HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Performance of the Department of Health and Social Care, HC 1515

Wednesday 17 October 2018

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Watch the meeting

Members present: Meg Hillier (Chair); Chris Evans; Shabana Mahmood; Stephen Morgan; Anne Marie Morris; Bridget Phillipson; Lee Rowley; Gareth Snell.

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

Questions 1-158

Witnesses

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

Examination of witnesses

Witnesses: David Williams, Director General, Finance, Department of Health and Social Care; and Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care.

Q1 **Chair:** Welcome to the Public Accounts Committee on Wednesday 17 October 2018. We are here today to look at the Department of Health and Social Care's accounts and generally to probe the Department on its financial sustainability and the financial sustainability of the NHS. Obviously this is something we have looked at a lot over the past few years—you will know our concerns, Sir Chris, so I will not repeat them. Our witnesses today are David Williams, the finance director at the Department of Health, the man with the magic touch—I suspect your bosses say that—in that you managed to get the accounts to balance, through various means, over the years. We will be probing the latest techniques, with the situation we have got today. Chris Wormald is the permanent secretary at the Department. I am also very pleased to welcome our colleagues from the Sri Lankan Public Accounts Committee, who are here today to see both what we do and what you do as a Department.

Before we get into the main session, I just want to pick up on a letter that Ian Dalton actually sent to me, Sir Chris, but I think you will know about it. It is about the wholly owned subsidiary companies that we raised in the Committee before the summer. I am very interested to note that there is a consultation going on, and a pause on setting up new subsidiary companies in most cases. You had written to me about this in May, and Ian Dalton has written to say that the consultation is under way, but we don't know the timescale for that. Are you able to tell us when the outcome will be for that consultation?

Sir Chris Wormald: Do you know, David?

David Williams: I am waiting to see the consultation documents, which I think are out either today or tomorrow, so I don't know the time scale.

Q2 **Chair:** The letter to me was dated 9 October, so the consultation has started but it hasn't gone out yet—is that what you are saying?

David Williams: I think Ian said in his letter to you that the consultation is due to start today. I think if the consultation documents are not out today they will be out this week.

Q3 **Chair:** So you don't know how long that consultation is going to be.

David Williams: No. I know he is doing it, but I haven't read the consultation documents.

Chair: We will definitely be keeping an eye on this. If you haven't got

more information now, we will probably write back to Ian Dalton to get further information on the questions that he has been unable to answer in his letter. So we will watch that one. I am going to hand straight over to Gareth Snell on another issue that we want to pick up before the main session.

Q4 **Gareth Snell:** I just want to pick up on the WannaCry incident and the report, and the ministerial statement that was tabled last week, in particular. The report says that the overall cost was just shy of £100 million when you include the follow-up IT costs as well as the original knock-on costs. Recommendation 22 of the report talks about CCGs and CSUs now having a responsibility to be "accredited…for coordinating a cyber response". Could I ask, given the disparate nature of clinical support units and the nature of the NHS now as multiple providers using multiple software bases, how are you going to ensure that is happening, and how robust will that be? How confident are you that, as we extend digital technology in healthcare provision, we are not going to become more susceptible rather than less susceptible to these future attacks?

Sir Chris Wormald: Those are all the right questions, if I may say so.

Gareth Snell: Can I have all the right answers?

Sir Chris Wormald: It is a work in progress, as I think we said. Just to say a bit about the cost we put out—this was something the Committee asked for at the hearing—essentially we have done the best we can in estimating, although this is a top-down series of estimates, as opposed to a figure that the National Audit Office would recognise.

Chair: Yes, we know it is not an NAO audited number. So what is the number?

Sir Chris Wormald: We took the Committee's challenge of "Give us the best you can." I think it gives us the right quantum.

Chair: We accept it in that spirit.

Sir Chris Wormald: In terms of the report itself, the overall picture it paints is that we have done all of the things we said we were going to do, but we have an enormous amount of work still to do, both to implement the current system and continue to keep ourselves updated, given the evolving threats that we see across the economy. Of course, those have evolved quite a lot even since WannaCry, with various international actors.

The approach we are taking on the specific question you raise—the Secretary of State has been saying more about this today—is to try to work by multiple systems but common standards. Indeed, we put something out today about, "What are the common standards we expect to see everywhere in the health service, regardless of the individual systems used?" We are then arming health service bodies—this is set out in the report—with a much more detailed toolkit of how you assess yourself against what you should be doing.

Q5 **Gareth Snell:** So it will be a self-assessment process, as opposed to a third-party equivalent process.

Sir Chris Wormald: Yes. We give them the toolkit for self-assessment, and then NHS Digital looks across the top and you have to report to NHS Digital on what the toolkit has shown you. NHS Digital and others then follow up with the individual points.

The other really big thing that we have done in this space—I think we described it when we came to do the WannaCry hearing—is that cyber-security standards are now part of the CQC inspection regime, so when the CQC goes in to inspect things, one of the things they are looking for is, "How cyber-prepared are you?" The idea is that we have a set of local standards, and then national checks that are carried out.

Chair: We have got that. Thank you.

Q6 **Gareth Snell:** The other part of recommendation 19 said that there was going to be a large-scale test in autumn 2018 as a national cyber-rehearsal. Has that taken place?

Sir Chris Wormald: I do not think it has taken place. Let me write to you specifically on that.

Chair: Because I know autumn in the civil service stretches to January.

Sir Chris Wormald: Yes, it does stretch quite a long way. We have done a series of tests, some of them desktop and some others, but I will write to you specifically on what we have done there.

Q7 **Gareth Snell:** There is a second part of that sentence. It refers to one in autumn 2018, and the next large-scale test in spring 2019, so at what point does spring start in your calendar? We would be happy to know that as well.

Sir Chris Wormald: As I say, I will set out the details of what we have done, because there has been a series of small tests and then we were doing the ones you refer to. I will set it out for you.

Q8 **Chair:** You mentioned that the CQC is going to go in and inspect. What skill and expertise does it have in inspecting such matters?

Sir Chris Wormald: Obviously, the people with direct skills are in NHS Digital, which is working with the individual trusts. The CQC goes in and checks that the things that the trust is supposed to have done in governance terms have actually been done.

Q9 **Chair:** So there is a checklist of the bits of paper?

Sir Chris Wormald: Yes. One of the things we are doing, which was one of the recommendations in the report, was that all boards of trusts get proper training.

Q10 **Chair:** Just to be clear, the CQC is not going in to check if the digital systems are up and running.

Sir Chris Wormald: No. They are not doing the coding.

Chair: That is reassuring, because I do not think that is their skillset. I was just interested to see if they were having mission creep. That is fine.

Sir Chris Wormald: It is, however—

Chair: That is fine. Do we need to follow on? They are not looking at digital. That is fine.

Q11 **Gareth Snell:** I have just one final question. Given that trusts and clinical commissioning groups are responsible for sourcing their own software within their framework, having added the new caveat that providers have to be in line with these new regulations, what consideration has the Department of Health given to essentially closing down the market to one or two small providers that meet those standards, and therefore potentially driving up costs by driving out competition?

Sir Chris Wormald: We do not want that to happen. We want there to be—

Gareth Snell: I do not want it either, so I am asking what we are doing to stop that happening.

Sir Chris Wormald: Sorry, I am struggling to think of a specific thing we are doing to stop that happening. Let me go and check on that. I do not think we have seen that happen. I am not sure we have anything built in that actively prevents it, but let me go and check.

Chair: Mr Snell raises a fair point, because we have seen this narrowing of the field in many other areas of Government, so we are throwing that out as a warning.

Sir Chris Wormald: As I say, through the standards approach that the Secretary of State set out, we are trying to do the exact opposite. What we want is lots of people—

Chair: Let's hope that Gareth Snell's question is not a prescient one in the end; that we will have avoided that. We now need to move on to the main session, which is to look at the accounts. I am going to ask Mr Snell to kick off on that as well.

Q12 **Gareth Snell:** Sir Chris, can I start by looking at your overall budget figures? The 2017-18 statement suggested that the Department of Health had an underspend of £692 million. Can you think of any areas of NHS or health spending activity where that money could have been put to use?

Sir Chris Wormald: Well, let's just firstly explain what that underspend is. David?

David Williams: The underspend is against the parliamentary resource vote for the Department, which includes the non-cash ring fence covering depreciation and other accounting charges, and almost all of the underspend—in fact, more than 100% of the underspend—is accounted for

by underspend against that depreciation ring fence. It is not a cash-backed underspend, as it were; it is a technical issue in terms of the way in which the parliamentary vote for the Department is drawn. In practice, against our Treasury control totals, we were about £40 million over at the end of the year, so there was no headroom for additional spend or investment within the year in the way that you ask.

Q13 **Gareth Snell:** Okay, fair enough. Let's look at the other area where there was a recorded underspend, albeit maybe not in cash terms. That is the AME expenditure, which I know relates predominantly to your clinical negligence provisions. The figure that we have is that there was an underspend of £14 billion, which represents more than half of the budgeted amount for that figure. I appreciate that, given what that is used for, spending less of it is possibly a good thing, but would that not suggest that the Department is somewhat ignorant of its own exposure to clinical negligence?

Sir Chris Wormald: That is another one for David, but we were not happy to run up that number, although it is both AME and non-cash. We would want to be closer in our estimate.

David Williams: Annual management expenditure, by definition, is difficult to plan and forecast. The particular challenge we have with clinical negligence liabilities is that the current estimate of future liabilities is based on a set of assumptions, and is very sensitive to very small changes in those assumptions. For example, the difference between plus 1% and minus 1% on the discount rate is a £25 billion spread. The way Parliament supplies, the way our accounts are audited, and the way we manage this particular element of the budget naturally encourage a cautious and prudent approach to ensure that there is appropriate cover. It is not backed by tax measures; it is a technical measure of movements in future liabilities, and it is essentially set up so that all of the downside is if you underestimate it, rather than overestimate it.

