provide, or through any payments from the financial recovery fund, which Julian and his team administer. Therefore, the need to rely on top-up cash support from the Department will be reduced.

All of that is part of the overall NHS long-term plan to return the provider sector in aggregate to financial balance and then deal with some of the more troublesome individual trusts that have particular structural financial issues. You may want to hear a bit more from Julian on that.

Q20 **Chair:** We might hold Julian Kelly back, because I know we are going to come to that in the main part of the session. It was extraordinary. It hardly got a headline. I noted that.

I wanted to touch on the extra funding during COVID. Obviously there are the COVID costs that are being covered. That is up until July of this year. What is the plan for funding post-July? We are almost in June already.

David Williams: The additional costs break down into a number of categories. The NAO set out a report on the Government's initial response yesterday. Some items of cost are borne by the Department. We have spoken about PPE purchases, where we are in a rolling and constructive dialogue with the Treasury on financial envelopes within which we can plan and deliver those deals. Spend within the NHS, whether it is on workforce or capacity linked to the independent sector, has been agreed in terms of the parameters of those arrangements, as you say, until this summer. One of the issues that we and NHS England colleagues are currently working through is how and at what level those need to be extended.

Q21 **Chair:** When will hospitals or providers of all sorts know how they will be

funded post-July for COVID issues?

David Williams: Those are live discussions now, and I would expect decisions to be made quickly.

Q22 **Chair:** Will that be in the next couple of weeks?

David Williams: That sort of order of time I would think, yes.

Q23 **Chair:** It would have to be or they would not be able to spend it in time. In terms of oversight of spending during COVID, perhaps briefly Mr Kelly and Mr Williams could comment on this. A lot of money is going out of the door very quickly, quite rightly, to protect people, our NHS, and save lives. Are you content that all the normal controls are in place to make sure we are watching how that money is being spent and, indeed, learning lessons about how it can be spent quickly and effectively in ways that have not perhaps been done through the traditional structures of the NHS and the Department?

David Williams: We are working within a framework in which Treasury Ministers have made it clear that NHS, social care and, indeed, wider public services will get the financial support they need to tackle coronavirus. We have agreed a range of forward spending envelopes with Treasury colleagues and some of these were set out in the NAO report yesterday. That means we can make decisions at pace on individual spending opportunities or deals without having to agree each of those individually. In those circumstances, Treasury Ministers are relying in particular on assurances from me, as an accounting officer in the Department.

We are maintaining financial control and investment decisions, but against what is, as you will appreciate, quite a high risk appetite. We are streamlining those where appropriate to support the pace of decision-making that is needed, but they are still in place at an appropriate level.

Julian Kelly: We have given providers, for example, block contracts and a level of guaranteed income, for which they have to give an account. They can claim additional costs retrospectively. In that situation, we have put in place audit arrangements so that we can check that people are applying proper due diligence, discipline and control. Across a range of providers where we have put in those arrangements, including the independent sector, we have put in specific controls or audit arrangements to make sure money is being spent properly.

Q24 **Sarah Olney:** A massive issue in my constituency is that we are seeing a real drop in people referring themselves to GPs or hospital services for things we would normally see, like early cancer symptoms. We are not seeing the same levels of heart disease or stroke patients. I gather that this is an issue across the NHS. I wonder if you would agree with me that this indicates perhaps a stacking-up of cases to emerge later in the year. If you think that is the case, what are you doing to plan for that and

make additional resources available to hospitals and primary care to try to manage that backlog?

Sir Chris Wormald: The issues you raise are extremely important. Yes, we see that across the board. I might ask Professor Powis to comment, as clinical director of the NHS. We know that NHSE has been taking a rather keen interest in those issues and quite a lot of action.

Steve Powis: We have seen reduced numbers of people accessing healthcare, particularly during the peak of the virus. That has concerned us. It was exactly for that reason that I started speaking out, and other colleagues did, as far back as April. We launched a Help Us Help You campaign in April to bring it to the attention of the public that, in particular, NHS emergency services are, and have been all along, still open. If you have symptoms—you might worry about a heart attack or a stroke, or a child with severe asthma—it is really important to contact the NHS as you usually would, through 111 and GPs—during the pandemic we would like people to phone first—and 999 if it is an emergency.

We have all been talking out about this. We have launched the campaign. We have started to see numbers for the emergency services come back up again. We have seen an increase in the number of attendances, for instance at A&E departments for people with symptoms of heart problems, so we are beginning to see that pick up.

Q25 **Sarah Olney:** Sorry to interrupt, but are you planning for later in the year to need significant extra resources? Is that part of your current approach?

Steve Powis: Yes, but you need to break that down. There are people who we want to come with emergency conditions, and the emergency services have been there all along. We did not step down cancer either, but some services have been disrupted and in some individual cases, quite rightly, clinicians have delayed treatment. That is now starting up again and people are coming back.

We had to step down elective services during the peak of the epidemic so we could focus on releasing beds for patients with coronavirus. Simon might want to say more about this. We are now beginning to work on stepping up those elective cases again. That will require a transition period, which will certainly last for the next few weeks as staff are redeployed back from the different duties they were doing, which Sir Simon was talking about earlier, as we get the supply issues sorted out that we have been talking about, and as we move into recovery and restoration mode. It is important that we do that because we know, as the chief medical officer has said many times, there is potential harm to delaying treatment. It is a real focus at the moment for the NHS to get those services stood up again as quickly as possible.

Q26 **Sarah Olney:** Are you confident that all patients will get the treatment they need when they need it? I understand that they are not presenting

at the moment, but when they present will they find that the NHS is ready to receive them, as it were?

Steve Powis: For patients with emergency conditions, yes. As I said, for patients with urgent conditions such as cancer, we want to see those volumes going up again. We need people to be confident to come forward with those symptoms. For elective surgery, I am confident that we are working on those plans at the moment to make sure we have the capacity. For instance, as Simon said earlier, we have brought on independent sector capacity. Those are very live discussions now to bring that capacity back on, to make sure we do not get behind in treating people in a timely way. I am sure Simon would like to come in on that.

Q27 **Chair:** Before Sir Simon Stevens comes in very briefly, because I am aware of time, could you be clear what specialities you will be focusing on? Are you going to be very clear in guidance about which specialties will be a priority, apart from COVID?

Sir Simon Stevens: Since the start of the coronavirus pandemic, NHS hospitals have treated 89,000 coronavirus inpatients. That has meant there has been a huge need to provide the treatment capacity for them. At the same time, as Steve Powis has just said, emergency services have remained, but we saw a big drop-off in emergency admissions and A&E attendances. Having looked at the sort of conditions that went missing, as it were, it turns out that, for the most part, they were less urgent or more minor conditions, perhaps by a ratio of something like 14 to one.

