

Public Accounts Committee

Oral evidence: Department of Health Annual Report and Accounts, HC 398

Monday 16 October 2017

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Members present: Meg Hillier (Chair); Heidi Allen; Geoffrey Clifton-Brown; Martyn Day; Caroline Flint; Luke Graham; Gillian Keegan; Shabana Mahmood; Bridget Phillipson; Gareth Snell.

Sir Amyas Morse, Comptroller and Auditor General; Adrian Jenner, Director of Parliamentary Relations, National Audit Office; Mike Newbury, Director, National Audit Office; and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-53

Witnesses

I: David Williams, Director General, Finance, Department of Health, and Sir Chris Wormald, Permanent Secretary, Department of Health.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Report by the Comptroller and Auditor General

Financial Sustainability of the NHS (HC887)

Examination of witnesses

Witnesses: David Williams and Sir Chris Wormald.

Q1 Chair: Welcome. Today, we are looking at a number of health-related issues, with Chris Wormald, the Permanent Secretary at the Department of Health—you have been knighted since we last saw you, Sir Chris—and David Williams, the Director General of Finance at the Department of Health.

This is a reprise of a hearing that we hoped to have earlier, but the House of Commons had not managed to establish this Committee by the Monday that we had intended to have you in. We are keen to ask you some questions about the accounts. After about half an hour, we will move on to look at an investigation by the National Audit Office into NHS shared business services, and an hour or so after that we will look at managing the costs of clinical negligence in trusts, with some slight changeover of witnesses along the way.

At the beginning, I should mention that Sir Amyas Morse, the Comptroller and Auditor General, is a trustee of the Royal College of Surgeons—just for information.

The issue of the NHS accounts, as you know, Permanent Secretary, is something that the Committee has been looking at with concern for some time. We were pleased to see that this year the accounts did not come out on the last day Parliament sat, but two days before—a slight improvement—but we are still concerned about the long-term sustainability of the accounts, which we hope to be looking at again with you in January.

For today's purposes, first, how are you making sure that the NHS is on a sustainable footing as winter approaches?

Sir Chris Wormald: My partners in NHSE and NHSI have been very vocal on this recently, and we have set out the plan for the NHS over the winter. We think it is a very strong plan. We think that the NHS is better prepared for winter than it has been before, but that is not to underplay the challenges that it faces. It will not surprise you to hear that our overall assessment of the challenges facing the NHS is basically unchanged from when we discussed it with this Committee before. It is obviously very tough. As I was saying, we think we have got comprehensive plans with our partners, but it will be a challenge for the whole of the health service to deliver those.

Q2 Chair: What has changed since last year? We had some very, very big warning signs from senior people in the Department last week about the potential for particularly big challenges this winter. Why are you particularly worried this year? What different plans are you making compared with last winter, which was acknowledged to be quite a mild one with no flu epidemics and none of the extra danger signs?



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Sir Chris Wormald: The thing that has particularly concerned the NHS has been the flu position. We do not yet know exactly how difficult flu will be, but there are some indications from Australia and New Zealand that this might be a difficult flu year. Given the challenges that the NHS faces anyway, that has been a prompt for everyone to up both their levels of concern and their levels of preparedness even further.

Q3 **Chair:** So how are they doing that? There is talk about freeing up a lot of beds. What does that mean in practice?

Sir Chris Wormald: We have done a whole variety of things. As you know, we put extra money into adult social care at the time of the last Budget, and we expect local authorities to be doing their part on DTOCs—delayed transfers of care. We are also expecting the NHS to be able to reduce the number of delayed transfers of care within the health service, which, as you know, is—

Q4 **Chair:** Sorry, but can I stop you there? We looked at that particular issue not that long ago in this Committee—I suppose I should say the previous Committee—and it was not going terribly well. The money from hospitals that was going into social care, to try to stop delayed transfers of care and ensure that people were not going to hospital in the first place, was not delivering very well. So are you speaking with great confidence now, or hope?

Sir Chris Wormald: As I hope I have set out in all my answers so far, we believe that this is a challenging situation. We are not trying to downplay the issues at all. I was referring to the extra money that we have put in, this financial year, to the local government settlement to ease pressures on local government.

