

Health and Social Care Committee

Oral evidence: NHS Capital, HC 129

Tuesday 22 October 2019

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Angela Crawley; Anne Marie Morris; Andrew Selous; Dr Paul Williams.

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Witnesses

[I](#): Foluke Ajayi, Chief Operating Officer, University Hospitals of Morecambe Bay NHS Foundation Trust; Emma Greenwood, Director of Policy and Public Affairs, Cancer Research UK; and Chris Hopson, Chief Executive, NHS Providers.

[II](#): Anita Charlesworth CBE, Director of Research and Economics, Health Foundation; Sally Gainsbury, Senior Policy Analyst, Nuffield Trust; and Sir Robert Naylor, Chair of the independent review of the NHS estate.

[III](#): Simon Stevens, Chief Executive, NHS England and NHS Improvement.

[IV](#): Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, Department of Health and Social Care; and David Williams, Director General of Finance, Department for Health and Social Care.

Examination of witnesses

Witnesses: Foluke Ajayi, Emma Greenwood and Chris Hopson.

Q1 Chair: Welcome to the Health and Social Care Select Committee. We are going to be discussing NHS capital today. We have four panels, so we will need half an hour for this panel. We will probably try to direct all our questions to each of you individually, rather than have everybody answering every question, if that is all right. Before we get started, it would be helpful if you could introduce yourselves and say whom you represent today.

Chris Hopson: I am Chris Hopson, the chief executive of NHS Providers. We are the membership organisation for 223 acute community, mental health and ambulance trusts.

Foluke Ajayi: I am Foluke Ajayi, the chief operating officer at University Hospitals of Morecambe Bay, an acute and community provider. I am here to give a view from the frontline.

Emma Greenwood: I am Emma Greenwood, director of policy at Cancer Research UK. We are a large fund-raising charity that funds medical research into cancer and provides information to patients and the public, as well as influencing the policy agenda.

Q2 Chair: Thank you so much, all of you. Obviously, NHS capital covers much more than just buildings, and it would be helpful, Chris, if you could set the scene for us about where we are, the state of the maintenance backlog and all the issues around capital affecting the NHS.

Chris Hopson: There are a number of different ways to describe it, but the way we would describe it is that there are basically three broad buckets of need. One is backlog maintenance, which as we know has now risen to £6.5 billion. It has risen by more this year than we were actually trying to cut it, so the backlog is growing—not shrinking.

The second set of needs is rebuilding and replacing ageing buildings. In the NHS, we tend to do these things in phases. There was the Enoch Powell hospital building programme and, clearly, the PFI programme sponsored by the Labour Government. There is a real sense now, looking at the age of our buildings, that there is a whole bunch of buildings that need to be replaced. Crucially, it is not just acute hospitals that need to be replaced and rebuilt but mental health and community facilities.

The third bucket we would describe would be investing in delivering the long-term plan. If, for example, you want to deliver the cancer outcomes in the long-term plan, we will need to increase our diagnostic capacity. If you want to introduce the combined primary and community services new pathway for elderly people, we will need investment there. If you want to improve the NHS's digital capacity and capability, we will need to invest there.



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There is pretty broad agreement that the current amount we are spending on capital across all those three buckets is insufficient. Provider spend fell by 21% in real terms between 2010-11 and 2017-18. I am sure you will get some interesting answers from the different panels today about how much extra is needed. Our view would be that, in an ideal world, you would probably want to double the NHS's current capital spend. That, we think, would enable us to meet all three buckets of need and would bring the NHS's capital spend up to that of comparable economies.

If you asked where we think the recent announcements have got us, we would say that they have been helpful in focusing on one element of that need in terms of a commitment to rebuilding a number of hospitals. The problem at the moment is that we actually cannot see the picture across all that need. We need a holistic strategy with some firm commitments for each of the next five years on the Department's capital limit, so that we can see whether the extra amount that is being promised for hospitals will be matched by extra money for all the other needs or whether there is a danger that, important though hospital rebuilds are, we are spending too much of the extra capital on hospital rebuilds if there is not going to be more for the other needs.

The health infrastructure plan that the Government published two or three weeks ago says that they want a holistic strategy looking across all those buckets, but at the moment, until we can see what the entire strategy looks like, and until we know exactly how much will be allocated to the NHS over each of the next five years, it is very difficult to come to a clear view about whether this is the right strategy, and a complete strategy, when all you can see is a part of what needs to be done.

Q3 Chair: What worries your members the most in terms of capital? Is it the backlog and the crumbling infrastructure?

Chris Hopson: It depends on where you are. In some places, clearly, the backlog is a real problem. I am very struck by the number of our members who say to us that they have fire risk, for example, that they cannot fully manage. We have mental health members saying that they had an enforcement notice from the CQC to remove ligature points because there is a risk of patients taking their own life.

There were 4,800 clinical service incidents last year related to failures in estates and infrastructure, and, to give you one example, one was a power failure that effectively meant that 1,800 outpatient appointments and 100 elective procedures had to be cancelled. Clearly, if you are in that kind of hospital, where your power is out, you are going to be worried about that. Equally, at somewhere like Hillingdon, which I visited relatively recently, they are worried because they have a 1960s building and, unless they can replace or rebuild it quite quickly, they are simply not going to be able to provide quality of care. In fact, they had to close a couple of their wards a couple of weeks ago because of subsidence issues.



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It depends on where you are, but everybody recognises that we simply are not spending enough money in terms of capital to invest in the infrastructure and estate that is so vital for the provision of high-quality care. To be frank, wherever you go, my description of it is that we are asking our staff to do their very best while tying an arm and a leg behind their back, because we are not providing them with the equipment and facilities that they need to provide outstanding care.

Q4 Chair: Can you set out the difficulties that trusts experience in actually getting the money? We often hear that the money is promised but it does not actually make it to the frontline.

Chris Hopson: Again, there is widespread agreement that the current capital prioritisation and allocation process is pretty broken. We have said that for three or four years. The kinds of issues that our members talk about are, first, that they would like to see clear allocation of a set amount of money to the NHS, where the money for all but the really big hospital schemes—over £100 million, to pick an arbitrary figure—gets delegated down to an appropriate level to make decisions. At the moment, there is real nervousness that we are cutting capital into small penny pots that you have to bid for, and the penny pots are allocated according to the priorities of the day. Then when you bid for them and win, the money does not actually reach the frontline. An *HSJ* story about two or three months ago said that, of the £2.5 billion that has been allocated since 2017, only 3% actually reached the frontline.

What our members are looking for is a clear amount allocated to the NHS. Can we then delegate prioritisation and decision making over the vast majority of that down to the right level, where decisions should be made? Then can we have clear and rapid sign-off procedures, so that we can spend the money? At the moment, you have to get Department of Health sign-off, Treasury sign-off and NHS England and Improvement sign-off. We have members saying that, if they do a lot of work on a business plan, they have no clarity on whether it will be accepted or not. We also have members who say that they feel that they have approval to go ahead and are suddenly asked for more rework, or for three different sets of information from three different sign-off people. They find that they have to go rapidly round and round the loop.

There is real frustration that, effectively, people are not able to do the job they would like to do, because they are caught in an almost Kafkaesque bureaucratic system. They cannot make priority decisions and they are caught up in bureaucracy. To give a simple example, you will remember that, in August, 20 trusts were allocated £850 million for what were called hospital upgrades, projects ranging from about £20 million to £100 million. I was very struck by the number of trusts that said to me, "It's great that we've got the money but, to be frank, we would like the chance to spend it in the way we would like to spend it now. The bid was 30 months, or two and a half years, ago, and we now have a different need, so is there any way we can have a conversation with the



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Government, who have just announced this money, about spending it in a way that is more up to date?"

Part of the problem is that, if you want to do the job effectively, you need certainty about what the total figure will be over a three, four or five-year period. Then you need to delegate the decision making down to the local areas that are best placed to make the decisions, rather than have the decisions made at a higher level.

Q5 Chair: It is a staggering figure that only 3% made it to the frontline. To make sure that I have heard correctly, your feeling is that the key reason for that is the sheer bureaucracy and delay in the current system.

Chris Hopson: To be fair to our friends at the Department, they have a complex task to ensure that the Department stays within its budget. As we know, one of the things that has been happening over the past few years is that we have been making transfers from the capital budget to the revenue budget.

Part of the Department's job is that Ministers come up with bright ideas, and they like to see them funded, so announcements get made: "Let's put some capital into this or capital into that." Then there is insufficient capital to go all the way round. Again, part of my argument is that our members get very frustrated that they have to bid on a national basis for all the different penny pots that reflect priorities of the day. They would like to see a clear allocation made to the Department, ideally over a five-year period, so that everybody knows where they stand. Then, as I said, the vast majority of that, apart from all the really big schemes, should get delegated down to the right level, with decision making at the appropriate level, not waiting for national politicians. It is a combination of a number of different things, but, yes, bureaucracy and a very slow process, with triple sign-off, are good examples of where trusts say they are being held up in spending money they need to spend.

Q6 Chair: And then being told that it is frozen and they cannot spend the money; they are all ready to go and then it is frozen.

Chris Hopson: Yes. The Department's finance director will no doubt explain his perspective, but our perspective would be that, as the year goes on and, potentially, there is a financial squeeze, we can understand why people are saying, "Can we stop that and can we slow it down?" Again, people do not know where they stand.

The key thing to remember about many of these projects, be they IT systems, hospital buildings or whatever, is that they tend to run on multi-year planning cycles. If you want the money used effectively, you need to give people as much certainty as possible. Because they need fairly complex business cases, you need a slick system that enables people to be clear about what they are meant to be spending when, which would enable them, once they had the approval, to get on with it and make it happen. The problem at the moment is that capital is not being allocated



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with enough certainty across a long enough period of time. As I said, the problem is that it is not being delegated enough down to a lower level.

Chair: Thank you. That is very clear, and we will ask you some more questions at the end.

Q7 **Anne Marie Morris:** Emma, can I ask you for the other perspective, in a sense—the patient perspective? You are very much the user of the service. While Chris has made quite a lot of reference to that and, clearly, the two are inextricably linked, could you give us some examples from a cancer patient perspective of how they see the lack of capital?

Emma Greenwood: Absolutely. I think, and Chris alluded to it, that we are in a situation where we have an ambitious long-term plan for the NHS, but we do not have a long-term investment plan to go hand in glove with it. That is the case not just for capital, of course, but for other key funding streams, such as workforce investment, social care and public health. That is problematic.

In cancer, the long-term plan sets out a strategy to deal with increasing demand. We will see more patients going through the system, simply because we have a growing ageing population, and cancer is predominantly a disease of old age, so we will have to do more to keep up. In parallel, we have a set of ambitions related to wanting to deliver better outcomes for our patients. If you look at any comparable international countries, and at variations across the country itself, we know we should be doing a lot better, based on the knowledge we already have. Either of those agendas is huge in its own right, but, when you combine them, what we need to be doing for cancer patients is significant.

If you get a diagnosis today—the waiting times data will highlight this—the system struggles to get patients referred to tests, get results from tests quickly and then get them through to treatment. That is having an impact on patient experience; it is a very anxious time for patients, and we hear that a lot. It is also starting to impact on our ability to diagnose cancer earlier and drive the improved survival we want to see.