Gareth Snell: I understand the risk, Mr Williams.

David Williams: Nevertheless, at 50% of the estimate, as you might imagine, we are having conversations with NHS Resolution about how we can tighten that up.

Q14 **Gareth Snell:** The reason that figure concerns me is that in February 2018, that particular budget line was increased by £13 billion to £27 billion, and within that year, you did not spend that much. In fact, you spent half again, so what I was trying to understand is how confident you are that the Department understands its own potential risk and exposure. If you are doubling budgets one year and then underspending by half the following year, that, to me, suggests that the Department of Health does not really have a clear understanding of its liabilities.

David Williams: The problem is that the annual charge reflects a movement in the totality of future liabilities over an extended period. The way NHS Resolution build up their view of that figure is based on actuarial input, and what we do in a supply process is pick a spot estimate for a

whole range of variables, whereas they are working—quite sensibly—for a range. In the supply process, we pick a prudent spot to ensure that there is appropriate parliamentary cover for the movement in liabilities. It is not that, between the Department and NHS Resolution, we don't have a good handle on the potential range of those variables. You have to be exactly right on all of them in order to get that number spot on.

Sir Chris Wormald: I think it is fair to say that we always, for the reasons that David has set out, take very defensive estimates on that.

Gareth Snell: Sorry, Sir Chris—

Sir Chris Wormald: Let me finish my sentence—

Q15 **Gareth Snell:** I understand the point that, with a number of variables, you are never going to get the number spot on, and I understand that you want to be prudent and considered. Do you think that having more than half of your budget left at the end of a year is both prudent and sensible?

Sir Chris Wormald: No, we think we should get closer than we already are.

Q16 **Gareth Snell:** So let me ask you this. That was for 2017-18. Do you happen to know, for this current financial year, what your estimated outturn is in its budget for that same expenditure?

David Williams: I don't have that at this stage, because the estimate is largely driven by an actuarial review, which, annoyingly, reports right at the end of the year.

Q17 **Chair:** The end of the calendar year?

David Williams: The end of the financial year. NHS Resolution will take an early cut of that actuarial advice at around the month nine point—around the end of the calendar year—to inform our input into the supplementary estimate process. The actual number is a consequence of the final actuarial valuation and engagement with the National Audit Office about whether the NHS Resolution accounts and their assessment of liabilities represent a true and fair picture.

Q18 **Bridget Phillipson:** Is there any way of aligning this process, so that you don't have these problems in understanding what is going on?

David Williams: I have asked, but apparently not. It is a question that I am asking again.

Q19 **Chair:** When you say "apparently not", is there an accounting reason why not, or is it to do with the internal workings of NHS Resolution?

David Williams: I think it is particularly to do with the relationship and internal workings between NHS Resolution and the Government Actuary Department about how far through the year we need to be in order to have a sensible actuarial update.

Chair: I can see that you can't do it too early.

David Williams: Yes.

Q20 **Gareth Snell:** I appreciate that we're not looking at this current financial activity, but what I want would be possible—I'm sure this would be possible—because you will know what Parliament voted for at the beginning of this financial year, and you will know roughly how much of that budget you have spent so far. Is that something that you can share with us later on? If we get to this point next year, clearly the model that we are using is not working.

David Williams: I do not have the first of those in my mind, but it will have been set out in our main estimates—I can absolutely give that to the Committee after the hearing. On the second point, it is not a budget that is spent through the year. We make an assessment of liabilities at the end and it is then a number—often a very large number. You only need a few of these assumptions to go in the other direction for it to become a very large negative number. It is not a track in progress—it is a point decision towards the end of the financial year that determines this number.

Q21 **Gareth Snell:** I appreciate that. Looking briefly at the list of NHS providers that are either in surplus or in deficit, do you happen to know how many of your NHS providers reported a deficit?

Sir Chris Wormald: For last year, I have the numbers in my head for how many were on plan, which is not the same thing.

Gareth Snell: No, it's not the same.

Sir Chris Wormald: A bit over 70% are on plan.

Gareth Snell: So 30% are not on plan.

David Williams: For 2017-18, 131 of the 234 providers were breaking even or in surplus—by a process of elimination, 101 were in deficit. Some of those would have been on planned deficits as opposed to overspend deficits.

Q22 **Gareth Snell:** So there will be a mixture of those that have accepted a control total as their deficit and those that simply haven't accepted a control total?

Sir Chris Wormald: Yes. Our measure of whether a trust is financially well managed is against the control total, not against breaking even. As part of the long-term plan process and longer-term investment, we want to get back to a position where those two things are the same—where you would expect trusts to be breaking even, rather than the slightly curious process we do at the moment of agreeing an overspend and then covering it from elsewhere in the budget. One of our objectives is to align those two things.

Q23 **Gareth Snell:** If I could ask the same question in terms of clinical commissioning groups, how many of them do you know have reported an

underspend or an overspend?

Sir Chris Wormald: I don't have those numbers in my head—

David Williams: In terms of the annual report and accounts, 75 CCGs ended the year with an overspend. That is on page 5 of the annual report.

Q24 **Gareth Snell:** Of those, do you know how many were small and manageable within variations that were acceptable? How many were huge overspends that would suggest that they are entering financial special measures or are looking for turnaround directors or the equivalent?

Sir Chris Wormald: In CCGs?

Gareth Snell: In CCGs.

David Williams: We could get that. I don't have the information to hand.

Q25 **Gareth Snell:** The point that I am trying to get at is that obviously you present the accounts for your Department as a whole, but really you don't have a great deal of control over the income and expenditure of trusts because they are dependent on contracts from clinical commissioning groups.

Sir Chris Wormald: Yes, and the challenge we set to the NHS, between NHSE and NHSI, is that the whole of the NHS is in balance. We have not set objectives for any individual institutions within that to be in balance. Basically, we expect the overspends and underspends to net off. That is a system that we put in in 2016, as you know.

Chair: We know.

Sir Chris Wormald: It is also a system—we may have described this to the Committee before, but the long-term plan is now our process for doing it—that we want to get out of. We want to get to a position where we are in balance at institution level as well as at system level. In terms of our accountability, it is to keep it in balance at system level.

Q26 **Gareth Snell:** So I suppose my question to you is how far away you believe that point in time is. I will give a very quick example. I represent a city whose CCG is about to be in financial special measures. I have a hospital trust that is hundreds of millions of pounds in deficit every year. It is cold comfort to me and my constituents when the whole system is in balance but the significant regional variations mean that there is a danger in some places to patients. Who is responsible for resolving that situation and protecting the patients in those constituencies?

Sir Chris Wormald: In terms of protecting the patients, we expect the NHS to go on meeting its clinical and access objectives regardless of the balance, although we expect a balance overall.

In terms of intervening in individual institutions, it is NHSI for trusts and NHSE for CCGs. In terms of your first question, about how long, one of the reasons we wanted a five-year financial settlement was to create a longer-

term flightpath where it was conceivable to put those things right. I would probably guess two to three years.

David Williams: I would think so. It is something we will agree with NHS England and NHS Improvement as part of the sign-off of the plan. One of the financial tests that the Government have set is that we should return to that more specific set of financial balances during the duration of the long-term plan. It absolutely won't be year 1.

Q27 **Gareth Snell:** This is my last question on this point, before we look at capital. Given that, in reality, a lot of this is wooden dollars being circulated around a system, and given that hospitals and trusts that are in financial special measures or haven't agreed a control total and the deficits that they accrue come with a higher interest repayment to the Department, and given that they cannot access sustainability and transformation funds and all the various other things, would it not be more financially prudent for the Department to use the underspends that are available from other areas to net this off across the system internally, as well as looking at it simply across the whole? That would therefore give greater longer-term financial sustainability to a number of institutions and CCGs, within that timeline of two to three years.

Sir Chris Wormald: Yes, that is largely what we are looking to do. The announcement that NHS England and NHS Improvement made about the changes to the financial architecture was the first step in that direction. I will not rehearse the reasons why we structured it as we did in 2016, but we were aware that by putting in the measures that were needed to balance the system as a whole—which was our first thing—we would create some perverse incentives at the local level. NHSE and NHSI have just begun unwinding those perverse incentives. It will take a couple of years and we have to do it without returning to the pre-2016 position, where we did not have final control.

Chair: But that is cold comfort to Mr Snell's constituents.

Q28 **Gareth Snell:** It is, and given that we then have a situation in which the deficits accrued by trusts are charged at a higher interest rate, you are building in longer-term unsustainable financial pressures.

Sir Chris Wormald: No, of course that is one of the things for David.

David Williams: As of today, only one trust is being charged 6% on new loans, so it is not a widespread rate that we apply. We apply 3.5% to those trusts that have not agreed a control total or are still in financial special measures but improving, but if you take the interest rates alongside the dividend payments on their assets, which they also owe the Department, the one largely balances out the other. At the aggregate level, the Department has put in—at the top, as it were—more money for these interest payments than we have got back. Table 39 shows that there is a net contribution of £75 million at the aggregate level. We absolutely need to understand the behavioural impact on individual organisations.

Picking up on Sir Chris' comments, NHS England and NHS Improvement have just launched a consultation on tariff for 2019-20. There is essentially a move to progressively put the full value of money—which is currently going into the sustainability and transformation fund, linked to control totals—into prices. We all want to end up in a position where providers are routinely able to generate through their activities the income that they need to cover the cost of those activities.

Chair: I can see this will now go on for an hour.

Q29 **Gareth Snell:** Not in this meeting. I will happily have a long conversation about market forces and how they disproportionately affect communities like mine, but that is not for now.

David Williams: Which is also up for review.

Gareth Snell: It has been up for review for a very long time.

Chair: It seem that everything is always on the move. That is one of the challenges.

Q30 **Gareth Snell:** My last point is on the £20 billion additional funding that is coming into the Department, which we will talk about later. Given the pay awards, the commitment to parity of esteem for mental health and the potential challenges post exiting the European Union, is it not possible that that £20 billion will be swallowed up by just existing, rather than achieving some of the outputs?