We are now seeing a return of both A&E attendances and emergency admissions. Emergency admissions at the bottom of their numbers were at about 56% of what you would expect. They are now back to about 80%. Over and above that, because the number of coronavirus patients is coming down, we are turning back on urgent treatment services across the National Health Service. In answer to your question specifically, yes, working with the medical Royal Colleges and others, we have identified the particular services that now need to be restarted across the country over the next four to six weeks.

Over and above that, we have to balance the need for flex capacity in the event that coronavirus spikes in certain parts of the country. The NHS expects that the track, trace and isolate programme will be able to give us early warnings to prevent that spiralling at the sort of levels we saw in this first peak. We want to use the remaining capacity for elective care, for waiting list operations. We expect to sustain the relationship with the independent hospitals, no doubt adjusted somewhat, but that will give us some extra capacity.

I do not want to understate how much the NHS is going to have to change the way in which we offer care. The continuing background levels of coronavirus, the infection control regimes and the physical distancing you need across GP surgeries, outpatient departments and so forth mean that we want to lock in some of the big shifts to online consultations,

access quickly to specialists through telephones, rather than expecting to revert to where we were. In a world of coronavirus, the NHS cannot revert to where we were in mid-January, say.

Chair: We hear the challenge.

Q28 **Olivia Blake:** Data collection nationally has been suspended for elective surgery, but it is continuing locally. For example, 45,000 people were awaiting elective surgery back in February. There has been a dip of 20% of new referrals locally as well. How sighted are you on this issue and how can you possibly know and plan for the backlog if you are not collecting the data nationally?

Sir Simon Stevens: We are collecting the data on the referrals that are being made, but the big drop off has principally been due to a reduction in the number of people consulting their GPs, perfectly understandably given the circumstances. As those GP consultation rates, whether it is by phone, online or in person, go back up, we would expect a commensurate increase in referrals flowing back into the waiting list part of the system.

Olivia Blake: I do not think you got the thrust of my question there, but I will go on.

Sir Simon Stevens: Give me another go. I will try to.

Q29 **Olivia Blake:** Essentially, how are you planning for this going forward? Are you going to be taking clinicians out of retirement? Are you going to be doing weekend clinics? Are you planning to change the waiting times? How can you know without the data?

Sir Simon Stevens: The fundamental point you make is that there is clearly going to be a backlog of people who need treatment, not just in some of the headline conditions but for routine operations. In order to do what we can, we are going to need more hospital beds through the system. We are going to need to have more critical care facilities available—a permanent increase in those numbers. We are going to need to use the relationship we have with the independent hospitals as well.

It ties back to the question that was asked of David Williams a moment ago, in terms of the timetable for our planning on this. Over the course of the next several weeks, we will map out what we think the scenarios for the balance of the financial year look like, through to next spring. That will give us a sense of how much buffer capacity we need to hold going into the winter in the event that there are further coronavirus cases and so on.

Q30 **Olivia Blake:** How will you pay for this? Are you expecting there to be a financial bottleneck as a result of the increased demand? Have you modelled any of the costs? Finally, is the purchasing of extra private beds going to remain en bloc or on demand?

Sir Simon Stevens: There will be incremental costs to this, so there will be a set of options and choices that it will be for Government to make.

Our job, as the NHS, is to set those out for Government. It is a very constructive dialogue as to what that will look like.

In terms of your final question there, we are obviously in discussion with the independent hospitals. We have a cost-based contract at the moment. The first part of this exercise was about creating the reserve capacity, should it be needed in the event of a coronavirus spike over and above what could be accommodated in NHS hospitals. This next phase is about using that capacity for additional diagnostics and outpatient and inpatient day case surgeries. We are in discussion with them about the right contractual structure for that. I will not say more than that, given that it is a commercial negotiation that we will have to land over the coming weeks.

Q31 **Chair:** We may well come back to you on that in writing. We are having to find creative ways of working on that element. I wanted to bring David Williams in very briefly. Sir Simon talked about being in good discussions—well, "good" is perhaps my hopeful term for it. He talked about being in discussions with the Department about how to fund that work. Is the Department ready to fund the backlog, or will other patients be thrown aside—"thrown aside" is perhaps a bit pejorative—or left to wait because of the risk of a coronavirus spike coming back? Will that necessary treatment be funded in full?

David Williams: As Simon says, we are in constructive dialogue about what the plans for the second half of this year should look like. As you will appreciate, that is against some continuing uncertainty about the progress of the disease and with one eye on winter coming as well.

Q32 **Chair:** Obviously, you are going to have to balance it up to a point, but will the money be there if there is capacity to treat people who do not have COVID-19 and have other problems?

David Williams: As Simon set out, we are expecting to refine a set of options on which Ministers will be able to make choices. I would expect the money to match the choices that we make.

Q33 **Chair:** It is very clear then, that Ministers will be deciding, effectively, who will have treatment funded who does not have COVID-19, from the options you present.

Sir Simon Stevens: I would not overstress the fact that this is a financial question. I do not think that is principally what the question here is. It is the fact that we still have, as we speak today, 8,000 coronavirus inpatients across the health service. We have a certain number of staff who have been working heroically under incredibly stressful circumstances. We are going to see emergency pressures going into winter. Frankly, this is going to be more a question as to what the capacity of the health service can practically be than it will be a financial discussion per se.

Q34 **James Wild:** I want to move on to testing briefly. If I take my area of

Norfolk and Waveney, there is local testing capacity that, as with the national effort, has ramped up considerably. There is unused capacity there, but people are going on to the national website, which is directing my constituents to locations that are many miles from where they live, including even Scotland in some cases. We also have the mobile pop-up sites coming round. When is there going to be better co-ordination between the national, local and pop-up testing sites?

Sir Chris Wormald: David Williams is going to answer on testing as he has been overseeing that area.

David Williams: As you set out, there are a number of routes to tests, both within NHS capacity and through the testing enterprise that we have built over the past six or seven weeks. Joining up the capacity with demand, reflecting the prioritisation for use of those tests and thinking about the user journey from needing a test to booking one, getting it and getting the results back is a process of continuous improvement. Matching of demand across those pillars and how we do that better is something we are looking at now. I do not have a hard date for you, though.

Q35 **James Wild:** You are looking at whether people can go to a national booking system and, if there is capacity in my local CCG-provided testing sites, people would be referred to that, rather than sites that are quite distant. Is that something you are looking at?

David Williams: As we think about moving to the next phase of the response to the disease, we are thinking about how testing can support a variety of decisions and activities. Simon mentioned that, as we look to reopen elective care, we may want to test the people going in for those services. That may well lend itself, for example, to home testing, rather than onsite NHS testing. It is looking in a more sophisticated way at how demand best matches the various channels we now have, rather than necessarily using them simply for the purposes they were initially set up for.

Q36 **James Wild:** Following the welcome statement from the Health Secretary about extending tests to all adults and children over five, are there going to be more national testing sites? I am particularly concerned about the east, but also about other parts of the country.