Capacity, both in capital investment and in workforce—obviously, the two things fundamentally go hand in hand—is one of the most significant barriers, if not the most significant, to our delivering that level of transformation. You only have to look at endoscopy services, or how we fare on investment in CT scanners and MRI; we do not stack up to any comparable countries. We are bottom of the league table.

We go out and talk to local patches about what is getting in the way of them delivering on their waiting times and on their new ambitions to go even faster, and it is entirely about capacity. It is a real challenge for the system, and it is something that patients really feel as they move through the system. We are struggling to understand how exactly some of the new initiatives in the long-term plan that are not yet online, such



as rapid diagnostic centres and lung health checks, all of which are about diagnostic capacity and will require doing more tests, will be possible without increased investment in kit and people.

- Q8 **Anne Marie Morris:** To drill down for a minute on capital, you are absolutely right that the people piece needs to go with it, but today we are looking specifically at capital. Clearly, there are different pots, which are largely what Chris set out. One of the pots, which seems not to be specific but spreads across, is the one for equipment and IT.

In Chris's definition, it would be in the long-term plan but, clearly, it is also about the here and now. There is no point in having a hospital without an operating theatre and some of the other kit. For patients, is the issue more about the quality of the fabric and the impact that might have on their health, or is it about the lack of equipment, so that they cannot actually have the tests done? Which of those, in your experience and your patients' experience, is where there is the biggest problem?

Emma Greenwood: Looking across the patient pathway, we find that the biggest problem is the delay in being able to access tests. It is absolutely about being able to access a CT or MRI quickly enough to be able to move.

- Q9 **Anne Marie Morris:** That is one of the key pieces, as opposed to necessarily having a wonderful physical building in which to have it.

Emma Greenwood: Yes. There are patches across the country; there are certain hospitals where there is an issue with the buildings themselves. Fundamentally, across the country, as a generalisation, lack of kit is definitely getting in the way of diagnostics. We could also talk about radiotherapy machines, for example. It is becoming a real challenge to deliver speedy and innovative care for patients.

- Q10 **Anne Marie Morris:** Do you think that there is a proper, joined-up strategy with regard to the equipment piece, or is there too much focus on buildings?

Emma Greenwood: We do not feel that there is a joined-up strategy across the piece, certainly on cancer. We have a long-term plan with cancer ambitions, but we have not yet seen the detail of what would be needed from an equipment, kit or workforce perspective across the board. That is a real gap, and a concern for us.

- Q11 **Anne Marie Morris:** Particularly with cancer, we have some innovative solutions going forward across a number of different cancer areas; CAR-T therapy would be a case in point, something really important that we have managed to get available and accessible. I often hear about the challenge with breakthrough medicine, whereby the NHS says, "Yes, let's go for it," but then the site and the peculiar facilities you need is a cost that does not seem to have been taken into account when the therapy was approved by NICE.

Particularly with cancer, because you are in a sense at the forefront of all



this, do you think enough focus and attention is given to costing the availability of something new and therapeutically of the next generation? Is there a lack of attention to the extra bits of what is more than kit—the facility plus the kit—to deliver it?

Emma Greenwood: We are absolutely finding across the pathway, and it is possibly even more acute in diagnostics, that we are doing a lot of work to understand whether something is clinically effective and therefore should be available to patients, but we have not been great at thinking what transformation is needed in the service to deliver that new intervention, what pathway would need to change and what the kit and workforce components are. Again, the long-term plan sets out an ambition to think differently in that space, but I would characterise the conversations at the moment as still completely fixated on dealing with the matter in hand, which is the increased demand that we are seeing and the waiting time targets.

In a system that is struggling because it does not have the capacity to deal with what is current, it is very challenging to think innovatively about how we would introduce new interventions or pathways of care. There simply isn't the bandwidth. You almost have to tackle the fundamental capacity issue before you can even start to think about the new innovations that are going to come down the line.

Q12 **Anne Marie Morris:** There are two sides to this. The capacity issue is because we are doing it the old-fashioned way, whereas if we did the diagnosis piece it would presumably impact on the capacity piece. You mentioned diagnosis several times in your evidence. What are the bits of capital that we need to get the diagnostic piece working?

Emma Greenwood: The ambition on early diagnosis is all around how we can catch cancer at a much earlier stage. It has also to be how we can get people into the system and then move them through for tests quickly. Some of the initiatives, such as the rapid diagnostic centres, which are an ambition to bypass some of the current systems and pathways, will require kit to be successful. We will have to do more tests. That is a fundamental, whether we are looking at CT, MRI, lung health checks as a new possible screening intervention, or upgrading our current bowel screening programme with more endoscopy suites. Any way you cut it, if we are really about driving improved survival, which might then reduce the need for some of the drugs that you mentioned, at the latter end of the pathway, it is all about investing more in having the kit and the people to get people through those tests as quickly as possible.

Q13 **Anne Marie Morris:** Presumably, part of that is about IT, which you have not mentioned specifically, collecting all the data on who might get what, so that you have a list of patients and so on. How do you feel we are doing as the NHS in providing the necessary IT piece, particularly to make your diagnostic piece work?



Emma Greenwood: I definitely think that IT, data and interoperability between different parts of the country is a big challenge for us. Again, it is something that we have not seen as much thought given to in terms of how some of the ambitions are going to play out. We see patches across the country coming up with their own solutions. For example, in the east midlands there is a real effort to make sure that there is networking across the patch so that people can share scan results, and so on. There is a need for increased investment and a more joined-up approach.

Fundamentally, we are never going to have as many staff as we would optimally like; it is not realistic. Solutions such as how you network across a patch, making best use of IT and data and, increasingly, AI are absolutely going to be part of the solution. But we have to get the fundamentals right, even just being able to use different hospitals' email systems and sharing a copy of a scan between different patches. Some of those fundamentals are not happening at the moment. We have to be a bit careful that we do not always go after the big, shiny new areas of investment in things like IT and AI before we have resolved some of the fundamental issues first.

Q14 **Chair:** Thank you very much. Foluke, could we come to you to talk about your experience as a chief operating officer and how access to capital constrains you in what you do?

Foluke Ajayi: I am happy to do that. Chris and Emma have described some of the experiences that we have. Certainly in our organisation, we have seen impacts on our operating theatres; in the last five years, I have had at least one theatre go down at least once a year, and sometimes more. In the last five years, we have cancelled 600 patient operations as a result of theatre breakdowns, and those operations are being cancelled at short notice, for some patients on the day.

The impact of that is that a patient has made arrangements for care at home—some of them tell us that they have had a mother come down from Scotland, for example, to be with the kids so that they can take time off to be in hospital—and then we tell them on the day that the cancellation occurs and everything has to be reversed. Other patients have cancelled work, and those who are on zero-hours contracts cannot get the work back. We have had to pay out to individuals for lost hours of work, because we have had no choice. That has been the impact.

The impact on our workforce is on the ability to do the work they are paid to do. Some of them bear the brunt of the frustration of patients and the public, when they ring them to say that they have to cancel appointments. There is a significant impact, which then has an impact on our performance as an organisation, and our ability to manage our waiting lists. In the end, those 600 patients need to be seen again, in capacity that we did not have and now are struggling to put patients back on to. We see a reduction in our performance on waiting times for patients. The waiting times for patients at the end of it, when they have



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been waiting 18 weeks to be seen to be treated, have a significant impact.

There is an impact for us around recruitment and retention. The impact on staff in what they have to manage daily is significant. Earlier this year, two of our CT scanners broke down at the same time, the only two we had in the Royal Lancaster Infirmary. Both went down at the same time; over a 12-day period, we had at least one of them out, and for a 24-hour period we had both of them out. The impact was that we could not scan any patient who came through the A&E department. Those who were at significant risk had to be diverted to local hospitals. We have a hospital an hour and a half away from us, one of our trust's, in Barrow, so we sent patients either to that hospital or to one down the road that is about 45 minutes' drive away. Regardless of the distance, there is an impact on patients with life-threatening diseases and conditions when we have to divert them.

Q15 Chair: When you are in that position, when you lose a major system like that or lose access to an operating theatre, how do you get hold of the capital you need to put things right? How complex is that?

Foluke Ajayi: With great difficulty. In all these instances, we have to make decisions locally and reprioritise our already prioritised capital programme. At the start of every year, we prioritise what we are going to invest our capital in, based on our own risk assessment. What we end up doing is deprioritising other areas so that the immediate issues are addressed straight away, so we end up building our backlog. Five years ago, 30% of our risk rating for our backlog was significant to high risk, and this year it sits at nearly 70%.

Q16 Chair: Seventy per cent of your maintenance backlog is significant risk.

Foluke Ajayi: It is either high risk or significant risk, yes.

Q17 Chair: Gosh, that is quite striking. When we met before for a roundtable discussion, you spoke about the way that trusts that are already in difficulties seem to be particularly disadvantaged. Could you talk a bit further about that?

Foluke Ajayi: Yes, that has been my experience. About two to three years ago, we went through the capped expenditure process. We were one of the trusts that was sitting on a significant deficit and, as a result, we did not have access to additional capital. We were limited to the capital that we could raise within the trust, typically about £10 million, which does not go very far when you are sitting on a backlog of at least £200 million. We had that experience. We have waited significant lengths of time—nearly two years—to have some loan approvals made. I do not know whether colleagues knew I was going to be here, but it is interesting that yesterday we had confirmation of a £34 million loan.

Q18 Chair: Wow. The benefits of appearing before a Select Committee.



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Foluke Ajayi: Yes, I should come here every day. We started that application process back in February and it was formally submitted in April, and we have only just got confirmation. What that means is that events have overtaken us, and we will have to reprioritise; the timing of how we make the investments will change.

As Chris said, having the information much earlier enables us to make smarter decisions. Often we are told, with three months to go, "Here's capital for you to invest in A&E performance," and you are given that money in October to spend before December. No time is allowed for you to make important decisions, so you end up making short-term decisions, when actually you could make much better and smarter longer-term decisions if you had the run-in time to do your planning and look at the most effective way to invest your money.

Q19 **Chair:** If you had the certainty of a multi-annual settlement, you would have discretion as a chief executive to spend in the right way for your trust.

Foluke Ajayi: Yes.

Chair: That is what you are calling for.

Foluke Ajayi: That would make a significant difference, and an assurance that we are going to get the pipeline coming through. The stop-start effect does not work for anybody, and we end up managing failure. That is what I feel I am doing at the moment—failure demand management.

Chair: Just firefighting, with no room for advance planning.

Foluke Ajayi: Absolutely, yes.

Q20 **Chair:** How often do you go to all the effort of planning, only to find that it falls by the wayside?

Foluke Ajayi: That was our experience two to three years ago. We were doing all the detailed planning and often incurring costs to do that, and actually not going anywhere, so I took the decision two years ago that we were not going to do that any more. I would rather we spent the money on things that we knew we could spend money on than use the limited capital we had to develop plans that were not going to go anywhere. Unless we had assurance that it was going to get us further, it felt counter-intuitive making the investments to develop business cases.

What we developed were high-level plans. It was not that we were not doing any planning, but before we committed additional capital we needed to be sure that there would be something at the end of it, otherwise we had lost another £3 million, or whatever it was—£200,000, or whatever it was—to create a plan that did not go anywhere, when you could have fixed something else.