Sir Chris Wormald: No, we do not believe so. As I have said to this Committee before, it is not a sum of money that means there will be no tough choices to be made. While it is a very high settlement by recent standards and by the standards of the rest of the public sector, by historic NHS standards it is not that high. We believe—as our modelling suggests—that as well as meeting demand increases, there is headroom to address the kind of things we have just been talking about. But that is very dependent on the ability of the NHS to make productivity and efficiency gains, and to manage demand effectively. How much headroom there will be over the longer term depends on those two things.

Q31 **Chair:** That is a lot of words explaining how it would work in an ideal world. Can I drive you down to the capital issue? We have raised concerns about needing capital budgets to support day-to-day spending, so why are you continuing to do that?

David Williams: We undertook a capital to revenue switch in 2017-18, as planned at the time of the last spending review, and we plan to do so in this financial year.

Q32 **Chair:** Why are you still doing it?

David Williams: As we have set out for the Committee before, a judgment was taken at the time of SR15 that, exceptionally, it was better to put more money into day to day operations of the system at the expense of long-term investment through the capital budget. The bit I was

going to come on to is that my expectation is that with the application of new money through the long-term plan, we will not be making central capital revenue switches from 2019-20 onwards. We had planned to phase them out over a period of time. In the year covered by the accounts it was £1 billion. This year our plan is £500 million, and I think it will now be zero from 2019-20. In addition to that baseline position from the spending review, as the Chancellor set out at Budget '17, additional capital investment has been made available to the system.

Q33 **Chair:** Exactly. So you've got additional capital funding, and yet you are turning your capital into resource with the other hand, so why are you getting capital funding if you are not going to spend it on capital?

David Williams: It is just a device of how the spending review 15 baseline has been built up, on which we have then layered additional asks of the Government and which the Chancellor has then funded for specific programmes on top of the underlying core capital budget.

Q34 **Chair:** Can you name specific programmes?

David Williams: The main element, £2.6 billion over the period of the £3.9 billion that the Chancellor put in during 2017, relates to transformation investment through STPs, but it also includes some of the investment we made for urgent emergency care last year. It includes an element of investment in productivity gains, so e-prescribing and e-rostering systems as well as a slice for back-up maintenance and catch-up.

Q35 **Chair:** So for many starved trusts that have been thinking, "Good, maybe we'll get some of this capital to spend on creaking buildings and new bits of equipment," from what you have described a lot of it is going on transformation programmes, which is a legitimate expense in some ways, but they have got this long backlog now of lack of capital investment in physical infrastructure. What risks have you identified cost-wise and in terms of service to patients?

David Williams: In 2017-18, although the system underspent the capital available by about £360 million, the spend in the year was £5.2 billion, up £600 million in cash terms from the previous year, so we are beginning to see more money going on.

Q36 **Chair:** That is some of it, but we know that the assets, the infrastructure, have been starved of investment because of the way you have chosen to do the accounting to make sure you balance the books. What risks have you identified? Are you worrying about equipment not being bought and hospitals needing more money spent on them because of this backlog of work that needs to be done?

David Williams: Look, I absolutely recognise the fact that the capital budget has been tight over the last couple of years. It is beginning to relax now. As I have said to the Committee before, one of the challenges we face is our ability, both with the system and at local organisational level, realistically to plan and then manage the profiling of capital projects.

Almost all of the £360 million underspend last year was in the provider sector. Almost none of it was forecast until the end of the year.

Q37 **Chair:** Are you saying that was a programming issue?

David Williams: Well, it is something about the capacity and capability of the system as a whole to plan capital. There is an optimism bias about the rate at which money gets out of the door, even when money is available. On the backlog maintenance, it is not simply a capital constraint issue and therefore not particularly made worse by the capital-to-revenue switches. If you are a hospital where your goods lift is broken, if you call the engineers out to repair the lift, that is revenue; if you rip the lift out and put a new one in, that is capital. It is not a simple question of capital availability; it is a balance between capital and revenue.

Chair: We know that. It has been said that you are the man who manages the magic. You can explain away anything, Mr Williams. Bridget Phillipson next.

Bridget Phillipson: In advance of planning for Brexit, has any additional capital investment or spending been required in order to meet potential costs that may arise, in particular in the event of no deal?

Sir Chris Wormald: So far, the only money that we have spent has been on the non-medicine supply chain, which the NHS is responsible for providing for itself. In stockpiling medical equipment, basically, we have authorised expenditure—I cannot give you the exact figure because it is commercially confidential—in the low 10s of millions on creating the stockpile and on warehousing space. That is the only direct money that we have spent.

Q38 **Chair:** What particular bits of medical equipment are you stockpiling?

Sir Chris Wormald: Well, everything. Our stockpiling comes in two parts: there is the medicines part—

Chair: Yes, you mentioned that, but then you were talking about equipment, so which bits of equipment are you stockpiling?

Sir Chris Wormald: And then medical equipment, which is basically anything from rubber gloves—

Chair: So which bits of medical equipment are you having to stockpile?

Sir Chris Wormald: We are building up a central stockpile, basically, of all consumables in hospitals—

Chair: Give us some examples. Do you mean gloves, dressings—

Sir Chris Wormald: Gloves, dressings.

David Williams: Syringes.

Q39 **Chair:** Anything that comes from outside the UK, basically?

Sir Chris Wormald: Yes, and through the EU—I was reading this at the Exiting the European Union Committee this morning—which is about 56% of our medical consumables.

Q40 **Chair:** So over half of our medical consumables come through the EU?

Sir Chris Wormald: Yes.

Q41 **Chair:** That is a challenge of quite some scale. How many weeks of stockpiling will you have?

Sir Chris Wormald: We are aiming for a six-week stockpile across medicines and the rest. That is the only direct money that we have spent so far, other than staffing costs. We have made it clear, and I said it this morning to your sister Committee, that we are analysing the returns that pharmaceutical companies have given us—

Chair: We know you touched a lot on medicines this morning, so we are not going to cover all that now. Ms Phillipson.

Q42 **Bridget Phillipson:** What about big-ticket items? Are you having to stockpile, say, X-ray machines or anything like that? You talked about gloves, syringes and so forth.

Sir Chris Wormald: No, we are not. We are doing the things that you consume day to day.

Q43 **Chair:** Just on the big items, I do not know where we get, say, X-ray machines, but if there is a big supplier within the EU, have you put in place any mitigations or any advice to trusts about whether they should be purchasing such things before 29 March, planning for that process?

Sir Chris Wormald: We issued advice to trusts last week—

Chair: Last week? Not 12 months ago—

Sir Chris Wormald: Not on that specific issue. We asked them to look at the contracts that they hold for the provision of everything; to look at the Brexit consequences. We are not currently saying anything about those big items, because obviously they accrue much more slowly.

Q44 **Chair:** You are saying something, but are you confident that trusts have got to grips with the challenge that they might face? If they have a crumbling bit of equipment that they were planning to replace, but perhaps had not got as far as that yet, they now have five and a half months to go. They might have a problem replacing it if they don't do it now, or order it probably now in time for delivery before 29 March—potentially, working on a worst-case scenario.

Sir Chris Wormald: We would expect trusts to be thinking about the—

Chair: You would "expect" them, but are you aware they are?

Sir Chris Wormald: But we have not communicated with trusts on that particular issue.

Q45 **Chair:** Have you had feedback from trusts or the provider bodies about this?

Sir Chris Wormald: Not to my knowledge, no.

Q46 **Chair:** What level of risk do you think is out there?

Sir Chris Wormald: I would have to go to look at that specific question. It is not one of the ones that people have raised with us.

Q47 **Chair:** You talked this morning about things that keep you awake at night. Is this something that keeps you awake at night, because you don't seem to know much about it? I am worried that it is not keeping you awake at night because it is just not one of the very top things, or that it is not keep you awake at night because you haven't looked at it yet.

Sir Chris Wormald: To be honest, that particular issue of big equipment has not been on my radar. I described this morning the things that were on my radar, but I will see what we know about that question—

David Williams: It is not a category of equipment that is particularly time-sensitive.

Chair: We appreciate that there is a big difference between that and consumables. Ms Phillipson can speak to that one.

Q48 **Bridget Phillipson:** As I understand it, you say that you are not giving advice to trusts and providers on the big items, but are you aware of trusts and providers taking action to stockpile larger-scale items?

Sir Chris Wormald: No. As I say, this has not been on my radar.

Q49 **Chair:** We would like you to write to us about that. On the capital issues, PropCo obviously took over a lot of properties from local areas when the Lansley reforms came in during 2011. Will those PropCo bits of the estate be able to bid for the capital budget in the same way as local trusts?

David Williams: Yes.

Q50 **Chair:** On a level playing field?

David Williams: Where capital plans come in on a multi-organisational level, as an STP pitch, it is entirely reasonable and appropriate for Property Services' property and investment to be part of that. Otherwise, I agree a capital budget with Property Services on a rolling annual basis, to allow them to invest in their property.

Q51 **Chair:** You talk about collaboration on these projects. Will the local estate strategies work? We hear quite interesting stories about how hard it can be to work with PropCo. These assets were local, and everybody had an idea about the future plans. Some of them—one almost thinks by a stroke of the pen, or a mistake, in some cases—went into PropCo, which

is an anonymous body with no real local accountability. Are you saying that any estate management plans involving a PropCo premise are easy to do and have no particular special challenges, in capital funding terms?

David Williams: It is an extra organisation to join up with, and it is not an organisation that is routinely around the table on other issues in an STP footprint. However, we are specifically interested in STP-level estate strategies covering the totality of NHS property, not simply provider or provider and commissioner.

Q52 **Chair:** In the accounts, those assets are, importantly, on the books. Any attempt to do an estate deal locally might diminish that asset in some way, because you might have plans to sell it, to gain capital for the centre, or to pass it back, or parts of it back. There are all sorts of configurations. How much do you see it as a financial asset, and how much do you see it as an asset for the NHS to deliver services to patients?