David Williams: I do not have a specific answer on that. We are currently working through and are on track to deliver the increase in testing capacity to 200,000 tests a day by the end of the month. That is across viral and antibody tests. As we review our future testing requirements, we need to look at which of those channels, located where, best meet our needs and best support members of the public and key workers to get the tests they need in a timely way.

Chair: I would simply observe that, when I passed the testing centre in Hackney and Dalston only at the weekend, it was empty. I leave that as an observation for now and I do not expect you to know the detail of that

one, but they need to be in the right places. It is no good for many of my colleagues around the virtual table today if they are available in Hackney but not in their area where they need them.

Q37 **Olivia Blake:** There has been plenty of reference to a second phase or new phase today. Many epidemiologists fear a second spike. Can I ask you what modelling you have done, both financially and of demand management, regarding a potential second spike?

Sir Simon Stevens: We are in dialogue, Steve Powis particularly, with SAGE, which is looking at what the scenarios for the next three to 12 months might look like. Once those are approved by SAGE, we are going to factor them into the capacity model that we use for the rest of the year, recognising that there is significant uncertainty around that. We absolutely think that has to be taken into account. That is one of the reasons why, for example, we intend to keep at least the majority of the Nightingale hospitals in reserve. Fortunately, they were not needed this last several months, but we think it would be prudent to sustain that buffer capacity. Other elements of this need to be factored into the balance of the year as well. I do not know whether Steve wants to add to that. If the question is whether that is at the very front of our minds, it absolutely is.

Steve Powis: As Simon said, we have all along worked very closely with SAGE and SPI-M, which is the modelling subgroup of SAGE, to model our capacity assumptions from the assumptions that SAGE has approved in its reasonable worst-case scenarios and other scenarios. That has been iterated a couple of times as the pandemic has progressed. I fully expect that SAGE will be reiterating other versions. As before, we will model from those new assumptions as they are made to plan capacity going forward. We need to take into account, as you have said, the possibility of R going above one, which is not Government policy, as I understand it; that does not mean there might not be a circumstance when that happens. Therefore, we have to plan the surge capacity to manage that.

Chair: We are now going to move into our main session, although it flows quite neatly on in many respects.

Q38 **Mr Holden:** This is very much to Sir Chris. Before I start, I would like to flag that a huge amount of work has been done by local pharmacies. On the testing issue, that is an area in which there is existing capacity that we could definitely look at. Certainly in my local area it would be very important.

Going to the main substance of the report, if you look at figure 10 on page 23 of the NAO report into capital funding, we see that the providers have been looking at an overall deficit. Even with the transformation fund and the provider sustainability fund of around £1 billion a year, is it possible in the long term for NHS England to keep cross-subsidising these deficits with what looks like capital funding?

Sir Chris Wormald: It is not exclusively capital funding. The Government's plan pre-COVID, as agreed with the NHS, was that we would not run the system as we have run it before. Fundamental to the financial aspect of the long-term plan was to move from the situation we had established via the financial reset we did in 2016, where the NHS as a whole has been in balance—using some techniques that have perverse effects, as we discussed with this Committee many times, but nevertheless achieving financial balance—first to a position where both the commissioning side and the provider side are in financial balance, and then to the eventual end state that we want, where individual institutions within the NHS are all in financial balance as well.

Moving to that position was planned over several years, as the additional investment set out in the long-term plan and the Government's financial settlement came in. That is undoubtedly the objective, to move away from the position that you describe. Overall, the 2016 reset that we and NHS England did achieved its objective of keeping the NHS as a whole in financial balance during a financially challenged period, of which you are all aware. It is time to move on from the measures that we used in 2016 to the different financial regime that we set out in the NHS long-term plan. Mr Kelly is possibly best placed to add to that about progress. Of course, a lot of this has been disrupted by our COVID position.

Julian Kelly: First, I would emphasise Chris's point that it is not principally capital funding that is being used. It is more how revenue funding is distributed. Progress was made in 2019-20, but there is further to go. The aim is that we continue to reduce the deficits of trusts and commissioners over a number of years in a sustainable way, such that the support to those trusts and commissioners that found themselves in deficit reduces and we can return much more to population need, allocation-based funding.

Q39 **Mr Holden:** Sir Simon, if we move to figure 12 on page 27, picking up on what Mr Kelly has been saying, it is pretty clear that the shortage has been in acute, where they have been running deficits in acute services.

That seems to have been essentially cross-subsidised by mental health, ambulance services, specialist and community work. Would you say that, up until this latest funding settlement, that has been the case?

Sir Simon Stevens: On mental health, I would make the point that we have set in place what is called a mental health investment guarantee. That ensures that funding for mental health services grows more quickly than for the NHS overall. That was achieved last year for 2019-20. Your other point is that most of the deficit has been sitting in the acute sector. That is clearly accurate historically. It is worth remembering that the reports we have before us relate to two financial years ago. It is financial year 2018-19, not even last financial year, 2019-20, which has just come to a close.

The new news I can tell the Committee is that the NHS in the round, before we had the exceptional COVID expenditure at the end of the financial year, once again broke even. We halved the proportion of trusts that were in deficit, as we promised, so three-quarters of trusts ended the year in surplus. Three-quarters of CCGs broke even or were in surplus at the end of the year as well. Significant progress has been made during the last financial year, 2019-20, compared with the position reported here for 2018-19.

Q40 **Mr Holden:** Can I drill down into this a little more, particularly around mental health? The report says that 87% of mental health trusts were either breaking even or in surplus. It is all very well for us to see more money going in, but, if it is not being spent and is then being reallocated to different parts of the health service, does it not just continue the issue around mental health that everybody is seeing and everybody knows is such an issue facing the country? It is one that, during the COVID epidemic, might have long-term consequences for people as well.

Sir Simon Stevens: I can reassure you that that is not what has been happening. We publish quarterly the tracked mental health spend, broken down by each area, so we can show that mental health spending has been growing faster than the overall NHS revenue growth.

Q41 **Mr Holden:** That is spending, not budgets.

Sir Simon Stevens: That is spending. That is actual outturn spending. If you look, for example, at the plans for CCG expenditure for 2019-20 on mental health, to meet that commitment I have just described—the mental health investment standard—they would have needed to spend, I think, an extra £527 million. In aggregate, they spent an extra £739 million. Those are off their unaudited accounts and we are in the process of auditing that.

Q42 **Mr Holden:** Another issue that often raises its head alongside mental health, although it has obviously been severely affected by coronavirus, is waiting times, particularly A&E waiting times consistently being missed. I know up in my area Durham has faced real sustained pressure over a very long time on that, yet the COVID-19 epidemic has seen the entire

situation for A&E change fundamentally. I have a couple of very quick questions on that. First, is it right that we are still measuring the performance in A&E in this way? Secondly, given the changes coronavirus has made to the overall system and the fact that some things have perhaps been brought forward, what are you looking at to deal with this situation going forward?