Q21 **Andrew Selous:** Chris, could I come back to you? We have had it clearly



outlined that the length of time it takes between a capital allocation decision and when the money arrives is basically taking local discretion from brilliant trust chief execs like Foluke next to you. What is the solution to that issue, to speed up the time between allocation and the arrival of the cash?

Chris Hopson: Our view would be very clear. In the Rebuild our NHS campaign that we launched, we have called for, first, very clear multi-year—the health infrastructure plan commits to five years—clarity on the amount of capital the NHS will have, so that we all know what there is going to be. Secondly, there is a need for a commitment to devolved decision making on that amount of money. You would need to divide it up between, let us say, the 44 STPs or ICSs with, effectively, devolution of decision making on that money down to STPs and ICSs. Then they will be able to make the decisions to prioritise according to local needs. Our view would be that you keep back only a small amount at the centre, which is the amount needed for the really big schemes—major hospital rebuilds that cost more than £100 million. Then, effectively, you are placing the prioritisation and allocation at an appropriate local level.

Q22 **Andrew Selous:** I have two further questions. I think originally the idea was that the tariff would generate something like a 5% surplus for trusts, which they would use for routine maintenance to prevent a backlog from coming up. We are a long way away from that world now, aren't we? How does the whole tariff model need to be recreated to get back to that world, or should we be looking at funding routine maintenance in an entirely different way? We do not seem to have a solution to that quite significant problem.

Chris Hopson: Andrew, that is a great question. When I first arrived in the NHS seven years ago, the vast majority of our members were able to generate that level of surplus. As you describe, they were able to generate sufficient amounts of money to do their backlog maintenance on a day-to-day basis. What has happened is that as the financial squeeze has come on over the last nine years—as we know, it is the longest and deepest financial squeeze in NHS history—trusts are simply not generating enough money on a consistent basis. Some are, because they are still in surplus, but we know that 70% of acute hospital trusts are in deficit.

It has been particularly difficult for trusts like Foluke's that have had long-term deficits. There is a very good reason why Foluke's trust has a deficit: it is trying to run three acute hospitals with lower volumes of patients coming through than the tariff assumes, so it is very difficult for them to make a surplus. Those trusts in particular have been starved of capital.

If we want to get back to where we need to get to, I am not necessarily wedded to the tariff, because I think in a sense that we are moving away from the tariff and in some areas we are probably moving towards block contracts and risk-sharing arrangements. But we need to pay trusts a



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sufficient amount that not only reimburses them for the costs of providing the care but gives them an appropriate amount—it is pretty widely accepted that 5% is the right amount—sufficient to create the surplus to then invest in the backlog maintenance. To be frank, Andrew, I would not set up a separate system for backlog maintenance to be done somewhere else. The trusts should be able to generate sufficient surplus themselves to do it; that is the right way to do it.

- Q23 Andrew Selous:** Can I ask about NHS Property Services? We have had a few slightly disobliging comments, I think it would be fair to say, from a range of trust chief executives. We get told that properties are left empty because rents are centrally set higher than the market will pay locally. We are told that there is failure to be imaginative in redeveloping sites that could potentially generate income and be more efficient. What is your view of NHS Property Services as an organisation? Do we need a redesign or reorientation of what it is purposed to do?

Chris Hopson: Chief executives feel quite strongly that they would like to take greater responsibility and accountability for their own estate. The Government set up a scheme about a year ago, as you are probably aware, to enable trusts to take accountability for their estate. The scheme got going only relatively recently, but the early feedback we have had from our members has not been particularly positive, in that it seems to be taking a long time to make the transfers, and a lot of barriers appear to be put in the way in making those transfers across.

We would be very keen that there should be some kind of formal review of how well that scheme is working. As we have discussed before, trust chief executives know that they have responsibility for looking after the valuable public estate that they have, and they are frustrated by their inability to do so because it sits with a third party.

- Q24 Andrew Selous:** Would you describe it as a very disrespectful way, quite frankly, to treat trust executives? These are serious players to whom we pay a lot of money to take responsibility, yet we give them accountability but not the actual responsibility and capacity to do the things that should go along with the accountability. Would that be a fair analysis?

Chris Hopson: There are forces pulling in different directions. There are those who argue that the estate is best managed by aggregating at scale and having a bunch of specialists, or an organisation that specialises in doing that, like NHS Property Services. Trust chief executives will argue that they are the people who care most about their estate, because it is actually within their footprint.

- Q25 Andrew Selous:** Where do you sit on that spectrum?

Chris Hopson: Our view would be that trust chief executives should have accountability and responsibility for their estate. Clearly, though, there will be plenty of occasions when they want access to specialist advice and support.

Andrew Selous: That is very helpful, thank you.

Chair: Thank you all for coming this afternoon. It has been very helpful.

Examination of Witnesses

Witnesses: Anita Charlesworth, Sally Gainsbury and Sir Robert Naylor.

Q26 **Chair:** Thank you all for coming this afternoon. I am not sure whether you were here for my opening with the first panel, but we have half an hour, if that is all right. We will not expect you to repeat answers to previous questions, unless there is something you feel you would like to add; then please give me a wave. Can we start by you introducing yourselves and saying whom you represent?

Sally Gainsbury: I am Sally Gainsbury, a senior policy analyst at the Nuffield Trust think-tank.

Anita Charlesworth: I am Anita Charlesworth, director of research and economics at the Health Foundation, an independent charity.

Sir Robert Naylor: I am Robert Naylor, the national adviser to the Government on NHS property and estates. Prior to taking that on about three years ago, I was the chief executive of University College London Hospitals for 17 years and, before that, chief executive of a major teaching hospital in Birmingham for 15 years, so I have seen a lot of this come around on a number of occasions.

Chair: Thank you very much.

Q27 **Andrew Selous:** Anita, can you give us your views on where capital spending in NHS England compares with other countries? What is the comparison internationally?

Anita Charlesworth: We did some analysis looking at spending on healthcare capital in the UK, not just the NHS, in the four countries of the UK, not just England, and how that compares with 10 other countries for which robust data is available, across north America—the USA and Canada—and eight other European countries. The way we looked at that was through the proportion of GDP that different countries spend on healthcare capital, adjusting for the different sizes of population and economy. Across the 10 countries for which we have comparable data, on average they devote 0.5% of GDP to healthcare capital, while in the UK we devote around two thirds of that, so we are spending around 0.3% of GDP. That data is from 2016.

We have some new work that we are currently finishing, which will come out at the end of the week, looking at what that means in terms of the spend per healthcare worker. The important thing that you were hearing from the previous panel is that, obviously, capital investment is very important for service quality, but it is also important to help the healthcare workforce to be productive and do their job. In the wider



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economy, we think of productivity, generally speaking, as being enabled by capital investment; capital investment unlocks productivity gain. The NHS has to deliver productivity gains for the next five years of more than 1% a year, so the amount it invests in capital per healthcare worker is really important for its ability to deliver those productivity gains.

What we see is that, in the UK since 2010, capital investment per healthcare worker has fallen by 17%. It is fair to say that the data we are identifying across the EU shows that we are an outlier in that regard and that other countries are not cutting their capital investment per worker. They are investing more per worker, which is exactly what you would expect with digital technologies and the revolution in technological advance. In particular, we have cut most sharply our investment in plant and machinery, which covers things like the scanners that were talked about earlier. If we think just about CT and MRI scanners, we have the lowest rate of scanners across comparable countries; we have a third less than in Germany, and it would cost £1.5 billion of investment to get our MRI and CT scanners up to that average.

Q28 **Andrew Selous:** That is powerful; thank you for that. In terms of the capital spend that is getting through to the frontline, how well do you think we are spending the capital that we are spending at the moment?

Anita Charlesworth: There are a number of issues around spend at the moment. One is that relatively little is addressing the maintenance backlog. In the latest data, the maintenance backlog is £6.5 billion, and last year the investment to address that backlog was just £440 million. At the moment, we are not investing to tackle that issue. Investment appears poorly aligned to some of the things we have set ourselves as service improvement targets. If we think about the level of investment in mental health and the underpinning technology of an IT platform that works, you will have seen numerous reports from junior doctors about the time it takes to log on and get a functioning computer before you even start to think about advances in AI.

A lot of the new investment that is being talked about at the moment is very focused on acute hospitals, yet, as is clear from the long-term plan, we need to invest in primary care and mental health services. It seems skewed in terms of sector at the moment. There is a skewing in the extent to which we are maintaining and supporting the estate we have versus new schemes. The investment between different types of capital, like equipment versus buildings, seems poorly aligned with need. It reflects the fact that for the NHS as a whole there is no ongoing capital planning. People are now trying to put capital plans in place at STP level, but we have allowed that work, and the strategic long-term thinking and alignment of capital investment with what we want to do with the service and the workforce, to fall away.

Q29 **Andrew Selous:** I want to take you back to something you told the Committee in November 2018, which I was particularly struck by. You said—I am paraphrasing—that, if you want to know which buildings the



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NHS owns in a particular site, you only have to walk around and see the ones that are single storey. You went on to talk about a real lack of imagination in terms of redevelopment and what any other owner would do.

That struck me as a powerful critique and a serious allegation, actually, because it strikes me that with what we have we could be doing a lot more that could be revenue generating. I think you mentioned that it could be providing accommodation and so on. Why is there this lack of imagination? What are the constraints? Most importantly, what can we do to unlock that and start some of the redevelopment that I think you very helpfully point to?

Anita Charlesworth: We have got into a vicious cycle of very short-term investment plans. We have essentially used capital funding as the residual to balance the books. We have had stop-start in schemes and proposals. Organisations and areas are invited to develop plans and think imaginatively and holistically. They develop teams and put forward work, and then it is stalled and put on hold. There are real questions there.

If you want to do the sorts of things that I think people across the system would like to do, those schemes take time and typically involve partnership with others. They involve joining up what you are trying to do on your staffing and service delivery with thinking more widely about public services in a place, and opportunities. When you are totally focused on just getting through the week to deliver, as in most organisations at the moment, and you have no confidence in the amount of money available to you and your ability to commit and be a strategic partner, the odd scheme that gets through is more of a surprise than the fact that we are not doing more of it.

Q30 **Luciana Berger:** This question is for Sally. Obviously, there is a wider context in which we are having these discussions today. How do you believe that the overall financial performance of the NHS in recent years might have affected the current pressures that we see on its capital resources?

Sally Gainsbury: The NHS's underlying position over the last few years has been to build up an underlying deficit of £5 billion as of the end of 2018-19, and that is a figure that NHS Improvement has itself published. That means that there has been a £5 billion gap between the regular, recurrent, reliable earnings of providers and their outgoings. Part of that has been patched up with non-recurrent savings, the sort of hand-to-mouth savings that are not repeatable. There has been about £1 billion of those each year.

Then there has been emergency funding; you will be aware of the provider sustainability fund. Part of that is in order to balance the books at Department of Health level, because there have been reported deficits and large capital to revenue transfers of around £1 billion a year for, I think, almost the last five years. That has meant that there has been a



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major constraint on how much capital investment providers are able to make anyway.

As you heard from the previous panel, the system was built on the notion that providers would be able to make a surplus that they would then accumulate as a pile of cash, which they could essentially use either directly to invest in capital programmes and maintenance or to leverage additional borrowing for that capital. For the last seven years, deficits have been a major feature of the provider landscape. Clearly, there has been a £5 billion deficit, so very few organisations have been able to make a surplus. Given those two factors, there have been very few revenue surpluses around in the system to finance capital investment but, at the same time, there have been spending restraints at Department of Health level, which have meant that even those who managed to make a surplus—a third of organisations have continued to make surpluses over the last few years—have found their spending restrained because of the limits at Department of Health level.