David Williams: Primarily the latter. Routine disposals or capital investment by NHS Property Services is, from memory, about 10% of the NHS estate. It is not negligible, but it is not the lion's share of property at the local level.

Q53 **Chair:** So if a local body came to you about a PropCo property in their area and said that they could really use the asset for good, local services, would you be willing to consider that, or perhaps be willing to transfer it back to the local trust, if that was the most sensible way to run it?

David Williams: Yes.

Q54 **Chair:** That is very helpful. Thank you very much. Quickly on the pay award, there has been some concern. Doctors have been in touch with us, worried that their pay award has been delayed—for the first time ever, I think—from when it was announced until now. Will you fund trusts for the pay awards for those staff who are getting them?

Sir Chris Wormald: For this year?

Chair: Yes.

Sir Chris Wormald: It is contained within the overall NHS budget.

Q55 **Chair:** The simple question is: are you fully funding NHS trusts—yes or no?

Sir Chris Wormald: For doctors' pay, they have to meet it out of existing budgets.

Q56 **Chair:** So it is a pay award, but it is taking. Have you looked at how many staff they may have to lose in order to pay their existing staff this pay award?

Sir Chris Wormald: That is how we set the pay award. We believe that it is affordable within the existing budget. That is the calculation we made.

Q57 **Chair:** That is a different question. You just said that it is affordable

within the existing budget. Have you looked at whether that means a diminution in staff numbers as a result?

David Williams: We funded the Agenda for Change pay award for 2018-19. If you broke down the doctors' pay review body recommendations, for which no new money has been put in, the bulk of the cost relates to GPs. The staging of the awards for consultants and junior doctors means that the 2% is containable within the 1% budget in provider baselines. We chose not to stage the specialty and associate specialist doctors, but that is less than £10 million in total across the system. This year, it is essentially a GP cost, which we backdated to April.

Q58 **Chair:** So in future will you build this into the baseline budget? You are a magician. How will you translate that clever sophistry this year around the numbers—the delay and making sure that it is under the 1% cap—into next year's settlements?

David Williams: The advantage of staging for the individual, as it were, for a given level of investment in pay, is that they will start next year with a 2% pay award, rather than 1%.

Chair: Yes, but the 2% pay rise could be funded by those trusts. Will they get the extra money for that?

David Williams: We will be going back to a system. This year, because the pay award was agreed partway through the year, in conversation with NHS England and NHS Improvement we chose not to reopen tariff and pricing. However, the uplifts for the consequences of this year's doctors' pay review body and the continuing multi-year Agenda for Change pay deal will be factored into prices and tariff—

Q59 **Chair:** This is getting quite Kafkaesque, isn't it? We asked the question: are you funding it? What you're doing is actually putting up the tariff prices to fund the pay increase next year, and the tariff prices are paid for by the clinical commissioning groups. So where is the money coming from to pay for pay rises? You're squeezing the CCGs, or am I being dense?

Sir Chris Wormald: In a way, it's a bit simpler than that. We have set the pay awards so that they are containable within what we put in the NHS baseline this year. For future years, the long-term plan will need to have a pay assumption in it and you will need to contain NHS pay within whatever that assumption is, or you will have to trade it off against other services. So we won't be topping up what we have already announced for the NHS for future pay awards. We are saying that there is a sum of money and we will have to decide, year by year, what goes into pay and what is traded off against others.

Q60 **Chair:** Will all of this be covered in detail in the plan when it comes out next spring?

Sir Chris Wormald: It will have to include an assumption about pay, as we do—

Chair: I think the devil will be in the detail.

Sir Chris Wormald: Yes, it will. The money is what it is, and it can only go on either pay rises or on other services—

Chair: Professor Williams, you have always got to watch for that sleight of hand. Mr Snell.

Q61 **Gareth Snell:** To me, that is as clear as mud, to be quite honest.

Sir Chris Wormald: No, I don't—

Chair: Mr Snell can ask some questions that will help to clarify this.

Gareth Snell: To me, whatever your intention was, that was as clear as mud.

Sir Chris Wormald: There is a pot of money for the NHS. That is not going to go up or down. A percentage of that can be used for pay and you have to decide how much pay, just like any other—

Q62 **Gareth Snell:** My question is this: when you say that you have to decide how much, who will get the ultimate responsibility for whether that money is passported through for pay? And where you have CCGs that are using private providers outside of the various terms of Agenda for Change, or hospital trusts that have contracted out to various other third-party employers, how will changing the tariff not just mean that you are paying more money to people who are not on Agenda for Change terms, as opposed to trusts, which should have Agenda for Change staff?

Sir Chris Wormald: I am sorry, but I am not sure that I understood the question.

Q63 **Gareth Snell:** So that is about as clear as mud to you, is it? *[Laughter.]* You have basically said that you are putting the money into the CCGs and that can be reclaimed through the tariff, as an activity-based income stream, to pay for trusts' liability for the pay award. So my question is as follows. Where trusts have a third-party agreement for a contracted-out service inside their trust, or where a CCG has a contract with a private provider rather than an NHS provider—as certain CCGs in my constituency have—how will you make sure, first, that the providers inside trusts that are not on Agenda for Change terms can either get that pay award or be ruled out? Secondly, if you are changing the tariff only, how will you be certain not to give more money to private providers, where the Agenda for Change terms do not apply because they are a private employer?

David Williams: I will answer that in two parts. First, this year for Agenda for Change we have specifically uplifted the NHS budget, and because we are doing spot payments, as it were, we are targeting individual NHS providers and looking at directly employed Agenda for Change staff on the permanent payroll, but we are also now putting in some additional top-up for staff in contracted-out services where there is a dynamic link to Agenda for Change terms, so that some of that money will flow through as well.

When you are putting money into tariff there is necessarily some leakage at the margins, because you then set a rate regardless of the provider, so putting the money into tariff specifically does not address your second concern, but it is routinely the way in which—until this year, exceptionally—pay rises in the NHS have been handled. Even under a period of pay restraint where we were looking at a 1% uplift, it was a 1% uplift in tariff, which would not have been confined simply to NHS providers employing Agenda for Change staff. That becomes a financial issue for NHS England to manage within its mandate.

Q64 **Gareth Snell:** Just one quick follow-up: given that the market forces factor in the tariff sets a different rate of regional worth to an individual working for the NHS, a 1% uplift in the tariff for an operation carried out in Stoke-on-Trent would deliver a much smaller increase than that for a London-based hospital that might do the same operation, but the pay award would be the same because it is a national pay scale. How are you dealing with those differentials?

David Williams: That is primarily for NHS England and NHS Improvement, but as I understand it—

Gareth Snell: Sorry, I thought it was the Department of Health and Social Care.

David Williams: The review of the market forces factor that they are planning to undertake as part of their financial architecture for next year will look particularly at changes or differences in regional pay.

Q65 **Gareth Snell:** But that does not address the fact that the system you have been using for this year to make the pay award will have seen disproportionately larger increases to cover pay awards to trusts based in areas that are deemed to be more affluent and therefore to have higher costs than to trusts that have a lower funding rate because they are reckoned to be in poorer areas, even though the pay award is standard across the piece on a national pay scale.

David Williams: I would have to think about that.

Gareth Snell: Please do.

David Williams: I think we have, as far as we are able to, targeted the uplifts to reflect the costing—

Q66 **Chair:** We may want to follow this up with a letter, because the other concern is where you have trusts that routinely send a lot of work to the private sector, which is now quite an established way for the NHS to work. The tariffs will go there for the CCG, and some trusts will just have less volume going through. I know there is a market incentive to try to increase that, but in the meantime it means their baseline will be severely affected. A volume London teaching hospital that has a specialist centre may do better than—for argument's sake—Stoke-on-Trent, which may not have the same volume of that specialism. There are many variable factors in this, yet they all have to pay the same rate to staff. I think we will write to you, Mr Williams, unless you want to add a bit now.

David Williams: Actually, no; I don't want to add a bit now.

Chair: Very wise. We will look forward to the letter and we will crawl over the detail, as you might expect.

Q67 **Bridget Phillipson:** For quarter 1 of 2018-19, NHS Improvement is still reporting a large vacancy rate within the NHS—108,000 vacant posts. How well is the Department bearing down on the issue of temporary staffing costs?

Sir Chris Wormald: We work very closely with the NHS on agency costs, as I think we have described to the Committee before, and that has continued to decline. The main thing we have been driving at is a shift from agency work to bank. There is nothing wrong with having a flexible workforce in a system such as health; there are all sorts of reasons why you would have a number of vacancies at any one time. What we want is to have those covered in a cost-effective way by bank staff rather than very expensive agency staff.

Q68 **Bridget Phillipson:** You're right; we have covered this before. But obviously the difficulty with bank staff is that, although it might be nice for some NHS staff to have the opportunity to work a bit more or earn a bit more money, you are still relying to a degree on some of the same people doing the work, but just working more.

Sir Chris Wormald: Yes.

Bridget Phillipson: I am not sure whether it is really sustainable to be asking more of the same number, or in some cases a lower number, of people.

Sir Chris Wormald: No, and clearly what we want to see overall is more permanent staff so you have fewer people covered flexibly—although you would probably never want to get down to zero—and those people who are covered flexibly being covered by bank staff rather than agency staff. We are trying to shift down the system. Another of the things that we want to see in the long-term plan is a very clear workforce plan for the NHS that begins to address those shortages. There is certainly no magic to any of this—you have to do the classic things. We need to train more, which we are doing in a number of cases, and we need different routes into professions. We need to retain more, address some of the reasons why people leave the NHS and then, for our whole workforce, make sure that they can work flexibly if they want to and have that as a positive advantage in what the NHS does, rather than a disadvantage.

Q69 **Bridget Phillipson:** That is all right; I accept that. How much more difficult is that in the light of the uncertainty around staffing that arises from Brexit?