Sir Simon Stevens: You are right that the coronavirus situation means we are in a fundamentally different place on urgent and emergency care than we would have been even three months ago. As I mentioned earlier, we expect that we are going to need to provide more options for emergency and urgent treatment that are not just about people going to an A&E department. The Royal College of Emergency Medicine has set out some very important principles for what that reset on emergency care needs to look like. We are going to be working with them, with the Royal College of GPs, patient groups and others, on what that would look like.

In order to return to the status quo ante, if you want to have two-metre distancing between every person who is in one of these departments for A&E attendance, or indeed an outpatient or GP visit, just the square footage that you need is a physical impossibility as things stand. We are going to need to extend EDs, but we are also going to need to relook at elements of the model. Steve Powis, who has been leading the clinical review of standards, might want to add something.

Mr Holden: I do not think anybody wants to return to the status quo with overwhelmed A&E units.

Steve Powis: The clinical review of standards started with the long-term plan work nearly two years ago now. As I reported to this Committee, I think last year, we have been looking at four areas: urgent and emergency care, so A&E predominantly; mental health, where there are very few standards; elective care; and cancer. On A&E in particular, so urgent and emergency care, we set up a number of test sites in May last year and tested some of our proposals that we made in March last year over the course of the calendar year 2019 and into the first few months of this year. We have published a number of interim reports as to how that testing has been going. I will not reiterate the key findings.

One of the main premises of that work was to ask the question: are the things we are measuring in urgent and emergency care the right measures for the service we are providing? How has it evolved since the A&E four-hour target was introduced 20 years ago and how is it going to evolve in the future? We made good progress in the testing and with our professional colleagues in the royal colleges to look at what a new bundle of measures might look like.

That work has been put on hold a bit during the COVID epidemic. As Simon hinted earlier, as we see new models emerging out of the COVID pandemic, first because we will need to live with COVID for some time to

come, but secondly because we have seen transformational elements occur that we want to retain, we will need to go back, check on the work we have done so far and make sure we do not need to evolve it further again in the light of those service changes.

Q43 **Mr Holden:** That is very clear. The entire issue of primary care and how triaging can take place at an earlier stage, particularly in conjunction with A&E departments, is constantly mentioned to, I think, all MPs by constituents. It is something that is always mentioned to me when people go to the local NHS service. Anything that comes out of the COVID thing that plays into that will be very important. Going back to Sir Simon, you mentioned in the evidence in the overall COVID session that more beds will have to become a permanent situation. Is there anywhere you are particularly thinking of more beds? Is it going to be in community hospitals or ICU beds? What is the push on that, especially with the spending pressures that coronavirus is going to present in and of itself as an issue?

Sir Simon Stevens: We are doing the work on that right now. First, we believe we will need a permanent increase in properly staffed critical care. Secondly, we believe we are likely to need more general and acute hospital beds. Thirdly, we think there will be benefit in an expansion in rehabilitative and step-down care offered by community health providers. Fourthly, there is the build-out of the primary care multidisciplinary teams, which was already in train as part of the long-term plan. There is no world in which we would not want to double down on that.

A lot of this is driving off the long-term plan that was already there, joining up the way in which hospital, primary care, community and mental health services work together. A lot of it was about emphasising prevention. We have seen the importance of population co-morbidities, risk factors, other health conditions and the impact they have on coronavirus patients, so we want to double down on that agenda. In terms of the capacity, we are clearly now in a different situation, in that we need to have reserve capacity for coronavirus and to deal with the catch-up of the backlog of cases that have been displaced.

Q44 **Mr Holden:** Both of those points are well made. My local hospital at Shotley Bridge, which is currently a community hospital, has had to double the number of beds that it normally uses from eight to 16. They are looking for a replacement hospital at the moment, so, if there are any extra beds needed, north-west Durham is the place to put them.

Sir Simon Stevens: On that point, you may or may not know that Shotley Bridge is very close to my heart, because I began my NHS career in 1988 at Shotley Bridge General Hospital. I know it well. I have a picture of Shotley Bridge Hospital in my office.

Q45 **Mr Holden:** I am very much looking forward to welcoming you up there to see the plans we have for new hospital capacity locally. In places like Shotley Bridge—and this is what the report really drills into—a huge

amount of money is being spent on a lot of the NHS estate on patch and repair. There is money that could be spent from the capital side that would actually see a pretty good return on investment in those terms. What are you doing to ensure that, particularly in areas where patch and repair is costing a fortune at the moment, those are priority projects that are being brought forwards as part of the long-term plan?

Sir Simon Stevens: A lot of the investment case for the new hospitals that were promised for the next several years relates to places where there is a significant backlog of maintenance. Exactly as you say, it makes more sense to replace the whole facility than it does simply to deal with some of the backlog of repairs. Without prejudging decisions that the Government make, all the signals we are getting are that there is a strong interest and commitment in accelerating the capital investment programme in the NHS, not least in the light of everything that the health service has been through over the last several months.

Q46 **Mr Holden:** On my local one, one final time, they are spending £1.77 million a year on a relatively small community hospital that is quite historic, of which £786,000 is a landlord capital statutory compliance cost. They are spending almost £1 million a year on compliance alone just to keep it up to a general standard. How many hospitals are in this situation across the country? This has a knock-on in the care that people provide and can get, especially if we are looking at a situation where there is a backlog in elective treatment going forwards. We have to have a hospital estate.

Sir Simon Stevens: We agree completely. The NAO report on capital has the figures there for the increase in backlog maintenance, including the element that is safety critical. The improved public capital investment that the health service is getting and that we have promised over the next several years is not only welcome but also vital for tackling exactly what you are describing.

Q47 **Mr Holden:** Finally, on the Nightingale hospitals, you mentioned that they might have to be there for some time. Is this going to be part of the way we deal with elective treatment? Is this going to be a way to get people back in, or is the idea that the Nightingale hospitals will be the ones used and kept in reserve for COVID, while moving the normal NHS estate back towards providing normal NHS care and treatment?

Sir Simon Stevens: That is a discussion we are having with each of the areas of the country that host a Nightingale hospital. They are operating on slightly different models. For example, the London model is different to the Birmingham or Manchester model. Nearer to north-west Durham and Consett, we have Sunderland and Harrogate. The dialogue we are having there is what the best way of maintaining that capacity would be. It is likely that we will be keeping it as reserve capacity in the event that there is a further surge in coronavirus cases, but that may look different in different parts of the country. We will come to conclusions on that in the course of the next four to six weeks.

Q48 **Gagan Mohindra:** My question is to Julian Kelly. Notwithstanding what Sir Simon has said about the current outlook, within the report it stipulates that we continue to have many trusts in deficit. I wanted to focus my question on the 10 worst deficit trusts and what plans are in place to get them to first break even and then hopefully be in surplus.