Q31 Luciana Berger: We heard the announcement from the Prime Minister in August that there was an extra £1.8 billion for the NHS, which the Secretary of State for Health described as new. Do you share that assessment?

Sally Gainsbury: No. It was new spending in terms of the Department of Health's envelope, which the Department of Health could allow to be spent, but £1 billion of that was very clearly cash that had already been generated as surpluses by NHS providers. Between 2017-18 and 2018-19, NHS providers added almost £1 billion to their cash balances on their balance sheets, on their books. At the end of 2018-19, there were £5.8 billion cash surpluses held by providers, and held in a very lumpy way, which is part of the problem. Only a third at the moment can generate surpluses. It does not quite work out that the cash pile is held by only a third; it is obviously spread out a bit better, but it is very lumpy.

One of the reasons why that cash has built up is that there have been limits at Department of Health level. They have not been allowed to spend it, because the Department of Health itself has had to cut its capital spending allowance. That is the envelope in which it is allowed to work; it has had to cut that to offset the deficits. All that happened in the summer was that that spending allowance was raised to allow hospitals and other providers to spend the cash that they very clearly already had.

Q32 Luciana Berger: From what you said, can I deduce that it was £800 million of the £1.8 billion?

Sally Gainsbury: No, £1 billion.

Q33 Luciana Berger: Which was the new bit?

Sally Gainsbury: The new bit was the £850 million.

Q34 Luciana Berger: Right, thank you. What is your understanding of why



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trusts have been prevented from spending money that they received through the provider sustainability fund?

Sally Gainsbury: Excuse me if this is convoluted. It is arcane, but it was not me who invented the system. When providers fell into deficit, or when deficits became unmanageable at the end of 2015-16, for 2016-17, the Department of Health and NHS Improvement introduced a fund called the sustainability and transformation fund, and quickly had to forget about the sustainability element of it. It was £1.8 billion that would be used supposedly for a short period of time to offset deficits.

There was a lot of umming and ahing about how that money could be allocated. One way it could have been allocated was that you could have taken the £1.8 billion—which was not enough to offset the whole load of deficit, but never mind—and given it to all the organisations in deficit. They did not want to do that because it would be seen as rewarding failure. Up until now, we have worked on a quasi-market-based system, and the thinking was that if you simply gave that money to organisations that were in deficit, where was the incentive to get themselves out of deficit?

A system was developed whereby, to shortcut the explanation, everyone had a sort of fair dibs at the money. That meant that part of it went to organisations that were in deficit, as long as they met deficit reduction targets, but a significant chunk went to organisations that were already making surpluses, and they had to meet a financial target to make an even bigger surplus. In total, over three years, £2.3 billion was handed over to organisations that were already making surpluses as an incentive to get them to make even bigger surpluses.

Why would an organisation do that? At organisation level, it meant finance directors and chief executives turning around to their staff and saying, "I know we're balancing the books, but you can't spend X, Y and Z and we're going to continue with what are effectively austerity budgets in our organisation because we have to help to make a big surplus to offset deficits being made elsewhere in the country." That conversation was had across the NHS.

There obviously had to be a prize, and the prize was that over three years £2.3 billion in cash would be received by those organisations, in return for them making bigger surpluses than they needed to break even. They could not spend that cash in-year because, by definition, if they spent it they would not make a surplus, and the whole point was to encourage those organisations to make large surpluses that could be used partially to offset the deficits that were being made elsewhere. Sorry. I said it was convoluted.

Instead they were told, and the understanding was, that it was money that would be available to invest in capital. Ultimately, most surpluses that NHS providers generate anyway would be used to fund capital



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programmes. You can only spend the money once; you could not spend it recurrently.

Unfortunately, that then quickly hit the problem that the way the Department of Health had had to fund these deficits was by reducing their own capital spending envelope. In effect, organisations were given a cash prize and told they could spend it on capital, but then in almost the next breath they were told, "You can't spend it because we have paid for that cash prize out of our capital spending envelope." Over three years, about 100 organisations earned £2.3 billion in return for making surpluses they had no need to make. They made promises to their staff that there would be just one more year of austerity and one more year of extra push. We are talking about 4% efficiency savings against Government reports saying that 2% was a reasonable level, so they were making twice the level regarded as reasonable. The prize was going to be capital spending, which they then were unable to do because the Department of Health spending envelope had been reduced.

All that happened in August was that the last tranche of that was released—the last little bit that was earned in 2018-19. Effectively, they said, "You can now cash the cheque we gave you."

Chair: That is very helpful.

Q35 **Andrew Selous:** Can I follow that up by asking Sir Robert what sort of progress has been made since his report in 2017? Can you give us an update, please?

Sir Robert Naylor: Thank you. My report, "NHS Property and Estates: Why the estate matters for patients," dubbed imaginatively the Naylor report, was something I was asked to do by Jeremy Hunt when he was Secretary of State, prior to me leaving UCLH. I guess the reason he asked me to do it is that I have a long history of building hospitals, and I have seen the cycle of feast and famine over a number of years of investment in healthcare.

It became clear to me in preparing my report that the major problem was the underfunding of capital infrastructure over a long period of time, perhaps two decades. That has already been referred to by Anita. It has led to an unprecedented escalation in backlog of maintenance. Some figures have already been quoted, and I can give you a lot more if that is helpful. As there was a delay in publishing my first report, I did a second report specifically on London, because it became clear to me that London was the biggest problem and, potentially, one of the biggest contributions to the solution to the problem, because of land values in London. I drafted a report that was never actually completed and never published. It would not have been published, because it contained a lot of commercial in-confidence information about land values, and so on.

What Jeremy Hunt asked me to do was to look at the report for London in particular and cherry-pick perhaps five of the 20 recommendations that I



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drafted in that report and see whether I could progress them. I am very pleased to say that, over the last year or so, there has been a huge amount of progress with some of those projects. For example, we now have Moorfields hospital being built and, in the recent HIP announcements, there are recommendations to rebuild Whipps Cross hospital, Epsom and St Helier hospital, Hillingdon hospital and St Mary's hospital. Because of that focused amount of work, particularly in London, there has been a huge amount of progress, and I am advocating that the same amount of progress should be taken regionally across the rest of the country.

To go back to my first report, the conclusion I reached was that, without capital investment, the NHS estate could not deliver the five year forward view, and the existing estate would remain unfit for purpose and would continue to deteriorate. I came up with 17 recommendations that were either fully or partially accepted. The key recommendations were to establish a powerful new property board; to develop the capacity and capability to progress capital schemes, because that had been severely eroded over a number of years due to lack of capital investment; to develop strategic estate and infrastructure plans; and to agree to an additional £10 billion of additional capital investment to be funded from three sources, one from the Treasury, the second from land sales and the third from the private sector.

The private sector option is no longer possible because of the Chancellor's statement last December to stop PFI schemes, although that needs to be revisited, and I know that there are discussions going on in the Treasury and the property board about that. Since then, I am pleased to see that the Treasury has more than contributed its fair share of the sum, with its announcement in the 2017 spring Budget of £3.9 billion. We have already referred to the £1.8 billion, and the debate about whether that was new money or not. Most importantly, the Government's recent announcement of the health infrastructure plan, or HIP, as it is known, to create a five-year rolling programme, is almost exactly what I was arguing for back in 2016-17.

What we have not achieved in the NHS is a strategic approach to capital investment; in fact, the last strategic report on capital investment was in 1962 and was the Enoch Powell hospital plan for England and Wales. There has not been a strategic view of investment, and the recent announcement by the Government of the HIP scheme is exactly what is needed for the longer term.

In the past, we have taken much too short-term a view about capital investment; we need to take a five, 10, 20 or 30-year view and be thinking about preparing some of the major projects, because they take a long time. I was at UCLH for 17 years. We started building in 2000 and they are still building, two decades later. We need a strategic approach, which I think the HIP programme has, and in parallel with that we need a strategy to address the accumulated backlog of maintenance, which has



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already been referred to. We need to do two things in parallel: we need a strategy for the longer term, to be clear about what hospital infrastructure we want over the next two or three decades; and we need to address the short-term problems of critical infrastructure risk.

My final point is that that critical infrastructure risk, which has already been referred to, is particularly concerning in London. The level of critical infrastructure risk in London is about twice as much as the national average. Therefore, we have a whole series of problems that we are accumulating, and we have to deal with those urgently in the short term, as well as dealing in the long-term strategy with replacing our infrastructure over decades to come.

Q36 **Andrew Selous:** Can you explain, please, what the relationship is between the new property board and NHS Property Services? Do they do completely different things?

Sir Robert Naylor: Yes, they are totally different. You asked a question earlier about Property Services. My personal view is that the assets in Property Services should be devolved back to the foundation trusts, or back to the trusts. Property Services was essentially created in the first place only when the primary care trusts disappeared; there was a lot of property and no one was quite sure what to give it to. Some of the property went to trusts, and there are many examples of that, but the rest of the property was bundled together. My personal view, which I have advocated for a long time, is that over time Property Services assets should be devolved back to trusts, and the reasons for that were set out by Chris Hopson earlier. That is an organisation that manages property. We need to take into account that it is a small proportion of property; from memory, it is about 5% or 6% of the total property of the NHS. The vast majority of property is held by the trusts themselves.

The property board is an organisation chaired by the Health Minister, and its role is to look strategically at how NHS infrastructure should be developed in future. It is the board that has taken the lead in progressing the discussions that have led us to where we are today, in a much more positive mindset—I am, anyway—because of the HIP programme and the potential for long-term capital investment. I am delighted that what I was trying to say three years ago is now beginning to come to fruition. The key thing is not just the first phase of HIP, which has been funded, but subsequent phases of HIP. We need to push that forward strategically across the NHS, over a decade or two decades to come.

Q37 **Andrew Selous:** You said that there were obviously very high property values in London; you then said that they were double the level of need, which I must admit I had not fully appreciated. How does the property board work in other areas of the country where the assets that the property board might be looking at are worth a lot less than in London? Is there going to be a sort of national/regional transfer mechanism to make that up? Obviously, London property values are massively out of kilter with the rest of the country. Is there an issue there that we need to be



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aware of?

Sir Robert Naylor: Yes, it was an issue that was raised when my report was published: isn't this unfair on parts of the country that do not have high property values? Of course, we are only talking about a relatively small contribution from land sales to the total pot that is needed. The much larger pot is the capital allocation that is given to the health service every year, so there is plenty of opportunity for the Department of Health and others to redistribute those funds to where the priorities lie.

Q38 **Andrew Selous:** There is now a £3 billion hole in your pot, though, isn't there? You called for a £10 billion pot, and that was when PFI was still in fashion, before the previous Chancellor said it was off the table. Is it just the poor old taxpayer who, yet again, has to put his or her back to the grindstone to make up that money? Where is the £3 billion that you predicated coming from PFI now going to come from?

Sir Robert Naylor: That is a question that can only be answered by the Chancellor of the Exchequer. It is a live debate at the moment, and we are waiting for further information about whether there will be any form of capital investment back into hospital infrastructure in future. Of course, much of the NHS is funded by the private sector anyway, because a lot of primary care premises are owned by GPs themselves. This is something that needs to be resolved.