Sir Chris Wormald: We were discussing some of that this morning. We have not seen a large exodus of staff since the referendum. Indeed, the number of people in the NHS from the EU has gone up, not down. So we have not seen any challenges there.

Q70 **Bridget Phillipson:** We have seen a big drop-off in the number of nurse registrations though.

Sir Chris Wormald: We have seen a large drop-off in the number of nurse registrations on the NMC register, which appears to be driven largely by changes to the language test, which we are looking at. We have not seen that in other workforces, so there is something going on there, but we do not believe that it is directly Brexit-related.

Q71 **Bridget Phillipson:** When was the language test changed?

Sir Chris Wormald: It was changed at almost exactly the same time as the referendum.

Q72 **Bridget Phillipson:** On the graph, in July 2016 the figures just fall off a cliff edge.

Sir Chris Wormald: When the language test was changed for doctors, we saw the same thing but it happened at a different time. As I said, we are not seeing that in other workforces. The overall numbers remain high, and I will repeat what I said earlier: one of the most important things is that we continue to communicate with all our European staff about how valued they are in the health service.

Future risk is more about future immigration policy than about Brexit specifically. We continue to have more staff, both in health and in social care, from non-EU countries than from EU countries. Later this year the Home Office will set out its immigration White Paper, and we are in close discussion with them about the various medical workforces and, as you know, we have already made some changes. As the Secretary of State set out on "The Andrew Marr Show", we want to expand the British workforce so that we are not so reliant on overseas labour, but we also want to continue to be somewhere that the world wants to come to work.

Q73 **Bridget Phillipson:** We all want that. As an example, in Sunderland we have a new medical school that will be recruiting, but the time that it takes for those doctors to be qualified and able to work in the NHS is a long lead-in-time. In the meanwhile, in the north-east our issues are less focused on Brexit and more on how we grow our own. With some big vacancy rates in particular specialisms—it is not just nursing across the board, but care of the elderly, for example—I do not know what we are doing to respond to that.

Sir Chris Wormald: Yes, we are looking at that. As I say, when we look at the impact across the whole workforce, it does not look particularly dramatic. What we are doing currently is drilling down into both specific geographical areas and particular specialisms where the impact might be greater.

Q74 **Bridget Phillipson:** We look at these things quite a lot, but what I am keen to know is what is actually going to happen to address them. I have raised with you on a number of occasions the issue of the north-east carrying quite a high vacancy rate in some areas. We know it is there; it has been a problem for a long time and it is not new. What is going to

change?

Sir Chris Wormald: As I say, there is no particular magic answer, beyond relentlessly doing the things that we are already doing, including the medical school changes that you described. There is no quick fix to those problems.

Q75 **Chair:** Ms Phillipson is right; the pipeline for doctors alone is slow, but so is even changing a recruitment pattern. If, for example, there is a huge drop-off in nurses and other professionals from the EU—there are some very stark figures from the royal colleges and others—you have got to develop a whole recruitment system overseas while you are growing your own in the UK. The Filipino nurses programme is well worn and well trodden but it must have taken some time to set up—people come for three years and get a lot of support at the beginning to help them get settled, housed and so on. How long will it take for you to set up a scheme?

You have got the Migration Advisory Committee's advice, which needs a decision from Government. When you have got that Government policy, from that point how long will it take you to set up a scheme to replicate, for example, the Filipino nurses scheme in another country, if that was the agreed approach?

Sir Chris Wormald: As you say, there are already a number of schemes ongoing. I will write to you and set out what we are already doing. Mainly we will be scaling up things that we already do.

Q76 **Chair:** So, more Filipino nurses.

Sir Chris Wormald: I do not know whether that one is due to expand.

Q77 **Chair:** Can you give us an example of any that are being scaled up?

Sir Chris Wormald: We are certainly looking at GP recruitment.

Q78 **Chair:** That was a great success. I think you recruited fewer last time after the last run.

Sir Chris Wormald: Our challenge on GPs has been on retention, rather than recruitment. Training numbers are actually going up and some of the recruitment numbers are good. The challenge with GPs has been retention.

Q79 **Chair:** Have you been asking the Treasury to look at the pension issue? It is not just GPs—

Sir Chris Wormald: We have been discussing the issue. As I am sure you know, it is extremely complex.

Q80 **Chair:** It sounds like there is no shift from the Treasury on this at the moment.

Sir Chris Wormald: Any changes from our Treasury friends would be announced in the usual way at a fiscal event.

Q81 **Chair:** Possibly on 29 October.

Sir Chris Wormald: That is not a matter for us.

Q82 **Chair:** Okay, but the pensions issue, for example, is not just a frivolous question. A quick change on that could stem the flow of GPs and other senior medics leaving the profession. If it is not signalled and then dealt with quickly, we will see the same outflow that we are seeing in the Royal Colleges or with those who are expressing concerns.

Sir Chris Wormald: I would not want to leave you with the impression that it is simply that pension issue.

Q83 **Chair:** No, but that is one practical issue that could make a difference quite quickly.

Sir Chris Wormald: When we have discussed with GPs why they are leaving—this is entirely qualitative, not quantitative—it appears that some of the pension changes trigger the thought, but a lot of the underlying cause is some of the other things we have been looking at, so GP workload, GP indemnity and so on. The pension changes have triggered a wider concern, but they are not the sole cause.

Q84 **Chair:** I was not for one minute suggesting that it was the sole issue, but it is a quick potential fix. At the stroke of a pen, the Government could shift on that. You are lobbying the Government on that.

Sir Chris Wormald: We discuss these issues with the Treasury the entire time.

Chair: Perhaps "lobbying" is unfair, as you are a civil servant. Civil servants never lobby; only politicians do that.

Sir Chris Wormald: The pension changes were made for very good reasons.

Q85 **Chair:** We have touched on GPs, and you are trying to recruit from overseas. You have got a programme there. You are having discussions about pensions. What else? What other precise examples of schemes are there? I am not just talking about medics.

Sir Chris Wormald: There's been a whole series of things. There are the things we have been doing around nursing associates, physician associates, apprenticeship programmes—

Q86 **Chair:** These are newly created professions. That takes a while to get through, surely?

Sir Chris Wormald: Yes. Those are all in train.

Q87 **Chair:** What will be coming to fruition in March or by March next year? You have got five and a half months to go, so if you have not started it now, it will not happen. Let us take the ones that are already under way.

Sir Chris Wormald: We are not projecting in any Brexit scenario that there will be some sort of big change on 29 March.

Q88 **Chair:** No, but the change is happening now. We are seeing the drop-off

now.

Sir Chris Wormald: Yes, and we are building up the programmes I am describing.

Q89 **Chair:** You are building up programmes, but are you getting people into place or working with NHS England to get qualified people into place so that that drop-off is reversed in the next five and a half months?

Sir Chris Wormald: Just to be clear, we have not seen a drop-off. Overall, the numbers from Europe have gone up, not down.

Q90 **Chair:** Okay. I have got some evidence that we have received. I may write to you on that—

Sir Chris Wormald: There are some specific challenges on nursing, but when we look across the piece, we have more employees from the European Union than we did at the time of the referendum. There are specific challenges on nursing, where we are doing the things I have just described. I can write to you with a lot more detail about what we are doing, but those are the things.

Q91 **Chair:** I think that would be very helpful. We have got five and a half months to go, and we are seeing real concern about whether we will have the right people in the right jobs. Given all the other challenges that the NHS has got, this is a headache it could do without. Practically, what do you need to do between now and the end of March to see whether you can help ensure that we have got the right people—

Sir Chris Wormald: The point I was making—I will write to you with the details—is that this is not something where there is a March break point. We have a series of workforce challenges that you have described, many of which predated Brexit and many of which will continue post-Brexit.

Q92 **Chair:** But there is a March break point, Sir Chris. Whatever happens on 29 March, EU citizens will not be able to newly arrive in the UK and be able to practice as a doctor or a nurse, unless under the Migration Advisory Committee rules, which are yet to be finalised into policy. What happens?

Sir Chris Wormald: We, with our Home Office colleagues, will be setting out the immigration policy in the White Paper.

Q93 **Chair:** But if I were a nurse or a doctor working in France, Germany or Denmark now, and I had to start thinking about upheaving my life and my family to come and work in a hospital in London, Sunderland or Stoke, I might need to be thinking about that now—at least, before the end of the year. What you are saying is that we do not have a policy in place for the migration rules, because although the ideas have been put out there by the Migration Advisory Committee, there is no policy yet. Then you have to have a plan in the NHS and the Department of Health to make sure you are facilitating that, through any other mechanisms. At what point do you need decisions made in other parts of the Government so you can get that going? I think we are probably already running too

late, aren't we?

Sir Chris Wormald: As I say, we are not expecting there to be a big break point in March. Would it be easier, again we covered a lot of this—

Q94 **Chair:** Sorry, but we already have a lot of EU staff in the British NHS and after 29 March, almost whatever happens, they will not be able to come back in unless they are on a special list. There is no certainty at this point that if you are working in a European country you could come and work here. There will be a drop off.

Sir Chris Wormald: This is exactly what I was going to say. Our challenge, which I was describing this morning, is around the certainty we can give people and no, at this moment, we can't give the kind of certainty we would ideally like, for reasons that I suspect everyone understands.

Q95 **Chair:** So all the other bits and pieces are really tinkering around the edges, because we have a catastrophic problem?

Sir Chris Wormald: No, I think you are over-playing the numbers that come from the EU. That is a relatively small proportion of our workforce flow. We have a lot of wider workforce challenges, of which this is one part.

Q96 **Chair:** Really? I have looked at some of the figures and, depending on which you choose, there are differences in professional groups. We have highlighted nursing as one where there are high numbers. I am a London MP and if you go into any London hospital, there are an awful lot of European citizens working there. You say it is not a significant number. They are here now and they should be safe to stay. A number of them are already leaving because they are not happy to stay.