Chair: I am going to ask Caroline Flint to come in on this.

Q5 **Caroline Flint:** Permanent Secretary, when you were asked by the Chair about the plan for this winter, you said, “It is stronger and better prepared than before”—I think they were your words.

Sir Chris Wormald: Yes.

Q6 **Caroline Flint:** Could you be a little more succinct and clear about how you can stack that claim up? For example, with the extra money that has gone into adult social care, what can you tell us in a practical way about what that has delivered to ensure that people are either not kept in hospital longer or do not go in the first place? I am waiting to hear something about some practical things that will be operating differently this year, compared with last.

Sir Chris Wormald: Well, there are a whole series of things, and they were set out by—

Q7 **Caroline Flint:** Just give us two.

Sir Chris Wormald: We are introducing streaming across far more A&Es. We put £100 million into investing in A&Es to create more spaces. We have invested in adult social care, and we are working with—



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Q8 **Caroline Flint:** How much more space?

Sir Chris Wormald: I am sorry; I don't have a figure.

Q9 **Caroline Flint:** That is what I am interested in. The input is x million pounds, and then the general phrase is, "That has created more beds." I am just interested, as we come to the end of October, in how much more you can tell us about specifically what that is delivering in terms of capacity.

Sir Chris Wormald: I am sorry; I don't have a specific figure.

Q10 **Caroline Flint:** Could you write to us on that?

Sir Chris Wormald: Yes. Most of the information on what we are doing was published by NHSE and NHSI last week, in terms of in their winter plan, including vaccination rates, but I am more than happy to write to you.

Q11 **Chair:** I can't remember if you have written to us about which A&Es are getting extended, if you have got this money going in. Have you got a list that you could write to us with?

Sir Chris Wormald: We do have a list.

David Williams: It has gone to 102 trusts and 117 separate sites within those trusts. I don't have the list of all 117 here.

Q12 **Chair:** I am not expecting you to list them now, but could you write to us with that list? I know that colleagues around the House would be very interested. When will that extra space be delivered? Will it be in time for this winter?

Sir Chris Wormald: Yes.

David Williams: Yes. With the GP streaming, the investment is less around additional space than about managing the flow of patients through the front door.

Q13 **Chair:** That is with GPs in the hospital?

David Williams: With GPs in the hospital, or other ways of improving the patient flow in the emergency department.

Q14 **Chair:** So we are relying on that shrinking pool of GPs to fill those triage posts. How is filling those positions going—whether through a GP triage system, GP surgery at the front of the hospital or any of the various models of GPs being present?

Sir Chris Wormald: We are quite happy to send you a full update on that. This is a model that we know works, because it works in a variety of hospitals already.

Q15 **Chair:** Exactly. We have covered it many times in this Committee; it is not rocket science. I am just wondering how you are going to fill the positions, because we know that in many cases you cannot fill main GP



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positions. Is it that locums are happier to do this?

Sir Chris Wormald: It is done at local level, so it is individual trusts working with their local CCGs.

Q16 **Chair:** So it would be a good idea for every MP to ask what is happening in their local area?

Sir Chris Wormald: Yes.

Q17 **Chair:** We'll make sure we take that up, then.

Can I go on to one of the other big pressures on the budget? We have highlighted before the capital budget moving to support day-to-day spending. We had some good evidence prior to this from the King's Fund, underlining concerns that we have raised before. They say the cost of the backlog of high-risk maintenance work increased from £458 million in 2014-15, which is when we were beginning to highlight that issue, to £947.1 million last year. They survey trust finance directors, and that is obviously a sign that they are delaying or deferring capital spending. You acknowledged when you became Permanent Secretary, Chris Wormald, that this was a problem that you wanted to get resolved. How is it going? It doesn't sound like it's going very well.

Sir Chris Wormald: We set out last year our plan to eliminate the switches by the end of this spending review period. As I think I have said to this Committee before, it is a thing we do because it is necessary rather than because we want to. David, do you want to comment?

David Williams: The transfer that we made in 2016-17, the year covered by these accounts, was £1.2 billion, from capital into revenue. That is the high watermark. We plan to remove that switch entirely by 2021, as the Permanent Secretary has said, with the figures being on a declining profile between now and then.