Q39 **Andrew Selous:** Yes, okay. I have a final question, to try to be as clear as possible. You heard me come out with what Anita said to the Committee in November 2018 about the single-storey buildings that any other organisation would have redeveloped. Is that the issue that the property board is now focused on? Can you tell us with confidence that the NHS will maximise the value of its assets—perhaps for nursing accommodation, and for earning additional revenue from its assets—to put every penny back into frontline service? Is the property board going to deal with the issue, which Anita very properly identified, right across the country?

Sir Robert Naylor: Yes, I think it is. Of course, it is horses for courses, in the sense that what you would design in a rural environment for healthcare is quite different from what you would design in central London. My real focus over the last year has been on central London, because that, to my mind, has been the biggest problem, and the area where I think I can add most value. But certainly the projects we are looking at in London will be very high-rise developments.

I could give you numerous examples from existing hospitals. I can give you an example from my own experience at UCLH. When I went there in 2000, we had seven hospitals spread out across the central part of London. By the time I left, we had only two hospital sites, one of which is the main University College London Hospital site, which has been developed in five phases and now encompasses six of the original seven hospitals. The first phase was funded through PFI, but most of the



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subsequent development—probably £1 billion-worth of investment in one campus, which is now one of the leading academic health science centres in the world—has come from property development, from exactly what you are saying.

We made the best use of the assets we had. We did not just sell off our assets to the nearest property developer; we developed the properties ourselves and then sold them with development and planning permission. That is what we have to do in London; we have to develop the capacity and capability to replicate that, certainly across London and across the rest of the country. There is massive value to be had from the property we hold, and what we must not do is sell it off to the nearest property developer, because that will not give us value. We have to think about how we get value out of the estate, and how we reuse land that is currently unused or underutilised to clear land, particularly in London, to build new homes. Many of the schemes I referred to earlier encompass all those components.

Andrew Selous: That is very helpful. Thank you very much indeed.

Q40 **Chair:** Are there any points that any of you want to make before you leave this afternoon?

Anita Charlesworth: There is just one thing on the new money question, to give a bit of context to what Sally said about the aggregate numbers, looking at the DH accounts. The question of whether it is new money depends hugely on what your starting point was.

Back in July 2018, when the Department published its accounts, it said that for this current year it would spend £6.7 billion on capital. The problem was that, a year later, it said, “Oh no, we’re only going to spend less than £6 billion on capital.” By July 2019, we were down to a spend of less than £6 billion on capital. What then happened with the new announcement is that we are now back up and we are now going to be spending, if all goes to plan, just over £7 billion this year.

That £7 billion is more than they were saying in July that they were going to spend for this year, but, actually, the reason why, out in the NHS, it does not feel like any sort of new money is that a year before that, they were actually planning to spend £6.7 billion. As Sally was saying, how do you run a system, trying to help individual organisations to plan and allocate, when your total at Department level is moving around like that? It is almost impossible.

Q41 **Chair:** We heard from Foluke that they had effectively stopped making forward plans. Is that your experience talking to trusts across the country?

Anita Charlesworth: Yes.

Chair: Thank you all very much for coming this afternoon.

Examination of Witness

Witness: Simon Stevens.

Q42 **Chair:** Thank you for coming this afternoon, Simon. You need no introduction to people in this room, but perhaps for those following from outside you could introduce yourself.

Simon Stevens: Sure. I am Simon Stevens, the chief executive of NHS England.

Q43 **Chair:** Thank you. We are mostly going to focus on the situation with capital across the NHS, but then at the end, if that is all right, there are a couple of other issues I would like to raise with you, if you have time.

Simon Stevens: Bonus questions.

Q44 **Chair:** What we have heard from our previous panels is quite extraordinary: the extent of the maintenance backlog across the NHS, and the effect that is having directly on patient care; and the extent to which it is very difficult for trusts to plan ahead, because they are caught in a cycle of firefighting existing problems. It would be helpful to have your assessment about where we are now and the scale of the issues.

Simon Stevens: I agree with that as a description of the circumstances we have been faced with for the last several years. It is true that the amount of capital that NHS providers have been able to spend increased by around £800 million last year and is set to increase by another £1 billion on top of that, but we are coming out of an extended period of very constrained capital budgets. That obviously coincided with the absence of any alternative routes for capital investment in the NHS.

A combination of the end of PFI, which many people would say was a good development, with the absence of significant public capital investment, means that we have a situation in the NHS right now where one in seven of our buildings could have been visited by Nye Bevan when he was the Health Minister. In fact, the new hospital that the Prime Minister announced in north Manchester a few weeks ago could have been opened by William Gladstone.

Q45 **Chair:** Obviously, there is that issue and the need for a new building programme, but I will focus right now on the maintenance backlog and the critical effect that it is having in many places on safety and, even if not safety-critical, the effect it is having, for example, on the ability to run operating lists, the knock-on effect on waiting times and the impact on staff working in very outdated premises. We also heard that only 3% of the money is actually making it to being spent.

Simon Stevens: No, I think that is not quite what you would have been told. That would have been for major schemes that had previously been announced and the time it takes to get from an in-principle approval to the bulldozer turning up on site.



Chair: Sorry; you are quite right, yes.

Simon Stevens: The actual capital expenditure in the NHS for providers went up by around £800 million last year and, because of the recent agreement we have with the Government, we have another £1.1 billion-worth of cover for spending this year. We would expect that a significant part of that will be on backlog maintenance, which is sorely needed. But you cannot completely distinguish the backlog maintenance day-to-day pressures, and another £0.5 billion rise we have seen in that, reported even in the last couple of days, from the question of whether we can replace old facilities, not just hospitals but mental health provision, community and primary care.

About a third of our critical backlog maintenance, for example, relates to one hospital trust, Imperial College Healthcare, because a quarter of their buildings are more than 70 years old. As we get the major upgrades we are going to need in that part of north-west London, in one fell swoop that will deal with their significant backlog maintenance. In the meantime, we are going to need to help them to get their pressures in diagnostics or services sorted out, as we are in other parts of the NHS.

Q46 **Chair:** Leaving aside the backlog maintenance for now and looking at the future programme, is the balance right in the way we are going to be spending, in terms of what is going to new hospital infrastructure and what is going to communities? There has been quite a lot of criticism that not enough is going to community facilities and mental health, for example. How much were you consulted before the announcements were made?

Simon Stevens: I think the words used about the announcements were “initial installation” and “down payment”, so I do not think this is by any means the final set of schemes that the NHS will be working on over the next five and 10 years.

Six of the schemes already announced relate to primary care and mental health, but, frankly, we have big, unaddressed needs in mental health. I am determined that we use additional capital investment to, for example, deal with dormitory wards across the mental health in-patient estate. We have 350 wards where acute mental health in-patients are in three or four multiple-bedded bays, and we have to tackle that. We have a lot of unmet need in primary care as well, although the options available to us there are sometimes wider than those available in hospital services.

The initial set of schemes that has been announced is very welcome. Each of them individually will make a major contribution in the part of the country where it is located, but clearly that is the beginning and not the end of the line in terms of what we need to be doing over the next 24, 36 or 48 months.

Q47 **Chair:** You are confident, are you, that in the further schemes that have been announced there will be sufficient flexibility for local areas to



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distribute that money as they see fit across their local area?

Simon Stevens: That is the case we are making, and the case that the Department of Health and Social Care has in principle accepted in the health infrastructure plan that was published a few weeks ago.

We are talking about a three-part capital budget for the NHS. There would be local capital decided by trusts, STPs and local areas, according to their priorities. Secondly, there would be big schemes that require national investment over and above that, where we have to run a national prioritisation process. Thirdly, there would be public capital investment that we need to make outwith individual providers—for example, some of the technology investments and screening system upgrades. That is the right three-part categorisation.

We have to streamline the approvals processes for the locally generated schemes, and indeed a number of the major schemes, and I can explain a bit about how we are going to do that. Obviously, our ability to do that will be greatly enhanced if we have a multi-year capital budget for the health sector as a whole, against which we can then make prioritisation decisions.

Q48 **Luciana Berger:** I have a short addition to Sarah's question. You reflected on the mental health estate. You and I have had these exchanges on a number of occasions. I am looking at the numbers, which tell us that, of the six new hospitals announced in October, none was for mental health, and, of the 21 hospitals given £100 million to develop plans for replacement, none provided mental health care. Of the 27, nothing for mental health—

Simon Stevens: I am not sure that is quite right, Luciana.

Q49 **Luciana Berger:** The announcement in August that covered an additional 20 hospitals does not include some that provide mental health care. Forgive me, but, based on exchanges we have had, the commitment to parity of esteem for mental health does not seem to bear true, when you look at the numbers in the announcements that were made about those 27 hospitals.

Simon Stevens: We have six schemes that are for mental health and learning disability in primary and community care, in Norfolk and Suffolk, Mersey Care, Greater Manchester, South Norfolk, North East London and South Yorkshire and Bassetlaw. But I agree with you completely. This has been parcelled up into particular investable propositions, and there is a big mental health and learning disability investable proposition, in the same way, frankly, as there is for diagnostics. I think you have heard some of that from the Cancer Research UK evidence this afternoon.

We have an initial instalment on diagnostics of £100 million this year followed by £100 million next year. That will help with some of the older MRI and CT machines, and some of the screening equipment that we



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need to upgrade, starting with those that are more than 10 years old. But is that the totality of what we need to do on diagnostics? Clearly not.

I personally will be going in to bat very heavily for mental health capital investment where it is needed. Indeed, I have already said in the last several weeks that, as we do that, we potentially have the opportunity to look at the mix of NHS-provided versus independent sector specialist mental health provision, which in some places is probably not optimal. About a third of our specialised commissioning in adult services is commissioned from the independent sector, partly because mental health trusts have not had that capital investment themselves, and for 40% of CAMHS beds it is the same. We have to look at in the round.

Q50 Luciana Berger: Forgive me, but there are so many times when you have said in front of this Committee that we must look at it, and 47 hospitals have received—

Simon Stevens: No, that is not fair. We are doing exactly what we said we were doing on mental health. On the mental health revenue, because we have a revenue settlement, we said we would make sure that mental health revenue goes up faster than the overall NHS budget, and it is doing that. But we do not have a multi-year capital settlement, and therefore I have not been in a position to give any undertakings about mental health capital investment.

Q51 Luciana Berger: On the back of the independent review of mental health, which highlighted that the mental health estate is some of the worst—

Simon Stevens: This is Simon Wessely's review?

Q52 Luciana Berger: Yes. It is some of the worst in the NHS, and the review called for multi-year capital funding and commitment for mental health. We have heard nothing in response to that.

Simon Stevens: We do not have a multi-year NHS capital budget. I know that Matt Hancock, the Secretary of State, is very keen as well to make sure that we get one, and we are clearly going to need a 2021 capital budget by the end of March. We would all like that to be multi-year capital investment so that we can make exactly the kind of prioritisation decisions you are rightly talking about.

Q53 Dr Williams: How were the recent capital projects selected?