Sir Chris Wormald: As I say, we are not seeing that in the—

Q97 **Chair:** Well, I will write to you with the evidence we have received, but then new people will not be able to arrive.

Sir Chris Wormald: That is a question for future immigration policy.

Q98 **Chair:** Are you lobbying the Government?

Sir Chris Wormald: This is sounding like we are disagreeing with each other but we are not really. *[Interruption.]* I can't remember what I was going to say now.

Q99 **Chair:** We recognise that it is not all in your bag.

Sir Chris Wormald: As I said this morning, one of our great challenges around all our exiting the European Union questions is that we would like give people more certainty than we are currently able to. Everybody understands why and that is just the reality of the world that we currently live in. What you are highlighting are the problems that we face around those questions. The point I was making was more that this is a subset of a set of wider workforce questions that we have around growing our own

and future immigration. I am not particularly disagreeing with your central point.

Chair: I will write to you with some of the figures that I have, but we don't have time now.

Q100 **Gareth Snell:** Briefly, the date we all need to worry about is 21 January, because that is the date by which the political declarations have to be made or there will be an assumption that there will be no deal. In your worst-case planning, would 21 January to the 29 March be enough time for you to implement whatever it is you are planning as being the worst-case scenario?

Sir Chris Wormald: Again, as I said this morning, we don't have a single date for when we have to start implementing things for a no deal, which is why we have already started stockpiling medicines and in other areas. Whilst that is the political deadline, our real-world deadlines happen when they happen. That is why we went ahead with our stockpiling in advance of that. There is not a single date for us. That date you mention does not particularly resonate.

Gareth Snell: That's good to know.

Q101 **Bridget Phillipson:** Finally on this point, and then I will move on, I appreciate your point, Sir Chris, that Brexit is only one factor in some long-standing—

Sir Chris Wormald: I'm not trying to downplay its importance. I'm just saying that it's one factor in our workforce challenge.

Q102 **Bridget Phillipson:** I understand, but we are reducing the potential for people to come from the European Union to work in this country, and it is not clear to me that we are going to get a more liberal immigration system for those outside the EU post Brexit. Nothing I've heard from Ministers suggests that. You are telling me that the majority of people who come to work in the NHS will come from outside the EU, but it is not clear to me that we are going to say, "Let's reverse years of Government migration policy and make it far easier for people to come to the UK to replace EU migrants."

Sir Chris Wormald: We have already made changes to the tier 2 visa route for doctors, which go in the opposite direction to the one you are describing. I am not going to speculate on future policy. We have seen examples like that, where we have changed the immigration system to make it easier for the NHS to recruit staff. Where we have challenges, we would expect the Government to continue to do so in the way that my Secretary of State described on "Marr" on Sunday.

Q103 **Anne Marie Morris:** Sir Chris, the title of the Department has now changed, so you cover social care as well as health.

Sir Chris Wormald: We always covered parts of social care, but we have changed the name, so we are now DHSC.

Q104 **Anne Marie Morris:** The workforce in this area is quite important. I have

got two questions. First, how much engagement do you have with strategy, in terms of numbers, planning, etc.? Secondly, is there going to be a transfer of budget between Departments so you can look at how this gets funded?

Sir Chris Wormald: On the first question, we look at that a lot. Indeed, this Committee had a hearing on what we do around that. The MAC report picked out the adult social care workforce for particular description. As you know, there were some big challenges there for us.

On the second question, no, we haven't done any budget transfers between Departments. As I think you know, adult social care is a local authority budget. It doesn't come from the national taxpayer. We oversee, with our colleagues at MHCLG, what local government spends on social care. It is not direct spending by DHSC.

Q105 **Anne Marie Morris:** Post Brexit, social care is probably going to be even more heavily affected, certainly in rural areas like mine. The number of people who come from—

Sir Chris Wormald: Yes, and as I said the Migration Advisory Committee specifically picked out the adult social care workforce for attention in its report. We discussed with our Home Office colleagues what we might do about that for the immigration proposals coming out later this year, so we recognise that.

It is a completely different position from the NHS, in that we are not the employer—as you know, it is a number of private organisations—but the actual make-up of the workforce is very similar. We draw on the rest of the world more than on Europe, but we have a significant and much-valued European workforce. Again, it is something we are looking at, even at the macro level of the total workforce the numbers may not be huge in individual local areas. I don't know about your one, but in individual local areas it can be a very significant thing, and we are looking at it. Those discussions are under way. Again, there is no magic answer that I can give you today, but it is very much on our minds and our agenda.

Q106 **Chair:** We have discussed your role in shaping that market and the challenges in different areas a lot. We will leave that there for now.

Sir Chris Wormald: On the specific point of whether we are thinking about that in the context of exiting the European Union, yes we are.

Q107 **Chair:** There will be a lot of people without staff if the recruitment pipeline dries up.

Sir Chris Wormald: Yes, it is a challenge.

Q108 **Bridget Phillipson:** Since the Department was renamed, what has actually changed in the way you approach things?

Sir Chris Wormald: It certainly has, as you know—

Gareth Snell: This is reassuring, Sir Chris. You haven't actually said anything.

Sir Chris Wormald: It certainly has a lot of prominence in the national debate. We have a Minister of State for social care, who was not there before. As you know, we are developing our proposals for a Green Paper and the spending review, which will be the determinants of action.

Q109 **Bridget Phillipson:** How much did the rebranding cost?

Sir Chris Wormald: Almost nothing.

Q110 **Gareth Snell:** So something?

Sir Chris Wormald: It was a few hundred pounds.

Q111 **Chair:** Cheap signs, then.

Sir Chris Wormald: We haven't changed any physical signs. At my Leeds office, where they still have physical signs, they still say "Department of Health". We are only replacing things when they run out. When we run out of paper, we change it.

Q112 **Bridget Phillipson:** It doesn't sound like much else has changed, really. You have got a new Minister.

Sir Chris Wormald: As I say, the meat of what the Government will be doing will be in the Green Paper and the spending settlement. That will be the test.

Q113 **Gareth Snell:** What responsibilities does the new Minister have that were not part of the Department of Health's overall responsibilities prior to their existence?

Sir Chris Wormald: The big change was about the ownership of the future plan for social care and the Green Paper, which was previously done in the Cabinet Office and by Cabinet Office Ministers. In terms of the thing that changed, it was that—

Chair: I am sure that reassures patients an awful lot. I am sure they are jumping up and down in Sunderland and Stoke at the excitement of that.

Q114 **Bridget Phillipson:** It is just because it is such a big, pressing issue facing the country. I appreciate we have spent a lot of time talking about Brexit, but it is a big issue.

Sir Chris Wormald: Yes, and that is what I said to Ms Morris: we do place a lot of focus, particularly around the workforce, on social care. It does not have the other issues that arise in health that we talk about in exiting the Union, but workforce is very high up our list.

Q115 **Bridget Phillipson:** How are things are going for this winter?

Sir Chris Wormald: When we look at last winter it was obviously a very big challenge, with very high demand—quite, cold and a difficult flu position. I think it was generally believed that the NHS's planning for winter last year was an improvement on what it had done previously, even though it was happening in a very challenging circumstance; and the NHS is basically replicating what it did last year in terms of its—

Q116 **Bridget Phillipson:** Is it the same level of financial resource for winter planning this year as last?

Sir Chris Wormald: Well, we have just announced what we are doing on winter funding this year, which is mainly focused on social care, as it happens. The Department has been saying some things about this today, putting meat around what was said at the Conservative party conference about putting £240 million into extra care packages in local government with the aim of using that to be able to free up bids in the NHS. It is very focused on the delayed transfer of care issues.

Q117 **Bridget Phillipson:** There is no additional funding going directly to trusts to manage winter pressures this year?

Sir Chris Wormald: No. We concluded—it goes to your previous question about the focus on social care—that this year the most important focus needed to be getting people who should not be in hospital out of hospital and back into the community, which is why we have chosen to invest in social care as opposed to the NHS this year. Obviously we did put extra resource into the NHS anyway this year, at the last budget, so there are additional resources, not specifically for winter. The two big changes at national level are that we have done that considerably earlier than we did last year—I know this Committee was very critical of us putting money in late last year, so we have done it well in advance of the budget—and we are putting it into social care and the hands of local authorities as opposed to direct into the NHS. Those are the two changes.

David Williams: Just as the ask from the NHS was for agreement to some targeted capital spend, rather than revenue, so we have agreed £145 million of capital investment to increase NHS bed capacity and we announced earlier in the year I think around £36 million of investment in new ambulances. Again, we are hoping those will come on stream for this winter.

Q118 **Bridget Phillipson:** Equally, when it comes to the long term, winter comes around every year—the winter crisis in the NHS seems to come every year. The analogy I have heard is with the energy sector. The Government ensure that year-round there is capacity in the system to ramp up where necessary. Yet we seem often to still be quite reactive. I take on board what you said about social care, but we end up throwing money at things in the short term, rather than providing that stability across.

Sir Chris Wormald: This has been quite a long argument and, indeed, several years ago, before my time, we ceased making winter allocations and built it into the baseline, and gave it all to the NHS at the beginning of the year. That was also criticised as the Government not providing extra resources for winter. There has to be a balance between the two. The NHS does plan all year for winter, as you would expect, and it does build up its capacity in advance. This year, again building on what we did last year, we are seeking a more appropriate flow of elective activity, rather than expecting a lot of elective activity over winter and then having to cancel it. The NHS is in a constant state of doing those things.

The challenge we saw last winter was that demand went beyond the capacity that had been put in. As I am sure you all know, the NHS treats more people every year and has gone on doing so—it is just that demand, particularly last winter and particularly related to flu, went beyond that. It is not that the NHS does not think about it and plan for it; it is that the level of demand went a bit beyond it.

Chair: Okay. We don't need to rehearse this again.

Q119 **Bridget Phillipson:** How is the flu vaccination programme going so far?

Sir Chris Wormald: I don't have the figures in my head. I will send you our latest.