Julian Kelly: At the moment, subject to final audit and accounts, we are on track to halve the number of providers in deficit in 2019-20 compared to 2018-19. A number of trusts have significant deficits. In 2019-20, some of those trusts, again subject to final audit, will have both hit their plans and reduced their deficits. I mean trusts like King's and Barts, where we have had problems for a considerable time. That is a significant step forward.

Before we got into the emergency situation we have now, we were in the process of agreeing plans to continue reducing those deficits with most of the trusts that would have been in that 10 in 2018-19. We are in discussion with trusts and, indeed, systems about what further support could be provided for those that had the biggest challenges, to continue to drive productivity and efficiency and continue to see those deficits reduce.

Q49 **Gagan Mohindra:** I am aware that we have COVID funding in place up until July. What are the plans for after that?

Julian Kelly: We set the initial plans through to the end of July. We did not set plans beyond that just because of the level of uncertainty that existed as we went into the emergency. We are currently in discussion and thinking about what the arrangements are that should continue to hold after the end of July. We are in discussion with the Department and the rest of Government about some of the funding streams that have not so far been agreed. As was said much earlier in the session, we will need to set out what those arrangements are at some point in June.

Q50 **Gagan Mohindra:** I should declare that I am still a councillor, because I know social care has been mentioned during this meeting. My next question is to Professor Powis. It is to do with non-emergency health and the health system generally. My inbox is inundated with people requiring osteopaths, chiropractors or dentists, which are part of the wider health system. The Chancellor recently referred to a significant increase in chronic health issues. What is your clinical view on that? Is there enough capacity in the system when we start easing those lockdowns to make sure people have the care they need?

Steve Powis: I think we partly answered that question earlier. It is a priority for us to try to ensure we stand up as much capacity as possible for the full spectrum of health needs. As I have said before, emergency has been there all along, as has urgent care, such as cancer. We need a number of things to happen. First, we need the public to come forward. We know some of them, for various reasons, have not wanted to come forward with symptoms, and that now needs to happen. We are seeing

that happen, but we need to encourage it. Then, as Sir Simon and I have said previously, we need to work with our regions—our local health systems—to stand up the capacity required to deal with those health needs.

As I think Simon said earlier, and I would want to restate it, I would not want anybody to underestimate the challenge we have. We are not going back to an NHS that is the NHS we left in December and January. We are going back to an NHS where, at least for the foreseeable future, COVID-19 is going to be with us and we are going to have to deal with it. That means that not only will we need to deal with patients coming in with COVID-19 but we will need to put in place infection prevention and control measures, including social distancing, in our hospitals. That means that we will have to reconfigure the way we deliver care.

Some of that can be done through remote consultations, which is a direction of travel we wanted to go in in the long-term plan. We have switched a lot of services rapidly to digital first, to remote consultations, and that has worked very well. But you cannot get away from the fact that some patient care requires direct contact between clinician and patient. That will need to be done in an environment of different infection control for the foreseeable future. That is why we want to keep the independent sector in some form. Those negotiations will be ongoing. That is why we need to think differently, but it will still be a challenge.

On top of that, not only will we have to live with COVID as a background, but we need to keep the capacity, as Sir Simon has said, in case we see another surge, another peak, another wave. Those are all considerable challenges for the health service. Yes, it is an absolute imperative that we have that capacity and we bring it online, but we should not underestimate the challenge of doing that and that we are going into a different health service than we left in January.

Q51 **Gagan Mohindra:** As an aside, my own acute hospital, the West Herts Hospital, has a virtual 1,000-bed hospital, which seems to be working well. I agree with you, Professor Powis, that the new normal will hopefully be a different way of working. Adoption of technology should help that. My next question is to Sir Simon. A lot of maintenance budgets have been used to fund revenue. As a system, how are we going to address that to ensure that our operating theatres and the like do not have sewage coming through the floor, as I was aware of at another acute? That will have significant health issues.

Sir Simon Stevens: Yes, you are quite right about that. If what you are getting at in particular is the fact that frontline services have had to use some of their capital budgets to sustain day-to-day services, that has been the case, but we are ending it. If you think back four years, in 2016-17 we had to make use of about £1.2 billion of capital spending for that reason. That fell to £1 billion three years ago. It fell to £500 million two years ago. It fell to £470 million last year and our aim is that it falls to zero this year.

Q52 **Gagan Mohindra:** We have spoken about elective care historically. From my understanding, that ends up being a little more profitable than emergency. How has that affected trust finances?

Sir Simon Stevens: We have moved away from the activity-based tariff system for the first part of this year in response to coronavirus. We have essentially moved to block contracts, taking providers' costs from last year, uplifted, payment on account, and then auditable costs over and above that related to coronavirus. By July, when this initial first four months' arrangement concludes, we will be setting out what that arrangement looks like for the balance of the year. I very much doubt that we will revert to the old way of doing it. It will be some sort of hybrid between where we have been for the first four months of the year and where we want to go, which was a move towards more blended payments anyway.

Gagan Mohindra: My next question is to Mr Kelly. How are you managing the risk of fraud during this period, when controls might be a bit more relaxed in the interest of expediency?

Julian Kelly: As I said earlier, we have put in place arrangements for some of our big contracts and major providers to make sure we have appropriate audit arrangements, not just at the end of the year but through the year. We have agreed arrangements with CCGs, in particular, where they are looking at how they sustain their strategic supply base, so appropriate assurances and approvals are put in place before things are done. We, along with the Department and the NHS counter-fraud agency, are working closely with the central Cabinet Office teams and others around Government to make sure we are using the available analytical and other tools to do as much as possible to protect ourselves.

Q53 **Gagan Mohindra:** I look forward to those measures being robust, because otherwise I am sure we will have further reports to this Committee. Sir Chris, how are you ensuring that trusts have sufficient access to capital investment and can access it quickly during this pandemic?

Sir Chris Wormald: I will ask David Williams to add to this. Pre the COVID pandemic, Government of course had an extensive range of capital plans that they set out in their manifesto that they were pursuing. They had a number of decisions still to make about longer-term capital as part of the then planned spending review. Clearly, that situation was changed by COVID. We did make some relaxations of the capital position to ensure that people could meet immediate needs around COVID. Perhaps David Williams could add the detail.

David Williams: On the COVID response specifically, the big capital items have largely been met nationally. The set-up costs for the Nightingales and capital investment in medical equipment like ventilators and so on have been through additional funding nationally, rather than locally. Where individual providers have had capital costs to reconfigure

their layouts or increase capacity, those capital elements will be met as needed. A lot of the additional costs of the coronavirus response are more at the local trust level in the day-to-day operating costs, rather than capital.