Simon Stevens: NHS England and NHS Improvement did the first review of those. In doing so, we looked at the priorities that had been identified by STPs locally, some of which were not able to be funded in the previous round of STP capital allocations. Secondly, we looked at the parts of the estate that are oldest or have the biggest range of operational issues; hence the 1876 North Manchester General Hospital, for example. Thirdly, for the initial six, we looked at those that had already gone through enough of a scoping design consultation process that we could be



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confident that they could actually be delivered over the course of the next five years. That is the basis on which we made recommendations for the schemes that were subsequently approved.

Q54 Dr Williams: Who else other than NHS England and NHS Improvement was involved in the decision making?

Simon Stevens: The Department of Health and Social Care. We felt very content with the list that was arrived at, coming out of that process. Are there other areas that we would like to add subsequently? We have that opportunity. Absolutely. But were these the big, high-priority schemes that were ready for prime time over the next few years? Yes, they were.

Q55 Dr Williams: If there were a longer-term, multi-year assessment, you have already indicated that you would personally be going in to bat for mental health.

Simon Stevens: Yes.

Q56 Dr Williams: Are there any other priorities you would like to see for development over the next few years?

Simon Stevens: Yes, there are. Thank you for the opportunity. I have already mentioned diagnostics, where obviously we have not only capacity bottlenecks but there is an opportunity to modernise the way diagnostics works, linked to new technology. The Mike Richards review of screening has pointed to some of that, and we are going to make sure that we are doing it. Secondly, across primary and community health services, despite the up to £800 million that we would have been putting into the GP estate and technology since 2015, we still have a lot of GPs operating with inadequate facilities for the expanded primary community care offer that we want.

Thirdly, there are a number of technology investments that will not only make it easier as a patient to interact with some of the administrative aspects of the NHS but will free up staff time. You all remember the ONS pointing out that NHS productivity in England has been growing by 3% a year for the last year they have data for, far better than the UK economy as a whole. The productivity gains that the NHS has delivered very successfully over the last several years have nevertheless been partly as a result of staff working incredibly hard and partly as a result of constrained public sector pay. We are going to have to work smarter, not just harder. I think you heard from Anita Charlesworth about the fact that capital intensity per whole-time equivalent in the NHS has fallen by 17%. We obviously want to reverse that if we are going to use technology investments to drive productivity.

There is one other area that I would draw attention to, which is that we have to, as the NHS, step up work on our own greenhouse emissions and carbon footprint. We have seen that even in the course of the last several days, with the new data from King's College London around the impact of air pollution on avoidable strokes, heart attacks and asthma attacks. To



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the greatest extent we can, we need to decarbonise our own supply chains and operations, and that will require targeted capital investment.

Q57 Anne Marie Morris: Simon, the allocation for local projects is, as I understand it, principally to develop a business plan. We have been hearing from previous witnesses that they are now not doing business plans, because the business plans are, effectively, a waste of money because the project does not get delivered.

Are we absolutely clear that the right areas are being asked to do business plans? What is the likely success rate of those plans? How many do you expect to come to fruition? Where are we going to get the money from if those business plans prove to be viable and cost-effective? Is there anything you have heard from the Government that leads you to believe that the money will be forthcoming?

Simon Stevens: That is a very well-targeted question. You could look back and say that, to some extent, the process of business plans, local consultations and so on, given how drawn-out it has been, has almost been an implicit capital rationing mechanism across the NHS. In a period when actually capital investment is increasing, and is set to increase further, we need to take a lot of that delay out of the system.

There are various practical ways in which we can do that. The first is that we are going to remove, for many of the schemes anyway, the strategic outline case and combine the outline business case with the full business case to telescope the planning process. Secondly, we will look at alternative contract documentation. Thirdly, there will be a streamlined approvals process, so that it is done once by NHS England and Improvement and the Department of Health and Social Care, rather than as three separate processes, which is what it has been hitherto. Fourthly, we are going to create an expert estates team that will work with individual parts of the country when they are coming up with their proposals. If it is the first time you have done it in 100 years, you might be a bit rusty, so we can help to streamline processes that way.

Frankly, we would like to go faster. For the schemes that have been identified as HIP 2, so-called, for the 2025-30 period, we are saying to folks around the NHS that if they can come up with workable propositions that have the right local support quicker than that timescale, and can get going, we would like to support them in doing so.

Q58 Anne Marie Morris: How confident are you that the money will be there, if they actually get through that truncated process successfully?

Simon Stevens: I am confident, because the need is great and the commitment has been made. Obviously, were there to be any subsequent effort to go slow on some of those schemes, I am sure that you as representatives of your local areas would make the case strongly to the Government of the day.

Q59 Anne Marie Morris: Have you and the Secretary of State actually come



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to a view as to how much it will cost if they all come to fruition?

Simon Stevens: Yes, we have a view as to what a typical-sized, major scheme costs. The reason for getting the seed planning under way right now is so that people can realistically show us when they think bulldozers will pull up on site, and we can see what that then looks like in three, five or eight years' time, and so forth.

Q60 **Anne Marie Morris:** Have you and Matt Hancock come to a conclusion as to roughly how many of those are likely to come to fruition? I do not imagine that you expect 100% of them to come up with a business case and you go, "Yes. Tick. Made."

Simon Stevens: It is more a question of when than whether. All the schemes we have identified have a real-world need to be secured. I do not think that we are looking for any of them to fall by the wayside, but there is obviously an intense planning process we have to engage in with those parts of the country.

Q61 **Anne Marie Morris:** Excellent. We will be holding you to account for that, but it is good news. Assuming that we get a number of these projects completed, how are they going to be owned? In the earlier evidence, you probably heard some comments about a desire for anything new to be owned by the local trust, rather than being within NHS Property Services. There has also been some concern about the use of wholly owned companies. Can you give us a view, with all these new capital projects, on how you are planning on them being owned and managed? What might be the role of NHS Property Services, and what might be the role or ownership of the local trusts?

Simon Stevens: For the new schemes that we have approved in principle over the last couple of months, the expectation is that they will be delivered through NHS trusts and foundation trusts. I stand to be corrected on that, but I think I am right. There may be the odd exception, but this is not principally a funding stream for NHS Property Services.

Furthermore, there is an option for local trusts to take ownership of assets that are held in their area by NHS Property Services. What I have heard from trusts is that that process can be rather hard to unlock, so I have asked the estates team at NHS England and Improvement to see whether there is a way of streamlining that, with, hopefully, the support of the Department of Health.

Q62 **Anne Marie Morris:** Do I deduce from that that over time you propose to relocate the property in that central pot back to the trusts?

Simon Stevens: At least some of it. To put it in context, only about 12% of the overall property portfolio of the NHS is held by NHS Property Services and—

Q63 **Anne Marie Morris:** That is still quite a chunk.



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Simon Stevens: Probably about half of that is for GP or primary care provision, which might not necessarily end up in the ownership of a local community health trust. The option is there for people to propose why it would make sense, and, if we can get a streamlined approval process, in a sense that will reveal to us what is the right mix of local control versus the expertise that a national body in principle should be able to bring.

Q64 **Anne Marie Morris:** When you say “local control”, does that bring with it the power to decide how to use that land?

Simon Stevens: Yes, but one of the criteria that trusts are being asked to meet is that they should not simply take control of an asset in order to be able to sell it, on the grounds that that would tend to produce only a windfall gain in one particular part of the NHS rather than being prioritised on the basis of need for the health service as a whole.

Q65 **Anne Marie Morris:** What about the concept of wholly owned companies? There is concern about their use. Is that going to die?

Simon Stevens: I do not think that is material to the capital investment decisions that are being made, as far as I am aware.

Anne Marie Morris: Jolly good. Thank you.

Q66 **Andrew Selous:** Can I take you back to the green issues, which I was pleased to hear you touch on? My local hospital, Luton and Dunstable, is replacing its boilers, which is good. It will save £1 million a year in costs, and it is going to take a lot of carbon out of the atmosphere, but it is not a completely green system. Do you have target dates for your heating and your transport fleet, which is enormous and puts a lot of nitrogen oxide and other harmful elements into people’s lungs every day? Do you have dates by which you will green your buildings and your fleet?

Simon Stevens: We have overarching dates, but I think we are going to need to bring some of them forward, given the wider needs, not only the health impacts locally, but what as a country we are trying to do in this area. Between now and April, we are going to answer year by year what that needs to look like.

It is certainly about heat, LED lighting and waste disposal, but it is also about electrifying our fleet where possible and looking at our supply chain management. It is about the journeys—the 9.5 billion miles a year that are related to our staff, and visitors and patients interacting with the NHS. It is about the offer of digital appointments, where that makes sense, in lieu of face to face, potentially substituting some of those. Yes, we will put together a comprehensive proposal.

Q67 **Andrew Selous:** With new hospital builds, can we expect built-in photovoltaics in the ceiling and triple glazing? You can actually build net zero energy buildings at the moment and, I am assured by some leading British architects, not at significantly greater expense. The revenue savings year by year are then very significant, so there is a justification



for slightly extra capital spend, if you have savings on the running costs. Can we expect the brand-new buildings that are about to be built to be really green?

Simon Stevens: I think we should. Part of our issue has been that just under half of our buildings are over 35 years old, and they were not built at a time, in many parts of the country, where this was a clear and present danger—so, yes.

Q68 **Andrew Selous:** Can I take you back to what used to happen historically? I understand that the idea was that trusts would generally be able to generate a surplus of about 5%, and that would have enabled trusts to take care of their routine maintenance and probably some small-scale capital projects. At a time when 70% of trusts are in deficit and some trusts are configured in such a way that it is probably virtually impossible for them even to make a surplus at the moment, do we need a new financial model to make sure that routine maintenance can be taken care of within the in-year revenue spend, as you would expect every business up and down the country to do?

Simon Stevens: Yes, in some respects we do. Part of the reason why we will have to make dedicated injections of capital for backlog maintenance is precisely that that headroom has not been available to many trusts over the last five, six or seven years. I think we are still going to be financing a part of that replacement through a normal depreciation-type mechanism.

Without getting incredibly arcane, there are issues about the way the capital structure of trust balance sheets operates, with a split between public dividend capital and debt interest. The stock of debt is being financed at different interest rates, and we think there would be benefit in looking afresh at that particular financing mechanism, which is partly how trusts generate the cash that, in turn, they need to be able to finance capital spending.

Capital flows through the trust sector are something we are looking at, as is the question as to whether it would be possible to restructure the stock of debt that certain institutions are experiencing. We clearly want to retain the incentive for well-run organisations that are capable of generating a surplus to be able to deploy that into their own capital investment. That is a very important incentive that trust chief executives tell me and my colleagues we must ensure remains intact.

Q69 **Andrew Selous:** We heard from one of our earlier witnesses that we have had two decades of underfunding of capital in the NHS. To me, that does not seem a party political point, as it precedes the huge 2008-09 recession. Why is the UK so out of kilter in its approach to capital spending within health over the last two decades, compared with our OECD friends and neighbours?

Simon Stevens: Prior to the 2008-09 economic downturn, in the decade before that most of the big capital investments were principally financed



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through PFI, which I think is how you get your two-decade point, rather than through public investment, with the result that we have 106 operational PFIs across the NHS right now. Why were those PFI vehicles chosen at that time? I think it was for two reasons.

One was that, frankly, the Government at the time regarded it as a vehicle for having them off the public sector balance sheet. Secondly, the history of public procurement, which had not included whole lifetime costing of the asset and putting completion risk on the construction company, had not been great. There was, if you like, a bad reason and a good reason. In any event, the fact is that that is not going to be how we finance health investment going forward, so we obviously need public investment.