Chair: Thank you. If you could put that in a letter, that would be great.

Sir Chris Wormald: But I take the opportunity to say that the flu vaccination programme is very important.

Chair: Okay. We advertise to everyone that the permanent secretary is saying, "Get a flu jab."

Sir Chris Wormald: Excellent. Thank you, Chair.

Q120 **Gareth Snell:** The £240 million extra for winter pressures will go to local government, so with 150 tier 1 authorities, that means roughly £1.6 million per local authority. Given that those local authorities will have a budget cut of around £20 million this year anyway, how can you be confident that the money will not simply be used to fill the existing hole in social care provision, as opposed to being spent on specific activity to prevent winter pressures?

Sir Chris Wormald: We are asking local authorities to use it in exactly the way you describe, focusing it on the things that ease winter pressures and doing so in discussion with the NHS. David, do you want to read out the exact words?

David Williams: The Health Secretary and the Social Care Minister have written to parliamentary colleagues today. The language is that we are asking local authorities to work with local NHS partners on how best that money should be used through the winter in their areas, with a clear focus and expectation around additional capacity rather than looking at the sustainability of the sector. Individual MPs have had their local share highlighted today as well.

Sir Chris Wormald: The reason we are confident is that this builds on what we did last year, working very intensively with local government on how the better care fund was used. We saw the number of delayed transfers of care that were attributable to local government, as opposed to the NHS, decline quite a lot. We know that working with our local government colleagues and resourcing in this way does lead to those outcomes. This is not a situation in which local authorities and the NHS have opposite objectives; they actually work really rather well together to get people back into their own homes if they have the resources to do it.

Gareth Snell: I don't doubt that.

Sir Chris Wormald: So we are building on our success of last year.

Q121 **Gareth Snell:** I think Ms Phillipson's point is quite apt, though. A lot of this stuff is not winter pressure any more; it is just demand exceeding supply in an overstretched system.

Could I probe you on this point, though? Presuming a fair distribution on a per capita basis, this is a relatively small amount of money in the overall social care budget for most tier 1 authorities. It is not overseen by the Department of Health and Social Care or by clinical commissioning groups; it is overseen by the Ministry of Housing, Communities and Local Government. How are you going to ensure that that money is used directly to alleviate pressures on the acute medical-led clinical services that bear the brunt of winter pressures in their communities?

Sir Chris Wormald: As I say, we do not have hard levers. We do this via discussions with our local authority colleagues. We rarely find ourselves in a position of having to force people to do these sorts of things. The local authorities and the NHS work extremely well. I have never denied, in front of this Committee or elsewhere, the huge pressures that local government have faced around these budgets. This money is on top of the additional spending power that the Chancellor announced two budgets ago.

Q122 **Chair:** You mean the increase on the council tax bill?

Sir Chris Wormald: I used my words very carefully. It is spending power.

Q123 **Chair:** Yes. I am glad we are getting the message across. It is not free money; it is still taxation.

Sir Chris Wormald: It is still taxation. Everything we do is, of course, funded by taxation, but I chose my words very well.

Chair: And a regressive tax, but never mind—

Q124 **Gareth Snell:** And a tax that you do not control, either.

Sir Chris Wormald: Yes, and as we discussed with this Committee before, we are working with a system that is local government-owned. Various people at various times have suggested the nationalisation of that system, and no Government have chosen to do it—often for very good reasons, like local authorities tend to be the people who understand their communities, etc. It does have exactly the effects you are describing, and there is no getting away from that.

Chair: We are in danger of having an esoteric discussion about maybe nationalising social care.

Sir Chris Wormald: No, I was merely making the—

Chair: I know what you were doing, but we are trying to focus on the budget today.

Sir Chris Wormald: What you say is correct. We do not have hard levers over how much—

Q125 **Gareth Snell:** And what will happen, if we are being honest, is that most local authorities will dress up some form of existing activity to spend this new money on, because they do not have enough, but that is not the point.

Sir Chris Wormald: No, that bit I do not agree with you on.

Q126 **Chair:** Can you really guard against doing what Mr Snell has described?

Sir Chris Wormald: The experience of last year was that we did see the number of delayed transfers of care attributable to local authorities fall, so the processes we work with do have the effect we want them to have.

Q127 **Chair:** Sorry, but that does not mean that they were all doing what you expected centrally. It may mean that they were just able to do things they had had to stop doing before their previous budget cuts.

Sir Chris Wormald: Yes, but the purpose of us doing this is because we want to free up beds in the NHS for new people who need them.

Q128 **Chair:** So they can do anything they want as long as it frees up beds, presumably?

Sir Chris Wormald: I know it is an important question, but from my perspective, as long as the beds are freed up, we are achieving the objective that we want.

Q129 **Bridget Phillipson:** We did quite well on delayed discharges, but we also had additional funding for winter planning. Even if you think we are going to do so well on the delayed discharges, or perhaps marginally better, with the sum that we are going to get in, say, Sunderland, we are not getting additional money pumped into—

Sir Chris Wormald: No, and that is a choice we made this year. The biggest need that we wanted to invest in was on the social care side of the equation, for some of the reasons that went to your previous questions, to be honest. We had a lot of people, including the NHS, saying, "That's the problem in the system, and therefore invest there. We have good reasons to believe that will work, based on the experience of last year and"—

Q130 **Bridget Phillipson:** I bet they would love a bit of extra money for winter pressures, though. They would never turn down additional money for winter pressures.

Sir Chris Wormald: Of course they wouldn't, but they also made a hugely valuable contribution last year to freeing up beds in the NHS, which allowed us to treat new patients. As I say, there is not a misalignment of objectives here.

Q131 **Chair:** Stop-start funding is not very helpful. I am going to bring in Mr Williams briefly, and then Mr Snell.

David Williams: All I was going to say relates to the point about core funding. It is worth remembering that the additional funding in '17-'18 was against a year where the real-terms spread from the core budget was about 1.7%. With the announcement of additional funding in budget '17 for 2018-19, and with the pay award on top, the core budget of the NHS has grown by more than the '17-'18 budget did in real terms, so in some ways, the requirement for additional top-up funding for winter is less strong. As I said earlier, the NHS asked us for an agreement to spend capital rather than revenue support.

Q132 **Gareth Snell:** Can I ask about the cancellation of elective work? In the last winter pressure programme—I am going to use my trust as an example—there was a flat ban on any continuation of elective work because of that winter pressure programme. Obviously, there is a double whammy there, because it means that the income that would have been derived from those various tariff-related operations in that trust did not come in, and the winter pressure money did not cover the actual costs that my hospital trust told me they incurred as a result of the winter pressure. If we get to a situation in this coming winter where there have been no additional winter pressure moneys, can you give a guarantee that there will be no direct edict from the Department of Health to suspend elective operations, because that would leave huge holes in a number of trusts' operating budgets?

Sir Chris Wormald: No. As I said, I do not really give guarantees on anything in health. On what happened last year, it was a clinical panel that gave the advice on electives. The idea of that was to have a clear national position where it was done in advance, rather than what normally happens in winter, which is that a lot of electives are cancelled on the day. The system we want this year is, rather than to book a load of electives over winter and then cancel them, to have a better flow at trust level when booking things in the first place, so that we are not in a position of cancelling people. That does not come to your financial question.

Gareth Snell: No, it doesn't at all. It is completely irrelevant to my question.

Chair: It is easy if a hospital does only electives, because they won't get cancelled.

Sir Chris Wormald: Yes, and as you know, a number of hospitals are moving that way.

Chair: Yes, we know that.

David Williams: I cannot speak to the specific local issue, but at national level the NHS estimate is that in January this year, in comparison with January last year, the reduction as a result of this intervention was around 3% of electives. You are right that that will flow through into a reduction in income for providers, although to some extent that will be offset by a reduction in the cost of consumables and temporary staffing.

Q133 **Gareth Snell:** Sorry, may I challenge that point? That may be the case if

you are looking at electives in isolation, but most trusts will have seen a surge in their staff requirements to deal with the emergency side. Therefore, while you are looking at a cost reduction in isolation—we did net earlier so we know what net means—across the whole system there was no appreciable reduction in staffing costs.

David Williams: No, but there will have been income generated as a result of the additional unplanned emergency activity, so part of that cost will have been offset.

Q134 **Chair:** Really? So an old person on a trolley might have a couple of interventions but that is not a massive tariff benefit. They will have been sitting in hospital corridor waiting, with members of staff tied up elsewhere.

Sir Chris Wormald: This is one of the things that NHSE and NHSI are looking to change. In the current system, you make a profit on electives and a loss on emergencies. They are trying to rebalance that.

Chair: Hopefully not a profit on emergencies.

Sir Chris Wormald: The issue you raise is widely understood as not being—

Q135 **Gareth Snell:** I understand that you cannot give a guarantee, but how confident are you that there will be no financial penalty to trusts this winter if there is no financial pressure money put into the acute medical-clinical side, and there are cancellations of elective operations?

Sir Chris Wormald: Well, at the system level, very confident, because it is all the same money—it just accrues in the CCGs if it is not spent on the elective work in hospitals. On the individual trust level, I would need to discuss that with my colleagues at NHSE and NHSI and come back to you.

David Williams: Yes. The system point I was going to make was that where elective activity has been postponed or cancelled and there is a loss of income, that income is not being paid out by the CCGs. What you have seen through winter is a growth in the provider deficit but the ability of the commissioning side to balance that off. It is a net pressure to the NHS as whole, where those cancelled NHS operations are diverted into the—

Sir Chris Wormald: But the distinction you draw between what it feels like at system level and what it feels like at institution level is exactly right.

Chair: And that is the challenge for patients.

Q136 **Gareth Snell:** Mr Williams, I understand your point. I can talk only about an example, but my clinical commissioning group will have seen a benefit to its budget for having not paid out for elective operations during that long winter period when they were suspended, but my trust does not suddenly get given that money for good will; it has to pick up the slack later in the year. If it is unable to do that, it never recoups that money—that money just sits in the CCG's budget line until it decides to spend it

later or on an overspend elsewhere. I understand that from an accounting perspective you know where every penny is, but that does not mean that every penny is being spent on patient care.