Q18 **Chair:** But that is three and a bit years to resolve it completely. Have you done an analysis of what the impact is of that lack of capital funding—the money that is being taken out—and what backlog there is going to be in order to fill the hole that is being created in order to create resources?

David Williams: Not specifically around the backlog, although we are looking with colleagues in NHSI at the way in which backlog maintenance—

Chair: That is NHS Improvement, for anyone who doesn't know.

David Williams: Yes, NHS Improvement. We are looking at the way in which backlog maintenance is building up. Actually, not all of that is amenable to capital spending; some of it needs revenue to address it in any case. At the group level, which is clearly the level at which in the Department we have best visibility, the consequences of that capital switch are managed partly through realism of capital projects—traditionally, capital projects assume that they will spend money to a higher level earlier than in practice is the case—and by using those levers



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that we have in our control around central programmes or about loan funding into the NHS to try to manage within the budget that we have.

The provider spending envelope sits at around £3 billion a year within our overall capital envelope. To the extent that we are able to generate receipts from estate disposals, the available money to spend is higher, but clearly, understanding how that capital is allocated out between now and the end of 2021, and indeed what that capital budget might be beyond that, is something that we pay very close attention to.

- Q19 **Chair:** That is a very good long answer. You are very good at giving good civil service answers, Mr Williams, and I am sure that is one of the reasons you keep your job and have done so well in your career, but what you are saying is that basically you are shoving things to the right, and you don't know—all those words have not told me how you know where there is going to be a critical point, what sightline you have from Whitehall about what critical problems there could be at local level by delaying investment.

David Williams: Within the Department, we do not have a systematic way of understanding the detailed decisions that are necessarily the purview of local boards and executive management teams.

- Q20 **Chair:** But your job is to manage the risk, isn't it? You have to know what the risk is, so how do you have sight of that?

David Williams: Except we operate within a system where the majority of local capital funding is self-funded through depreciation and cash reserves where trusts have them, so actually our system visibility of what capital is spent on is necessarily limited. We are able to see, at the margins, where there is pressure. Clearly, we have a sense of where trusts are coming to the Department for loan financing to supplement their own resources. That allows us to build some picture, but it is not a full picture, just because of the decentralised and delegated system within which we operate.

Chair: I am going to bring in Mr Snell, Mr Graham and Mr Clifton-Brown to pick up on this.

- Q21 **Gareth Snell:** You said that potential disposal of capital assets would generate receipts that could then be used to help replenish some of the capital budget that has been taken out for day-to-day servicing. That is a future plan. Given that £1.2 billion has been converted already from capital to day-to-day spending or revenue, has any work been done by your Department on what the additional cost burden will be to complete those capital works in three years' time? Because if I do a job on my house that needs doing today, it is less expensive than waiting three years to do it, when it is in much worse condition. Is the growth of your spending envelope going to meet all the works that could be done now under the capital budget if you wait for three years? If not, how are you going to work with trusts to ensure that the work that needs to be done is done within that particular spending round?



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David Williams: The calculation that you describe is a perfectly rational one, but we operate within a system of fixed budgets, allocated to us by the Treasury and voted by Parliament, and one of the things that we need to ensure is that, within any one year, we do not exceed the level of capital spend available to us. For individual projects, there may well be a cost associated with delay if you are looking at refurbishment, either because the material state of the building would be worse or because of cost inflation within the project. That is a calculation that needs to be made in the first instance at the local level, set against the availability of funding in the short term to take these projects forward.

- Q22 **Gareth Snell:** You say that that is a calculation that needs to be made at a local level. Given that some of these budgets are being determined at a departmental level, and we are talking about billions at that level, is any work being done in your Department to have an oversight of that to ensure that we do not have trusts storing up long-term potential capital problems that may eventually exceed even their individual or local financial ability, which means that they will have to come to the Department? Ultimately, even if the trust does put off work, presumably its lender of last resort is to come to the Department of Health and say, "Look, we have got a big problem with our hospital." My hospital is currently converting corridors into bed spaces. They are doing it now, because they know that if they wait for three years it will be too expensive.