The good news is, of course, that you can finance this on long-dated gilts at under 2%. If we were to invest in our health capital at the level of the rest of the industrial world, the OECD, there would be an increase of about 50% on what we are currently investing. If we were to do it at the level of the European average, the EU27, there would be a 100% increase on what we are currently investing. We have need and we have opportunity.

Q70 Dr Williams: I have a couple of questions about efficiency. How much is the NHS currently spending on vacant or void space?

Simon Stevens: I will have to get you that number, Paul. I know that non-clinical space has continued to shrink, and the figures published by the estates data returns within the past week have shown a further gain over the course of the last year. That number is going down.

Q71 Dr Williams: Do you have a ballpark amount?

Simon Stevens: As I said, I will get you the precise number rather than an estimate. One of the other things that has been happening is that the NHS has been realising the value of unused or old land and facilities, and is able then to reinvest that. That has doubled over the last three years, with the unneeded asset sales that we have been able to make in order to reinvest in needed equipment and facilities.

Q72 Dr Williams: There is concern that the NHS is spending money on estate that is not being utilised.

Simon Stevens: You have to get under the skin of what is the ownership of that facility, and what the opportunity then is. In some cases, people are waiting for planning consents, if it is NHS-owned, to be able to maximise the value for the taxpayer. In general, that is one of the things that we continue to see as an opportunity for recycling off our own balance sheets.

Q73 Dr Williams: We asked NHS providers about other opportunities, not in this session but in a roundtable session we had with them as a Committee. They said that there were many opportunities for the



consolidation of estate and bringing services that are being offered in two or three locations into one, and that there were often political barriers to being able to achieve what they would like.

Simon Stevens: At this point, I hold a mirror up to yourselves. That is something that the NHS has to work with, recognising legitimate concerns. Yes, sometimes it stands in the way of what would be the right answer from a purely estates rationalising approach, but there are other considerations that the public and patients also want taken into account, in terms of convenience of access and continuation of local services. They have to be balanced.

Q74 **Luciana Berger:** I have a short addendum to the questions from Andrew Selous about the environmental opportunities within the NHS. I was wondering about all the new buildings that are going to be built. I hope you are aware of the green ratings for buildings. Can you confirm for the Committee whether all future projects will meet either excellent or outstanding green ratings and, if not, why not?

Simon Stevens: I will certainly have a look at that. I am aware of the green ratings, and I have had the discussion with the folks who do the assessments on those. Given that these projects are still in the early conceptualisation state, it sounds to me in principle a very good idea, but let me not shoot from the hip.

Q75 **Anne Marie Morris:** You talked about the strategy that we are going to have for capital investment going forward. We are talking at the moment about hospitals and buildings. Given the increasing move to care at home, and given some of the changing methods of delivering solutions, and the need, with CAR-T or something similar, to create special places where things can be offered and there can be managed access, how is that being factored into your strategy? I am a bit concerned that it is not. We are talking about building, and “equipment” sounds to me like just CT scanners.

Simon Stevens: No, but you are completely right to point that out. There is a separate technology and information capital investment fund that will be created. Some of the down payments on that are already in place; the £250 million that has been announced for AI across the NHS, with the new NHS AI lab, is an example. In thinking about what this new organisation, NHSX, part of NHS England and the Department of Health, will be doing, they are scoping that out very precisely, and that is the discussion that Matt Hancock and I are having with the rest of Government.

Q76 **Chair:** To try to sum up your message to the Chancellor, we have heard about the need for a multi-annual settlement. You have talked about your special plea for long-dated gilts for—

Simon Stevens: That was just a purely economic observation to the side. How the investments are made is not a matter for the NHS.



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Q77 **Chair:** Okay, but are there some other key points that you would like to make, if you wanted to put on record what you would like to see in the Budget, in terms of capital?

Simon Stevens: I think the opportunity to make a visible difference for patients across the country quite quickly is there in a number of those very targeted investments. I think that case is understood. It is not a question of having to start from square one; the case is well understood, and it is now a question of sequencing and mechanisms, and getting multi-year visibility. I do not think there is any in-principle disagreement with that. In fact, at the time when the NHS long-term plan was published, it records accurately that, in January, the understanding we had was that NHS multi-year capital would be set out in spending review 2019. Events have subsequently meant that we have not had a spending review that covers multiple years, but there would certainly be a case for looking at it in a category of its own.

Q78 **Chair:** Thank you. Can I turn to a couple of other issues? First, thank you very much for your recommendations to Parliament and Government for an NHS Bill and legislative changes. Is there anything you would like to say about that before you leave today?

Simon Stevens: First of all, thank you to the Committee for the role you played in gathering evidence and building consensus, as well as setting recommendations, which we have taken into account. Thanks also to the 192,000 people who responded to the consultation that we ran over the course of the summer.

The NHS England and Improvement board ratified a set of targeted legislative proposals at our public board meeting in September. We were very pleased that they were supported by a wide cross-section of NHS stakeholders, ranging from Healthwatch, Unison, the Local Government Association, NHS Providers, the Royal College of Nursing, the Academy of Medical Royal Colleges, the King's Fund, the Richmond Group of Charities, the Patients Association, the Royal College of General Practitioners and many others. I think you have before you a consensual set of proposals that, hopefully, under whatever circumstances prevail in Parliament in this Session or the years ahead, will inform the judgments that ultimately will be for you, collectively, to make.

Q79 **Chair:** Thank you very much. Another area the Committee has questioned you about previously is the ongoing failure to be able to provide the right drugs for cystic fibrosis. In the past, we have had the chief executive of Vertex in front of this Committee, and he gave some clear commitments that he was going to work and engage constructively. Could you give us your assessment of how that is going, because we still do not see a resolution to this very serious problem?

Simon Stevens: Negotiations have intensified in recent times between NHS England and Vertex. I am increasingly confident that we will be able to reach an agreement between NHS England and Vertex, provided the



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company accepts that, of course, like any other product or drug company, it needs to be capable of being endorsed by NICE. I take this opportunity to thank you for the leadership that the Committee, and indeed Health Ministers, have shown on this, keeping the focus where it rightly belongs, which is on the company working with the NHS in the same way as the vast majority of the life sciences sector does.

Q80 **Chair:** Is the current sticking point engagement with NICE?

Simon Stevens: I am not going to give blow by blow on that. Suffice it to say that, for agreement to be reached, that needs to be a part of it. As I say, I am increasingly confident that we should be able to announce an agreement quite shortly.

Q81 **Chair:** That is very encouraging, but if that does not happen, because we have been in this position before, where we are always on the verge of apparently getting an agreement—

Simon Stevens: We have not really been on the verge before.

Q82 **Chair:** If that does not happen, would you be prepared to look at what happened with, for example, PrEP, in trying to prevent HIV, and setting up a series of clinical trials as one of the options for making the drug available to those who could benefit from it?

Simon Stevens: We need companies to engage with NICE so that we are able to appraise the evidence of the impact of their treatments. As you imply, Chair, there is an exemption in the Patents Act that allows for medicinal product assessment to be undertaken for the purpose of determining whether to use it, or recommend its use, in the provision of healthcare. In principle, that is on the statute book, but, as we have said all along, the quickest way to resolve this would be through the normal processes, and I am hopeful that we will be able to do so.

Q83 **Dr Williams:** You have kind of asked this question, Chair; it is about the timescale. We know that families are desperate for an answer, and we learned from the drug company that it has been destroying stocks of the drugs rather than selling them to the NHS. Should we come back to this in four weeks' time or in eight weeks' time? When can people expect resolution?

Simon Stevens: We need to get this resolved as fast as we possibly can. Therefore, I think we are talking shorter timelines than that, one way or the other, and I am hopeful that we will be able to get a proper resolution. I do not want to say more than that because until this is concluded, it is not concluded.

Dr Williams: Understood.

Chair: Thank you very much for your time this afternoon.

Examination of witnesses

Witnesses: Matt Hancock and David Williams.

Q84 **Chair:** Thank you very much for coming. We have a lot to cover on NHS capital today, so I will kick off.

We heard from our first two panels the extent to which trusts are having to do firefighting rather than being able to plan ahead. Could we start with the maintenance backlog, which we have heard is increasing? What is your assessment of the maintenance backlog currently in the NHS, Secretary of State?

Matt Hancock: We accept the figures; there is around £6 billion of maintenance backlog, of which about £3 billion is critical. But, in a way, I would step back. In the premise of your question, you said that the challenge is to have a longer-term and more strategic approach, and then went straight into backlog.

Q85 **Chair:** No, I am saying that these are separate issues. Could we start with the backlog and come on to the—

Matt Hancock: Okay. The point I wanted to make, which is really important, is that they are not separate issues. In the past, one of the problems was that the backlog and the attitude to capital for rebuild and improvement have been seen as if they are separate, whereas actually managing the NHS estate is a job that needs much more join-up and a much more holistic approach. The aim of the health infrastructure plan, which, of course, in the debate about it was about the 40 new hospitals, HIP 1 with six and HIP 2 with 34, is to have a much more strategic approach over the medium term.

Q86 **Chair:** That will be very helpful in the long term for hospitals in my own area, like Torbay, which is on the list. It is very good news locally. However, that might not come on stream for another 10 years and, in the meantime, they are seeing critical issues. For example, recently the entire telephone and IT system went down because of a hardware issue. They are still having to catch up and, as you know, because I have raised it with you before, there is the closure of theatres because of air extraction systems. There is here and now an issue that they have to address.

I agree that, strategically, in the long term we need a rebuilding programme, but across the entire NHS estate we have heard that there is a critical maintenance backlog issue. To put the figures in context, as I understand it, the most recent data says that it is now £6.5 billion, of which £3.4 billion is classified as high or significant risk. We heard from trusts, when we had a roundtable discussion, and we have heard here today, that they feel they are firefighting all the time to try to keep up.

Matt Hancock: Yes, hence we need to move to a more strategic approach. I absolutely agree that there are challenges that need to be resolved, hence putting £1.1 billion more into this financial year this summer, the vast majority of which will go on the backlog and maintenance, as we announced in the middle of the summer.



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I see it as all part of an attempt to take a more strategic approach, which includes immediate remedial action, yes, but trying not simply to live hand to mouth and year to year, as has happened too much in the past, especially when, in the past, PFI was seen as the way to build big new builds and capital was for the short-term measures. It has been a disaggregated picture, and it has been unstrategic, and that needs to change. Hence the way I reacted to your first question: we cannot separate these things. We must address the immediate, but we have to address it in a way that is consistent with having a long-term strategy at the same time.

Q87 Chair: But do you recognise that there needs to be greater flexibility for local areas to decide how they are going to spend their capital budgets on things that they think are the critical priorities for their area?

Matt Hancock: I agree that there needs to be capability for local areas and trusts to make decisions, and, to do that, we need more clarity about the national picture. One of the reasons that some people got confused about the £1.8 billion of new money that was announced in August, and why they asked whether it was new money, is that any trust has to live within its local budget, but the system as a whole needs to live within the national budget. Because some trusts can spend capital money without asking the centre, essentially, and others cannot, it means that, when we need to ensure that we fit within the capital envelope voted by Parliament, there are only certain parts of the system that we can ask to constrain their capex so that we can fit into that pot. When a foundation trust in a strong financial position chooses to spend capex, that still counts against my budget, which David manages for me brilliantly, even though I have no say-so over it.