Sir Chris Wormald: No. What happens in practice is that the overall deficit on the provider side is largely covered by savings on the commissioning side. That is what happens at system level. As I say, we are agreeing on the general point. That is one of the things that NHSE and NHSI are looking at in their changes to the financial architecture, because we do agree—as I have said before, this was to some extent deliberate—that the set of things that we did to ensure balance at system level creates some quite perverse incentives at the individual institution level.

Q137 **Chair:** And at those individual institutions, in a postcode lottery almost, you get an inbuilt problem that just goes on for years.

Sir Chris Wormald: Yes, and that is what we are trying to unwind. We are completely unapologetic about having done it, because it was the necessary action to get the NHS back into balance overall, which is our accountability.

Q138 **Chair:** We on this Committee like seeing budgets in balance, but it is very rough when some hospitals particularly are at the acute end, where it is particularly harsh.

Sir Chris Wormald: Sorry; the point I am making is that we did go into that with our eyes open, as the price of getting the whole system back into budget.

Chair: Okay, and you are working to mitigate that.

Sir Chris Wormald: We are looking to unwind it for exactly the reasons that Mr Snell was pointing to.

Chair: I think Mr Snell has laid it out very clearly. We will be keeping an eye on how the new approach is going to work, so that individual patients are not losing out in different parts of the country.

Q139 **Bridget Phillipson:** Just a final area from me, in terms of 2018-19, for the figures that are available for the first quarter, in the provider sector there is a forecast deficit. I just wondered what your assessment was of that, and whether that is a concern.

David Williams: That reflects, yes, the position as at the end of quarter 1. The Department has been working closely with colleagues in NHS England and NHS Improvement. We broadly have a balance plan for 2018-19, partly by identifying some incentives for providers to improve their financial performance, and partly through some early identification of offsetting savings within the NHSE budgets. As you might expect in advance of the new investment kicking in from next year, in delivering financial balance this year there are a number of risks that need to be managed and mitigated as 2018-19 progresses.

Q140 **Bridget Phillipson:** Is the provider sustainability fund going to the right

place? Is it delivering the change that you wish to see?

David Williams: Largely. The challenge within the current system, and it is one of the issues that we are engaging closely with the NHS on as they develop their financial architecture plans as part of the long-term plan for the next five years, is that there is a smallish tail—fewer than 30 trusts—where the deficits are substantial, so more than £50 million.

Some of the incentives around the way in which that sustainability and transformation funding flows are more geared to getting the best performers to do a bit better than addressing some of the underlying issues in the most challenged providers. That is not to say that there aren't other approaches that NHS Improvement in particular has to adopt in those areas, but given the way the current application of that sustainability funding works it is, slightly more than I would like, encouraging the best to do better rather than trying to get the tail up to a more sustainable position.

Q141 **Bridget Phillipson:** How will that change with the new 10-year forward view plan?

David Williams: It is really a question of where the tariff consultation comes out, so partly stepping off over the period from the current approach of control totals and top-up sustainability funding to put more of the money into tariff and routine prices, so that routine activity generates enough money to cover those costs. We are in discussion around whether there is a need for some targeted interventions on some particularly challenged providers.

You can categorise issues at that end of the spectrum into: financial challenges that ought to be within the grasp and gift of trust management, and those which are a system issue; and the system architecture—the financial architecture—for the long-term plan places increasing emphasis on financial management, operational forms of management, across a geographical patch rather than institution by institution, and there are a few systemic issues as well.

Q142 **Chair:** The latter sounds all very well, but then—you were saying that finance directors will severally be liable for what happens in their area? Because legally, they will have to look after their own budget, and if you are a foundation trust that is quite a complicated element to the mix.

David Williams: It is not a change to the formal—

Chair: It has been discussed. It has happened before; I remember it happening when the PCTs in London did the same.

David Williams: Yes. It is not a change to the formal accountabilities and responsibilities, but an ability within an SDP or other defined footprint to flex control totals between organisations for—

Q143 **Chair:** You mean like a borrowed credit approval in local government, or something?

David Williams: As long as the SDP area balances, then if the precise flow of money between the commissioners and providers within that patch needs to change, then it being easy to make those sorts of changes that are at a local level—

Q144 **Chair:** Who will make the decision?

David Williams: It will be overseen, I would expect, by the regional tier of NHS England and NHS Improvement—but this is all up for discussion.

Q145 **Chair:** So if your area has a surplus, and a naming area has a deficit, possibly something to do with bad financial management, the surplus will be moved over by some bureaucrats from NHS England without—who is going to have sight of that? How would I know, as a local MP?

David Williams: I would expect it to be as a result of engagement and agreement of the constituent parties.

Q146 **Chair:** You have such trust, Mr Williams. Okay; from your point of view it will get sorted, but from our point of view I think there may be things we need to watch there.

Briefly, on the point that Ms Phillipson raised about the forecast deficit in the provider sector, you talked about putting incentives in to the provider sector to get them to balance the books. Can you give us some examples of incentives?

David Williams: We have been discussing two particular incentives with NHS Improvement this year as to the short-term measures; first, to make available additional sustainability funding for those trusts who commit now to an improved position against their existing control total, generating greater surplus. We talked earlier about the balance between trusts in surplus and trusts in deficit.

Chair: So if you increase your surplus you get a bit more money.

David Williams: You get a bonus, so there is a reward, as it were, for committing now, and then delivering.

Q147 **Chair:** That is for those trusts already with a surplus.

David Williams: For those trusts already in surplus.

Q148 **Chair:** What about the ones with a deficit?

David Williams: We are having some discussions around the treatment of profit on disposal of assets—whether that flows to capital or revenue budgets.

Chair: Once again.

David Williams: Actually, under conventional accounting as employed by NHS trusts, it would routinely flow to revenue anyway; there is a Government accounting rule which stops that. So those are the two measures which are being explored.

Q149 **Chair:** You say it is an incentive. Are you forcing asset sales? I am not quite sure where the incentive bit is in there.

David Williams: No.

Q150 **Chair:** If I were running a trust with a deficit, what would you come and offer me to try and get that deficit down? I am not quite sure where the positive is for the trust in deficit.

David Williams: The incentive is that if you are planning a disposal as part of, let us say, an SDP-agreed strategic estates plan, if you are able to generate that in this financial year—so sometimes it is bringing disposals forward—and realise a revenue benefit as a profit—

Q151 **Chair:** So a fire sale.

David Williams: Not a fire sale. I mean consistent with local estate strategies and plans for development of NHS facilities in the local area, that revenue may make the difference between you getting access to sustainability or whatever it might be.

Q152 **Chair:** Okay. Not exciting incentives, but—

David Williams: That is sort of cash in, as it were—it does not then necessarily stop the trust spending it as capital the following year, but it is just how you account for it on the way in.

Q153 **Gareth Snell:** Are there any restrictions on how trusts can receive those receipts and how that is accounted for if they have not agreed a control total spend? Because if you have not agreed a control total spend, you cannot access the transformation fund anyway, so if a hospital disposes of an old site and gets that capital income, how is that looked at in the round if it hasn't got a control total?

David Williams: I would have to get NHS Improvement to answer that one.

Q154 **Chair:** We will pick that up in a letter. My final question is about fraud. Obviously, the new Counter Fraud Authority was set up to replace the old system nearly a year ago and the estimated level of fraud has gone up. How much of that £1.29 billion do you think could have been prevented?

David Williams: The estimate has gone up from £1.25 billion to £1.29 billion—

Chair: Yes; it is not significant in some ways, but it is going the wrong way.

David Williams: It is an estimate with quite a range of confidence levels in the intelligence behind it. From memory, from the intelligence assessment, only about £35 million of that £1.3-ish billion has a high degree of confidence behind the evidence. Quite a lot of it, for instance, will be related to an assumption around payroll fraud. There was a study done—not particularly in the public sector—back at the start of the

decade, that suggested that 0.2% was a reasonable proxy for payroll fraud—

Chair: So some of these are very proxy numbers, then?

David Williams: So we have applied 0.2% to the NHS payroll figure. It is a very high-level issue, but nevertheless, it provides a starting point to help us in our identification of particular areas where targeted programmes may bear fruit.

Q155 **Chair:** So really, for you, it is a risk tool at the moment?

David Williams: It is a risk tool rather than an accurate description of fraud.

Q156 **Chair:** To take it back to the grassroots, in our surgeries people come to us and say that they owe some money to the dentist that they did not expect or whatever. They are often very bureaucratic challenges, such as that it was a benefit-dependant exemption from charges, and it is a bit complicated to understand. They are required to pay the charge, but very often such demands get overturned. Do you know what percentage of that estimate is around that level of bureaucratic procedures that affect patients directly, rather than the systemic fraud or payroll fraud that you were talking about?

David Williams: Not off the top of my head, no.

Q157 **Chair:** It just strikes me, when I see all those cases in surgery, that the amount of work to resolve a dental charge that has been required is enormously expensive compared with the charge itself, so maybe when you are looking at this, it would be worth considering the effectiveness of NHS business and how—

David Williams: I have not checked the coverage into dental surgeries, but one of the approaches that we are taking for wider efficiency and service reasons, but that will be of benefit here, is the roll-out of electronic prescriptions, which will at least make the data that we have available to—

Q158 **Chair:** It seems to me that there must be somewhere where there are an awful lot of people comparing bits of paper to see if someone has claimed their free eye test twice a year from different opticians, or something—not that I think most patients are doing that at all. It is very old-fashioned.

David Williams: A move to electronic data allowing us to use modern data analytics—

Chair: We will probe this in future, because it is clearly work in progress, but it is helpful to know how you are using that. I thank you both very much for your time. Obviously, we will keep a close eye on this and we will have you back in a month or so—you are regularly here. Thank you very much indeed.