David Williams: There will be a range of factors playing at a local level on whether trusts decide to prioritise or deprioritise investment in their estate, whether it is maintenance or new investment. I am in discussion with colleagues in NHS Improvement about the way in which that backlog of maintenance is building up and what sort of approach response might be needed, whether that is through local action or national facilitation. Those conversations are live at the moment.

Sir Chris Wormald: Just to be clear, we do not do the calculation that you suggest, but there is a series of mechanisms by which we do monitor the quality of the capital estates. The CQC, for example, reports on the capital estate when it inspects hospitals, particularly as it affects services. And NHSI in particular overlooks some of the absolutely crucial issues—

- Q23 **Chair:** It is a bit late in the day if the inspectors—

Sir Chris Wormald: Well, no. This is a delegated and locally managed system, and we then have mechanisms for identifying if there are big issues, which do get shown up in the way—

- Q24 **Chair:** A number of finance directors who have spoken to us over time understand what the pressures are very early on. They have been under pressure—on one level, quite rightly—to deliver to budget, but they know what the risks are.

Sir Chris Wormald: Yes. I just want to be clear. We do not do the calculation that Mr Snell suggested, but we do do a series of other things that keep us informed about the situation.



- Q25 Gareth Snell:** A final point on that. I appreciate that you may not have a calculation because those are locally sourced budgets, but patient outcomes are hugely affected by the state of the environment in which they are treated, so presumably the Department of Health is looking at what impact these delays in capital because of the conversion of capital to revenue—either backlog or things that will be cancelled going forward—will have on patient outcomes.

Sir Chris Wormald: In the way that we have described and shown up through CQC reports, yes, but, just to be clear, we have taken a judgment that, in the current climate, supporting revenue expenditure out of capital is better for patients. We have taken that judgment. Does it have some of the consequences in the longer term that you described? Probably, yes, but in the short term, that is the whole reason for the cap-rev switches in the first place—to support patient care.

- Q26 Chair:** You were talking just now about the fact that it is locally managed, and about the lines of sight that you have. STPs—sustainability and transformation plans—are being called into the centre for agreement. Is it about departmental accounts, or is it about local control? It doesn't seem to me that those two square.

Sir Chris Wormald: It is about a bit of both. On the STP bit of capital, which David can explain in more detail, we receive proposals centrally from STPs for major pieces of work. We funded a number of those in last year's budget, and the Chancellor made it clear that he would fund some more. So we do make some of those big strategic investments within a largely—

- Q27 Chair:** So what would qualify as a strategic investment that is suddenly called into the centre, and that you have that direct control over, compared with a rather large local expenditure that you said was not your responsibility just now?

David Williams: The principal difference is that those are driven by the allocation of new money into the system, whereas most of the capital spend by NHS providers is self-generated through depreciation and local cash reserves, which my ability to influence one way or another is relatively limited. The new money that the Chancellor identified in the Budget earlier in the year is something over which the Department has direct control and can therefore prioritise more explicitly. We do not set capital budgets for each provider within the system, so how they spend their money is primarily up to them.

The £325 million that we were allocated earlier in the year has gone to 25 schemes in 15 STP areas, based on a prioritisation linked to quality of the STP and leadership, impact for patients, improvements to performance, demand management and so on—a range of criteria to put that money in the right place.

Chair: It seems to me that you are relying on a very good working relationship between all the STP partners to get to that point and make sure that it actually fits in with our local priorities, but I will park that for a



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minute, because Mr Graham is going to come in, and then Mr Clifton-Brown.

- Q28 **Luke Graham:** Mr Williams, to pick up on your point earlier about oversight of capital expenditure with the providers, from what you have been saying in this session, am I right to understand that when a decision is made to take capital expenditure and put it into revenue, then you do not have the ability to trace down to the individual providers to map the impacts of that decision? Is that correct?

David Williams: I would make a slightly different point that within any fixed budget for capital, whatever the value, the direct line of sight between the Department and how that money gets spent at the local level is quite a complex chain, but that is the system within which we operate. It is not particularly that the change through the capital switch cannot be traced down; actually, line of sight through the system on the core capital budget is quite opaque. I am not wildly happy about that, but it is the system I have to operate.