More generally, as part of our improvement of the capital regime, we have been clearer about spending envelopes for the NHS, which have increased because of the ending of cap rev switches, as Sir Simon has said, and through increased investment from Government, as Sir Chris has set out. There is a much clearer focus on local prioritisation so that the capital that is available in the system can be directed to areas of greatest need locally, alongside nationally directed programmes.

Q54 **Gagan Mohindra:** David, are you able to confirm that there is now a lot more centralisation of approvals of capital spending above £250,000?

David Williams: What I think you are referring to is that, as part of the relaxation of financial controls in the first stages of the coronavirus response, capital approval limits were relaxed in guidance that NHSE and NHSI sent out. I think those have now been restored, but Julian Kelly would have the detail.

Julian Kelly: What David has said is right. In the first flush, those first few weeks, we gave a greater amount of discretion to trusts to commit capital below £250,000 so they could get on and do things that were necessary in the first flush of emergency. We have tightened those such that people need to ask prospectively where they are seeking additional funds. In the interim, we have given a baseline capital envelope to every system for the whole year for them to determine within the system how that capital funding is spent, of a total of about £3.7 billion. They know now what the amount of money is that they can spend at their discretion.

Q55 **Gagan Mohindra:** Building on that, probably as an extra question for Sir Simon, there has been a historic backlog of lack of money for maintenance. Do you think that had a bearing on our ability to respond to the COVID pandemic?

Sir Simon Stevens: In terms of being able to repurpose capacity to ensure that 89,000 coronavirus-positive inpatients got emergency care, hospitals have succeeding in doing that. It meant having to move heaven and earth, showing great flexibility. People have rolled their sleeves up and got on with it. I do not think that has turned out to be the main constraint, but clearly we have had to act very fast.

I will give you a prosaic example: ensuring that the oxygen piping through hospitals could absorb the large numbers of patients who needed oxygen support way beyond what you would normally expect. If you want a sense of what that felt like in hospitals over the course of the last month or six weeks, the BBC "Hospital" programme that was broadcast a few days ago at the Royal Free gives a very real sense of it.

Q56 **Gagan Mohindra:** I am aware of that because my local acute hospital is

Watford General and had the same issue.

Sir Simon Stevens: You know all about it then, yes, absolutely.

Q57 **Gagan Mohindra:** The purpose of the question was the mantra that a stitch in time saves nine. Do you think we could have learnt lessons by early and consistent investment in maintenance versus what we have seen—the national effort and logistical nightmare to address this pandemic, where you have all done really well, in my view?

Sir Simon Stevens: There are lots of reasons why having well-maintained hospitals and other parts of the health service is highly desirable. I do not think, based on what we are seeing right now, that that will turn out to be one of the key elements of the coronavirus response. That may not be true everywhere, but in general the constraints we had to overcome were staffing and turning successive floors of hospitals into surge critical care capacity. You would not normally do that as part of a backlog of maintenance programme. This is something quite unique.

Q58 **Sir Bernard Jenkin:** There has been a certain amount of reference to the NHS long-term plan. Sir Simon, how much would you like to rewrite that plan in the light of the COVID experience?

Sir Simon Stevens: The fundamental analysis that underpins the long-term plan is, frankly, as true today as it was a year ago. As a country, we have clearly seen the benefit of joined-up services in responding. It goes under the title of integrated care, but actually that is what people have been doing in the heat of battle in the coronavirus response. We have seen the impact that obesity, heart disease and other chronic health conditions have on the susceptibility of people to this terrible infection. We want to tackle that.

We know that we need to build our capacity, including strengthening the staffing support across the health service. We also know, as set out in the long-term plan, that doing it in the same old way is not the answer. We have to use technology to drive improvement. For example, just look at what GPs have done in the course of a few weeks. That points the way to what the future needs to look like. All that is unchanged and, if anything, the impetus to accelerate it is greater.

There are some things that are now different in the light of that. We have seen that we have the ability to tap into very strong public support through volunteering. There has been an uptick in interest in joining the health professions. At a time when the rest of the economy is going to be so severely disrupted, I think we are going to need to think much more flexibly and creatively about new routes into nursing and other health disciplines. I am sure we are going to take stock, in the light of the new circumstances, but, fundamentally, the prospectus for the health service continues to enjoy substantial support.

Q59 **Sir Bernard Jenkin:** I commend you for our local STP in north-east

Essex and south Suffolk, with Susannah Howard, Nick Hulme and Ed Garratt. The working relationships are very good indeed and the leadership very strong. The big lacuna in the NHS long-term plan was of course workforce planning. The NHS continues to carry 40,000 nursing vacancies and 9,000 vacancies for other medical staff, for example. What impact have these shortages had on the COVID crisis?

Sir Simon Stevens: As you know, and I know it is true in your area as well, we have seen an amazing response, on the part of not only the current generation of NHS staff but those who have left the workforce and come back. We have around 8,900 clinical staff, nurses, therapists and midwives, who have been redeployed back to frontline services and another 1,800 who have joined the coronavirus 111 service. There is also the next generation: 30,000 student nurses, midwives and allied health professionals came forward to be deployed into paid placements, as did 3,000 final-year medical students. It is the current generation, the previous generation and the next generation who have all come together.

The reality is that that is not a sustainable basis. We have to take the opportunity to better support the staff we currently have working across the health service and, as I hinted at a moment ago, look very creatively at new ways into the clinical professions. You think about what is happening in the university sector, and the big shift almost overnight to a lot of education having to be online. We have an opportunity to do some more of that, for example with nurse graduate degrees, so that people can earn and learn with more flexibility, rather than having to take three years out of the labour market if they are mid-career.

Q60 **Sir Bernard Jenkin:** For brevity's sake, I do not want you to write a new people plan now. The point is that, when you launched the NHS long-term plan, there was no people plan, so who is responsible for the people plan?

Sir Simon Stevens: At that point we did not have an education and training budget through Health Education England. The decision had been made to defer that to the spending review.

Q61 **Sir Bernard Jenkin:** The question I asked was who is responsible for the people plan in NHS England.

Sir Simon Stevens: We will be having a dialogue with the Department and the Government as to what the education and training investments need to look like for the future. In the circumstances confronting us now, I detect a very strong interest in giving us the wherewithal to produce a very substantial people plan.

Q62 **Sir Bernard Jenkin:** NHS England cannot just be responsible for delivering frontline care if it does not also integrate planning of the workforce. The NHS people plan came from another body. How can you run an organisation if you are not responsible for planning your own workforce?

Sir Simon Stevens: That may be a question for higher powers than me.

Q63 **Sir Bernard Jenkin:** That comes down to the problem of the lack of accountability in this.

Sir Simon Stevens: It is a separate agency. If what you are getting at is about Health Education England and its separate responsibilities, that is certainly true. The reality is that everybody is pitching in together on this and we have a completely aligned view as to what now is needed on workforce support and growth.

Q64 **Sir Bernard Jenkin:** Who should pay for it? Does it come out of your budget?