- Q29 **Luke Graham:** That is fine. So, from a reporting point of view, if we were to ask the question to understand the value from our investment for taxpayers, for constituents—if I were to say, “Let’s look at the capital spend; let’s split that”—first, are you able to split it between total capital spend, the percentage that goes on maintenance, the percentage that goes on improvement and the percentage that goes on new programmes and schemes, so we have traceability from Government policy down to the Department and local provision and our constituents and customers can track at the other end? Can you do that just now?

David Williams: At a high level, yes. I think there is a high-level split of this in figure 6, from memory, in the annual report and accounts, on page 21. Accounting for how the money has gone is relatively straightforward; planning how the money is allocated is also relatively straightforward. The link between the plan and how it actually gets spent is the thing that is tricky.

- Q30 **Luke Graham:** That would be my question. It is almost a bit of a reporting problem, then. Would you agree that there is almost a management accounts problem here? You can sit and say, “We will allocate this money here,” but you are not getting the budget versus actual analysis through to a level that you would be confident in and find reliable?

Sir Chris Wormald: Not in the way you are describing, no. We work with a system where the unit of aggregation is the individual trust. On your straight question of how your constituent can tell, it will be from the management account or the accounts of that trust, seen as a legal entity and a unit, as it were. People have different opinions on whether that is a good idea or not, but our unit of aggregation in Health is the institution and not the programme. We cannot trace down in the way that you describe. Through accounts and CQC ratings and everything that NHSI does, we can give you a very good view of whether that hospital is spending money well and delivering a good service. That is the basis of



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our aggregation. You could run it in the way that you suggest, but it is not in line with our current governing legislation.

Q31 **Luke Graham:** So there is a little bit of a gap and it is more opaque than you would like to see it, Mr Williams?

David Williams: Yes, personally, but—

Q32 **Chair:** Great, thank you; we like short answers. Thank you for that.

Sir Chris Wormald: It is not a question for us.

Chair: We appreciate that, but we can take that answer.

Q33 **Geoffrey Clifton-Brown:** Mr Williams, you have already told us that in 2021 the switch between capital spending and revenue will cease. You have a sustainability and transformation fund of a further £1.8 billion, which will cease in 2019; yet the demand from an ageing and expanding population is going up considerably each year. What is the long-term sustainability plan for NHS funding?

David Williams: On a point of detail, the £1.8 billion sustainability and transformation fund that you described is baselined in the NHS budget across the entire spending review period. There is a decision to be made after the next financial year on how that money gets into the system and whether that is through a fund—the way in which it currently operates—or is paid out through a different mechanism. But that money does not stop; it is not time-limited. It is built into the baseline.

For the Departmental budget, and in particular the share that goes to NHS England, the spending plans were set out by the Government in spending review 2015. That takes us to 2021, showing a material real-terms increase in RDEL over that period—

Q34 **Chair:** Could you just explain RDEL?

David Williams: Sorry. Resource DEL is the day-to-day operating expenditure of the NHS. What the budget does beyond that period is a matter for a future spending review, and I cannot really speculate on how that might go.

Q35 **Geoffrey Clifton-Brown:** So you expect those resources set out in that expenditure review to be sufficient to meet the increased demands that I have already talked about?

David Williams: The challenge in any spending review is to match the level of money available with the level of activity and output, or outcome, that you want to get. Obviously, you can have a conversation about either side of that equation.

Chair: Mr Williams, you are a master at this art. I am sure there will be a PhD written on your answers. Mr Clifton-Brown may want to push on that again.

Q36 **Geoffrey Clifton-Brown:** Yes; that was a very clever answer—



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David Williams: Thank you.

Geoffrey Clifton-Brown: But what qualitative analysis have you done of what resources you will have available and what you expect the demand to be by 2021? Do the two match?

Sir Chris Wormald: Shall I have a go?

David Williams: Yes.

Sir Chris Wormald: This Committee has discussed this several times. For this spending review, the settlement is predicated on the five-year forward view that was created, led by NHS England, and refreshed in March, earlier this year, I think at this Committee's suggestion; that was certainly one of the things the Committee wanted to see. It sets out what the NHS thinks it can achieve for the level of investment. Obviously, there is a lot of debate about that, but in terms of the process for this spending review—I think that was your question—it was a question of setting out an amount of money and what the NHS believed it could achieve for that money, and doing so very publicly. As I said, it was much debated, for some of the reasons you have said, but that was the process. It is difficult for us to comment on whether a future spending review would follow the same pattern, but it seems a pretty good one to me.

Q37 **Geoffrey Clifton-Brown:** I am only interested to 2021; that is all.

Sir Chris Wormald: To 2021, it was the five-year forward view that was the basis, but people will argue that. On your wider point, there is a challenge for all health services, certainly across the OECD but including ours, in that demand keeps going up. That will be a challenge for all Governments: how will our fiscal position keep up with the demands we make on our health service? I am sure that will be a big question whenever there is a new spending review.

Q38 **Geoffrey Clifton-Brown:** Can I switch the subject to potential rationing? Last November, the Vale of York CCG announced plans to delay planned operations for many smokers, or patients with a BMI of over 30, by either six or 12 months if they could not prove that they had stopped smoking, or lost 10% of their weight. The policy has recently been adopted in North Kirklees, where almost 24% of the adult population have an excessive BMI. Is that part of the Department's policy with trusts?

Sir Chris Wormald: No.

Q39 **Geoffrey Clifton-Brown:** It surely delays their expenditure, so are they doing it for financial reasons or good health reasons?

Sir Chris Wormald: There are a couple of points I would make. Simon Stevens will be here a bit later and he is very, very clear on these points. Those sorts of measure are appropriate when there is a clinical justification for them. I do not know the examples that you quote, but certainly NHSE has previously taken a view when it did not think that such measures were clinically appropriate, and intervened accordingly. I will not comment on the individual cases that you mentioned.



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Q40 Chair: Are you saying categorically that this is clinically led, not financially led?

Sir Chris Wormald: I am sure you have asked Simon this question before and can again. He has been very clear that, where people are taking those sorts of decisions, it needs to be clinically led.

Of course, we are asking CCGs to make efficiency savings and save money. NHS England is looking in particular at CCGs and practices where their prescribing or referrals appear to be out of line with national averages, and asking why. There are questions to be asked about CCG policies in this area, but I think NHS England has always been clear that they need to be based in good medicine as well as good financial sense.

Q41 Geoffrey Clifton-Brown: Given that these are local decisions, are you setting out fairly clear guidelines to CCGs so that we have a national policy? It is clearly unfair if one CCG is operating one policy and another is operating a different policy.

Sir Chris Wormald: Yes. Again, Simon is much more eloquent on this than I am, but you have to strike a balance between having CCGs that can respond to local circumstances—medical needs are different in different parts of the country, so you do not want complete command and control—with ensuring that there is consistency of practice. That is what NHSE guidance is trying to do.

Q42 Chair: No doubt this is a theme we will return to often. You now have the ability to pay staff in the NHS more by lifting the 1% cap. The Secretary of State said in the House that that would not happen overnight, it would be linked to “productivity improvements that we will negotiate at the same time.” What will the effect be on the budget and realistically how long will it take to have the productivity improvement negotiation that the Secretary of State mentioned?

Sir Chris Wormald: The Government’s approach to public sector pay was set out by the Chief Secretary to the Treasury.

Q43 Chair: We know that bit. What is the impact on your budget?

Sir Chris Wormald: The Secretary of State was not saying anything different from what the Chief Secretary set out.

Q44 Chair: We know that. What is the impact on your budget?

Sir Chris Wormald: The straight answer is, we don’t know yet, because the process that was set out by the Chief Secretary—

Q45 Chair: It is £0.5 billion for every 1% pay increase on your current pay budget, isn’t it? It is potentially a very big expense.

Sir Chris Wormald: Yes, but the Chief Secretary also set out a process of giving evidence to pay review bodies around Budget time and pay review bodies after that. We would not know what the impact on our budgets were until the playing out of that process. I think you are quoting the Agenda for Change numbers.