Sir Simon Stevens: At the moment, the budget for Health Education England comes from the Department of Health and Social Care.

Q65 **Sir Bernard Jenkin:** How big does it need to be to fund comprehensive workforce planning?

Sir Simon Stevens: That is probably as much a question for Chris as it is for me.

Q66 **Sir Bernard Jenkin:** You must have a view. You employ the people. They are meant to be training your workforce. What do you need? You must have a requirement.

Sir Simon Stevens: We do. We know that we were looking for at least 50,000 additional nurses.

Q67 **Chair:** Give us some numbers. You must have done the maths about how much money you would like to be bidding for.

Sir Simon Stevens: As you know, Chair, I never negotiate in public at the Public Accounts Committee.

Q68 **Chair:** Sir Bernard has asked you a legitimate and very sensible question. How much do you think it is going to need? You have already talked about the changes in how things work because of COVID-19. There are lots of opportunities, as well as tragedy, in this situation. It is early days to have done the numbers on that, but you must have some figures in mind that you are negotiating with the Department on. We will go to Mr Kelly if you will not answer, but try again, Sir Simon, to answer that.

Sir Simon Stevens: In terms of the expansion in the nursing workforce that we need, and obviously that is far and away the single biggest group and most important thing to get right, it was three routes for increasing the net numbers that we are intending. The first will be improvements in staff retention, the second will be growing more UK-trained nurses and the third will be international recruitment. In the light of coronavirus, we expect there will be disruption to international recruitment, at least for the first part of this year, if not beyond.

Equally, we think there will be new opportunities to provide routes into nursing and the health professions perhaps from occupations for which there is going to be less demand in the rest of the economy. Without listing them all, to take one example, in the early 2000s the NHS was losing nurses to airline crews. It may well be that the airlines are going to be under some significant pressure and perhaps we can think about recruiting back the other way.

Q69 **Sir Bernard Jenkin:** Just for the record, not the number, but have you presented a plan of your training and recruitment requirements to the Department of Health and Social Care, saying, "You need to deliver this. It will cost us about this"?

Sir Simon Stevens: Yes.

Q70 **Sir Bernard Jenkin:** Good, because you have obviously made it clear that you have too many demands on your own budget to take responsibility for your own people.

Sir Simon Stevens: It is not so much that. It is just that the actual financing of education and training has been vested through a separate route. We are in constant dialogue with the Department of Health and Social Care and Health Education England. Part of it is financed through the university system, rather than through the NHS per se.

Q71 **Sir Bernard Jenkin:** The other issue you have is social care funding, which actually declined in recent years and probably put further burden on the NHS. What do you think about the pressures on social care funding, in terms of what it does to demand for your services?

Sir Simon Stevens: I am not saying anything that I have not said on a number of occasions in the past. Social care is a good in its own right for the people who benefit from it, and that is not just older people. That is also people with learning disabilities and mental health services. It is also the case that, when those services are under pressure, that produces knock-on consequences for the NHS.

As it happens, the Government have made a commitment that future social care funding will grow such that it does not place additional pressure on the NHS. In any event, I suspect that is a pre-COVID formulation and I think we all expect that we should get much more substantial progress on social care, hopefully sooner rather than later.

Chair: There is a bid. It is only fair to bring Sir Chris Wormald in off the back of that.

Sir Bernard Jenkin: Can I quickly ask one more question?

Chair: Then I think I should bring Sir Chris in on that.

Q72 **Sir Bernard Jenkin:** Sir Simon, your board, to be fair, addressed the Government with a report calling for a review of national workforce roles and responsibilities in the provision of workforce as part of the update to

legislation. What kinds of changes to the legal and accountability framework do you need in order to deliver health and social care workforce across the country that matches the needs of local populations?

Sir Simon Stevens: The coronavirus pandemic has put into sharp relief the social care workforce questions and the fact that such a high proportion of those social care staff are on temporary or zero-hours contracts and in an unstable workforce. I think everybody can see the importance of creating proper career opportunities in social care. To the extent that nurses and therapists are working in social care, not just in the health service, the requirements need to be planned in the round. I think we are pushing at an open door in that regard, but that has to be one thing that comes out of the current circumstance.

Q73 **Sir Bernard Jenkin:** If I can address that question to Sir Chris, about the changes in legislation and accountability, when do you think the Government are going to be able to bring forward proposals?

Sir Chris Wormald: It is not going to surprise you that I am not going to give definitive answers to a number of these questions at this time. Sir Simon has already said a lot of this, but pre-COVID the governing party's manifesto had set out some very clear objectives for the expansion of the clinical workforce, in terms of both nurses and GPs. It is of course still the Government's intention to deliver on its manifesto, even though we have of course been focused on something else for the last five months. All those commitments to the expansion of the workforce stand.

The discussions that have not happened and will not be completed yet are whether, if and how those plans need to be adapted in the light of what we have learned from COVID. To be blunt, my focus, and Simon's and the Government's focus, has been on dealing with the immediate issues of the crisis. We accept that all the long-term questions Sir Bernard raises are there, but we are not in a position to answer them at the moment.

The same goes for social care, where the governing party had a series of commitments in its manifesto to the reform of social care, by which it continues to stand. As Simon has emphasised, there are a lot of discussions and decisions still to be had on what we have learned during the COVID crisis and the sorts of services we will need, both for the remainder of the time when COVID is an issue for us and in the future. Sir Bernard's questions are all completely fair, but now is not the moment to answer them finally.

Q74 **Sir Bernard Jenkin:** There is funding for the 40,000 nursing places. There are not any nurses; that is the problem. Training a workforce is a much longer-term business than putting promises in a manifesto. Maybe we should regard the training budget as capital expenditure because people are your greatest asset and they are the asset you need to be investing in. I am talking about the Department and the health service as

a whole. That is not reflected in the NHS long-term plan, and we have yet to see a comprehensive people plan with numbers and costs in it. When are we going to see that?

Sir Chris Wormald: I refer you to my previous answer. I assume that the governing party put those commitments into its manifesto because it agrees with your position that these things have to be dealt with long term, and that we should set long-term objectives for the expansion of both nurse training and the training of doctors. I would agree with all the points you make. I cannot at this moment give you a time when we will conclude the spending review that will set out how the Government expect to meet their manifesto commitments, for the obvious reason that we are in the middle of a crisis and the timings of those have been put in doubt as a result. I am afraid I cannot say more than this. All your questions are exactly the right ones, but I cannot at this time give you a timetable for when the Government will be answering them.

Q75 **Gagan Mohindra:** Sir Chris, this is a follow-up question on PPE. Can you confirm that there are plans in place that we will have sufficient PPE for when hospitals and GPs go back to the other services they have historically done? From my understanding, the PPE requirement for my own local acute hospital will be double what they are using today. Given your previous comments about supply chain, I would be interested to get confirmation that there are plans in place.