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Q46 **Chair:** The National Audit Office provided those numbers, so they are numbers that are agreed.

Sir Chris Wormald: Just to be absolutely clear, I think that is the number that relates to non-doctor NHS trust staff.

Chair: Perhaps the NAO can clarify.

Mike Newbury: As a rough rule of thumb, it is difficult to disaggregate the pay bill. I think that the total pay bill for the NHS is around £50 billion.

Sir Chris Wormald: That is for the trust sector, so that wouldn't cover GPs et cetera.

Q47 **Chair:** Just to be clear. You have talked about the process. When will the extra pay hit your budget? Whatever it is, there will be a negotiation when you can lift the cap. When could you lift the cap and therefore potentially have a hit on your budget?

Sir Chris Wormald: The next pay review body relates to the '18-'19 financial year.

Q48 **Chair:** So it could be from next April that you will deal with this. Then you have also got this productivity improvement negotiation. Does that go with the same timetable in parallel with the—

Sir Chris Wormald: Yes, it would have to. As I say, the Government have set out that they are prepared to be more flexible on the pay gap, but they would need to see productivity improvements.

Q49 **Chair:** But there is no new money?

Sir Chris Wormald: I will not talk about money because, as you know, that is discussed at Budgets and spending reviews. But any conversation about productivity and pay would be in the context of the process the Chief Secretary laid out.

Q50 **Chair:** So just to be clear, when you talk about productivity improvements, can you give us an example? Does it mean there will be one fewer nurse on a ward, or two, or they will share roles or work longer shifts? What does productivity improvement mean?

Sir Chris Wormald: When you look across trusts—this has come out of a number of National Audit Office Reports—we see some very different productivity rates between individual trusts and considerably better productivity rates in most of our outstanding trusts, who are the ones largely in surplus. Clearly, there are processes in some of our best hospitals that, if expanded more widely, would save us money, which would make space for some of the things we are talking about.

Q51 **Chair:** If that happened, there could be money available?

Sir Chris Wormald: Yes. The process we go through when we look at productivity is not, "Let's take one nurse off every ward." It is not that sort of process. It is about saying, "Where are our most efficient and effective



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hospitals? What are they doing and how could we spread that to other places?"

- Q52 **Chair:** It sounds like quite an ambitious target to have delivered all of that by next year, but we will come back to this in January. We need to crack on. My final point is about the 4% efficiency target, which Jim Mackey, head of NHS Improvement, said was a very stretching target to do over a long period of time. It is still there. NHS Providers gave us evidence suggesting that this saving level is a level that "No advanced western health economy" has ever realised. We have heard from many sources that this is what you might call in the private sector a stretched target, or an unrealistic target, to deliver 4% efficiency savings, when delivering efficiency in this timetable and at this pace is actually more than efficiency. It seems to cut deeper than that. Mr Williams, is it possible to keep this up? From your point of view, as a finance director, no doubt anything is possible. Have you had sight of what the impact will be of the 4% efficiency savings target?

David Williams: I would go back to the permanent secretary's answer earlier around demand assumptions. For this spending review period, we based our budget allocations on assumptions within the five-year forward view, which essentially looks for a recurrent 2% a year productivity improvement. Given the starting point of some trusts, it has been necessary for people to deliver more than that, but the recurrent rate assumed in the five-year forward view is that we get to around 2% productivity and may be able to pick that up towards the end of the spending review period. Against those sorts of assumptions the 4% that a number of trusts are identifying in their own cost improvement plans I suspect is probably not sustainable in the long term, but it is not the fundamental assumption that we are making in the way in which the budget has been set, or the way in which the prices are set through tariff.

- Q53 **Chair:** Okay. It is quite heartening news that you are not expecting it at a certain level. I will wind this session up here. We would love to talk more about the NHS budget. We could spend all day on this. We will have you back a number of times, and I warn you that in January we will discuss the sustainability of NHS funding. However, we have other areas to cover. I will remind myself who is staying and who is going.

Sir Chris Wormald: I'm here all day, Chair.

Chair: Mr Williams, you are off the hook for today. Thank you very much indeed, and I think I've given you a hint that you might get contact from students doing a PhD on answering questions—or not.