Sir Chris Wormald: As I said earlier, yes, that is our intention. I will not say that every single element of the plan is in place right now, but we are seeking to move from the position where we are meeting our day-to-day needs, to a position where we have projected demand over the coming months and have in place the arrangements to meet that demand. That is the change we are trying to make. I will not promise you that every single element is in place right now, but that is the planning assumption we are using.

Q76 **Chair:** I want to ask about testing of NHS staff; the same can apply to social care staff. I will start with Sir Simon Stevens. There is a great frustration among people at the front line about the slowness of testing. If you are a member of frontline staff in a hospital and you are showing symptoms, the test goes off and can take two days, usually, to come back, if not longer. In the meantime, that takes someone out of action and has an impact on their family, many of whom then cannot work because of the isolation rules. Are there plans to speed this up? If so, when will they be in place?

Sir Simon Stevens: The tests that are being conducted by NHS labs are much faster than that. Generally speaking, the turnaround is within 24 hours for most labs, often quicker. If we can get a point-of-care test, that will be a huge game changer because you will then get a result back in a few hours. David Williams can probably give you the authoritative answer for the wider testing, including the non-NHS lab testing.

Q77 **Chair:** What percentage of NHS staff tests are done through NHS labs? Presumably they are prioritised, are they? It is not all of them, so what percentage?

Sir Simon Stevens: The NHS labs are doing NHS staff and patient testing of the sort we need. David may have the figures for the non-NHS labs, which the Department is overseeing.

David Williams: Currently around 90% of people receive a test result within 48 hours of the test being taken. As we move into test and trace, as well as scaling up the volume of tests we can do on a daily basis, we are looking at how we can speed that turnaround up so we can get the majority of test results back within 48 hours of ordering the test rather than the swab being taken. As I think the Secretary of State set out yesterday, we have just started a trial in Hampshire of a new rapid coronavirus test, which potentially will allow results, without needing to go through lab capacity, within 20 to 30 minutes. That test will run over the next four to six weeks, I think.

Q78 **Chair:** That is a pilot and after four to six weeks we will have a better idea. Would that be suitable for NHS frontline staff? Is it a good enough test to cover the front line?

David Williams: It is being tested today, I think, in the acute hospital trust in Hampshire. As part of the test over the next six weeks, people from all sorts of backgrounds and professions will be included, but it will be trialled in a number of A&E departments, GP practices and care homes in Hampshire. We should get some useful information on all those settings.

Q79 **Chair:** Finally from me on this, Mr Williams, Sir Simon Stevens has talked about NHS labs turning things round quickly. What is the geographical spread? It is certainly the case in some trusts that people seem to be getting slower results. Obviously, that has a big impact, if one hospital or hospital group is getting slower results and another, because it happens to be nearer a lab, is getting faster results. Is that something you are looking at?

David Williams: I would have to take that away and see whether there is a correlation between local lab capacity and speed of response.

Q80 **Chair:** You both talk positively, but we all have examples of people who have been at the front line, been tested and had to wait some time before they get the results. Is that a historic problem, or do you acknowledge that it is still happening in parts of the system?

David Williams: The time taken is a combination of the logistics of getting the test to the individual, or the individual to the test site, how quickly we can process through the lab, where that is needed—for our tests to date, that lab work is a necessary feature—and the time to get the result back to the individual. Those will vary, depending on whether that is in an NHS lab setting, in one of our new Lighthouse Labs, and

whether the distribution is through a drive-through centre, a mobile unit or posting to an individual at home. Let me come back with better details.

Q81 **James Wild:** I have a question on mortality rates for Professor Powis. West Norfolk has double the mortality rate of a number of neighbouring local authority areas, although it is below the national average. Can you make a commitment that we will get an explanation for my constituents and other parts of the country as to what underlies those differences, as far as that is possible to establish?

Steve Powis: Work on excess deaths is more in the territory of Public Health England and experts in the analysis of excess deaths, which I think is what you are alluding to. I do not think it would be for me to make a commitment from NHS England. I know from conversations with the Chief Medical Officer and Public Health England that that is clearly an area of interest. I expect that an analysis of those excess deaths will be undertaken as we move through this pandemic.

Q82 **Chair:** Professor Powis, one of the big concerns that I am not alone in having is that, in my area of Hackney, we have the third highest death rate per 100,000 in London. We also have a disproportionate number—we are obviously still aggregating the figures—of black and minority ethnic people who are dying. We see that nationally. Even taking into account socioeconomic issues and underlying health conditions, it seems higher than usual. How are you collecting the data on this and who are you working with? What are you doing to tackle this in the moment as well as analysing it as a historic fact? It really is concerning people. Can you give us some reassurance that you are acting actively on this issue?

Steve Powis: Yes, of course it concerns us too. As you may know, Public Health England once again has been asked by the Chief Medical Officer to look at this and has been working on it. I believe the report is due by the end of the month. Other groups have looked at this. I believe the Office for National Statistics has published some data too. I think the questions will be what the specific risk factors are in BAME groups in particular, what underlying health conditions may be more associated with those groups, what may be additional factors and what may be socioeconomic. It is not my expertise or the expertise of NHS England to draw out those conclusions. That is, again, an area in which Public Health England and other academic groups I know are actively looking.

In terms of what we are doing about it, first, because many of our staff in the NHS come from those groups, we have worked with colleagues and NHS employers have been issuing guidance, partly produced with our support, by independent experts on how the NHS as an employer, or as a group of employers, can risk-assess members of staff. That is not just around the risk factors that we have seen associated with ethnic groups but also around risk factors of obesity and diabetes, for instance, which have been in the press recently. That is what we have actively been

doing. We have also put in a lot of support for our BAME workers, who are obviously concerned and worried about this.

On the wider aspect, we talked about the long-term plan earlier. One of the key focuses of the long-term plan was to address inequalities in health. Addressing inequalities in health will mean that some of the underlying conditions that have been associated with COVID but also other diseases, such as diabetes or cardiovascular disease, which we know are higher in certain ethnic groups, are addressed going forward, as part of our overall work in NHS England in the long-term plan.

Chair: If some of those issues were taken with any individual population group or disease, it would be seen as a major crisis. This is throwing up how some of those day-to-day inequalities have a big impact on people's survival rates. Thank you for that. We look forward to seeing that work as it emerges and changes in practice.

Can I thank our witnesses very much? I know you all have a lot on your plate at the moment. I want to reiterate the thanks of the entire Committee for the work your staff and all those frontline people are doing in health and social care to make sure we are safe and our NHS and social care system is able to cope.

We will be producing a report on the basis of this and may pick up some of the issues we have discussed in correspondence as well. We look forward to talking to you particularly about COVID preparedness on the back of a National Audit Office paper, which I think Sir Chris referenced a number of times, that came out just yesterday. Thank you very much indeed for your time.