The way we can have more flexibility at local level is to have more clarity about the envelope within which each system can spend each year, and then to make sure that the sum of the budgets over each system—by system I mean an ICS, as they are formed—is the sum of the national pot that we have. Otherwise, you get the problem that, in order to live within a national envelope, we have to constrain the capex of certain local trusts that we have power over but not others that we do not. That is not fair, and it is certainly not a long-term way to plan capital.

Q88 Chair: I do not think we necessarily want to spend too much time today arguing about whether it was new money or old money, because we have much bigger issues.

Matt Hancock: No, because there is total clarity that it is new money.

Q89 Chair: But I am afraid that I think there are very serious concerns about the way this was characterised as new money. Would you accept that?

Matt Hancock: No, I would totally reject that. The capital budget for the NHS was higher by £1.8 billion because of the £1.8 billion that we announced. It was entirely new money to the NHS.



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Q90 **Chair:** But it was not new money. This was money that the systems had saved and put on one side. They were then told that they could not spend it. It was frozen, and then you unfroze it. It is not new money if you unfreeze money that was already preannounced.

Matt Hancock: Maybe this is not worth the time, but the reason that it was new money, categorically—David will back me up on this—is that the NHS across England did not have the budget at a national level to allow that spending to happen. Ultimately, Departments are granted money by votes in Parliament on estimates, and Parliament had granted us £1.8 billion less than it will now grant us because of that announcement. An individual trust, which we had had to stop spending money, had it on its balance sheet, but there was no space for the expenditure on our annual budget that is granted by Parliament.

It was new money to the NHS, every single penny of it. I understand why, to some individual trusts, it did not feel that way, but that is precisely the problem I want to address in the health infrastructure plan and why we need a long-term approach. It is at the root of the reason why the approach to capital expenditure in the NHS has been hand to mouth. In a way, the row we had over whether or not it was new money demonstrated that there is a problem, because under the current rules, which we are changing, part of the system is allowed to spend money that counts against my budget, voted to me by Parliament, that we at a national level are not in control of. I hope I have explained that reasonably, but maybe David can clear it up.

Q91 **Chair:** A lot of people will, I am afraid, agree to differ with you on this issue.

Matt Hancock: They may do, but they are wrong. There is nothing I can say other than that.

Q92 **Chair:** There is a history of this, isn't there? Over the years, we have seen all sorts of things happening around capital to revenue transfers, and money being transferred into NHS England budgets.

Matt Hancock: Yes, and we are trying to tidy all that up.

Q93 **Chair:** That is then portrayed as an increase, when in fact it has resulted from shrinkages elsewhere.

Matt Hancock: Absolutely. The irony is that I have tried to clear that up in this approach. As a result, I had some people saying that it is not new money, when we are precisely trying to unwind some of the approaches that have been used in the past to give the impression that the budget is going up by more than it is, and to ensure that the capital regime is strategic, rather than in-year. I do not think it is a good way to manage the budget for something as important as the NHS that we get estimates, at the start of the financial year, of what foundation trusts where we do not have control over capex are going to spend, and then we have to try to find other places in which to stop the capex in order to live within the



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national budget. That is no way to run a system as big as the NHS, and we are going to change it.

Chair: Okay. We do not want to have an argument about it today, because we could spend far too much time on it, and we want to try to be more forward looking; it has been our decision that we do not want to spend too much time on it. I am going to give some of my colleagues opportunities to come in on the other things that we have heard today.

Q94 **Andrew Selous:** Secretary of State, one of the real complaints that we have had from trust chief executives is that their local discretion to take decisions in the best interests of their trust is, effectively, taken away from them because of the length of time between capital allocation and capital delivery.

Matt Hancock: Absolutely.

Andrew Selous: Can you give us a real assurance today that those two points will come together, so that trust chief execs can actually decide what they want most to spend the capital on within their trust?

Matt Hancock: Yes, within a budget where the budgets of the trusts and the ICSs add up to our total pot. The thing is that there is a reason why the system has been so poor at serving the trusts, especially trusts that are not foundation trusts, where they had to come to NHSI—now NHSE&I— and us for sign-off. The reason the system has been so poor is that half the system—the foundation trusts in good financial shape—can spend my national budget without my say-so, so we have to balance the capital budget by altering the decisions over individual projects of the non-foundation trusts and the foundation trusts that are not in financial good shape that we have power over. That is the explanation behind the previous answer.

I arrived in the Department to find people saying, "It's so frustrating. The bureaucracy is really slow on this." The truth is that the Department, in many cases, did not have the national budget and therefore did not approve things because they did not fit within our envelope. What we need is a proper planning envelope that cascades down to each local area, so that each ICS will live within its capital budget in the same way as trusts now have indicative budgets for how much they need to live within on the resource side, and the entire system of the NHS and the budgets of individual NHS trusts and systems add up to the total amount that is granted by Parliament and decided by the Treasury for NHS expenditure each year. That does not exist at the moment, which leads to all sorts of perverse and complicated things happening in the system. It needs to change.

Q95 **Andrew Selous:** One of the areas that trust chief executives have expressed frustration with is the behaviour of NHS Property Services. On the contrary, we have just heard some very good things from Sir Robert Naylor about what the property board is doing in terms of



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redevelopment, which seems very sensible, making good use of NHS assets. But we heard from a group of trust chief execs a few weeks ago about properties being kept empty because rents were being set artificially high by NHS Property Services. We were told that hundreds of millions of pounds were being locked up in the NHS estate, which was not being made best use of.

We also heard that your attempt to do something about that in May this year, which was some guidance on the transfer of assets to trusts, was not proving as easy to work with as I think had probably been the policy intention, in that it was perceived as slow and clunky. Is that something that you can have a look at again?

Matt Hancock: NHS Property Services does a good job at ensuring that the broad NHS property portfolio within its remit, which Simon said was around 12% of the overall property assets of the NHS, is managed effectively. However, it is very clear that often it is better if an asset is held by the local trust so that it can be used locally; it can be changed and different services can be put into it. In May, I introduced a new measure to allow for properties to be moved to local trusts where there was a decent business case. We have started to sign off some of those. My prior is that if you ask, and you have a half-decent business case, it will go through.

The truth is that we have not had many applications. I want to hear about it if people are saying that the system is slow and clunky. The applications have not got to us yet. Don't just rest on your laurels. If you have an example of this, people should not rest on their laurels but should write to me in the first instance. It is a departmental decision, a ministerial sign-off, and we will get on with it.

My presumption will be in favour, and that is what the guidance states. Of course, there has to be a business case, because properties come with liabilities and costs, and we need to make sure that they are fairly appropriated. If there is an NHSPS asset that a trust or an ICS thinks would be better managed locally by a trust, the presumption is in favour of transfer, and people need to get on with it.

If there is glue in the system that means it is not moving as fast as it should, I want to know about it. People may be saying that it is clunky, but at the moment people just aren't using the process. People should go for it. It may be that they are writing to the wrong people, because it is new, or what have you. I think two transfers have been made; there is certainly one that I know of, because it is in my own constituency. It came to me as a constituency case. Newmarket Community Hospital was owned by NHSPS but operated by the West Suffolk foundation trust, and there was no process for that transfer. Then I heard of other cases in Dorset and Devon, where people asked exactly the same thing, and on my visits around the country I heard the request many times, and I said, "Okay, we're going to have a process." We have a process, and a couple have been through it, but we are awaiting demand.



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Q96 Andrew Selous: You can't say fairer than that. We are only reporting back to you what we heard from trust chief execs a couple of weeks ago, but it is a very positive spiel and I am sure they will be pleased to hear it. I am sure the applications will be tumbling into your inbox as a result of what you said.

Routine annual maintenance was historically largely done when trusts were able to generate a surplus of 5% or so. You have 70% of trusts in deficit at the moment, so that is not possible for a lot of trusts, perhaps because of their configuration. In future, in terms of the routine maintenance that, traditionally, most businesses would do—they would have a 5% surplus that they would put into repainting and sorting out the outside of the building, and so on—what is the plan as to how that will be done?

Matt Hancock: In principle, we want to see the routine maintenance, and indeed some upgrades, come from the retained surpluses of trusts. The way we see it in the health infrastructure plan is that some capex will be funded bottom-up from those surpluses, and from loans, like the capital loans, some of which we approved today. Others are projects that are approved top-down and come from a national budget, such as the announcement in the summer of the Luton £100 million upgrade, and the HIP major projects—the 40 new hospitals. There will be some that are capex, generated from surplus locally, and some where it is a strategic national decision.

Q97 Andrew Selous: But it sounds as if there is going to have to be a national rebalancing if only 30% of trusts are in surplus and you have 70% in deficit. It sounds as if you are going to have an ongoing role looking after the 70%.

Matt Hancock: No, we want them to get back into financial balance.

David Williams: That links back to the Secretary of State's first point about how you need a strategy for backlog maintenance as part of an overall capital strategy, as well as short-term action. That is the right approach. Our long-term ambition is indeed that that tranche should generate through their routine activity enough income to cover the costs of that activity and a surplus for routine maintenance and upkeep, and low-level upgrade.

In the long-term plan, No. 1 of the five financial tests is about returning the provider sector, in aggregate and individually, to financial balance over the period. That will help individual organisations. Some of the challenge we have at the moment is where the money that has gone into the system on a revenue basis, as we heard from some of the think-tank witnesses earlier, has been skewed more towards trusts that are already doing quite well financially, rather than those that are doing worse.

We have quite a lot of cash in the system but it sits, on the whole, with a subset of providers, which, as the Secretary of State said, are those that largely speaking we have less central control over, but we still have need



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to meet elsewhere. The ambition in the capital strategy is absolutely that people should generate enough revenue to generate a surplus and be able to use it for capital investment.

Notwithstanding the point about timescales and doing something earlier, one of the particular criteria, as Simon Stevens said, for the last set of announcements—the HIP 1 and 2 programmes in particular—was around the age of the estate and the level of backlog maintenance and critical infrastructure risk. Those 27 projects and 40 hospitals, when delivered, would address 50% of the critical infrastructure risk that is there today. I know that is over a period of time, but a combination of local surplus and top-down intervention when needed is where we want to go.

Matt Hancock: That is why you cannot separate backlog maintenance from where you put the new build, because one of the criteria for where you put the new build is that if you rebuild a hospital, obviously you knock out a load of backlog maintenance at the same time, which makes the net cost lower.

Q98 **Chair:** Yes, but it is not going to be built for 10 years, in many cases, so you still have to deal with something in the meantime so that you can actually provide services.

Matt Hancock: Absolutely. It is a programme over 10 years.

Chair: We have heard very compellingly the impact that this has on productivity across the NHS as well.

Matt Hancock: Absolutely, yes.

Q99 **Chair:** As a matter of interest, where do you think we should sit in terms of the level of our capital investment, compared with OECD or EU levels? Where would you like to see it?

Matt Hancock: This year, I think we should sit where we are, after the uplift we got in August. Then for next year and future years, we should sit at the level we agree with the Treasury at the next capital review.

Q100 **Chair:** That was not answering my question. It is a serious point.

Matt Hancock: Of course it is a serious point.

Q101 **Chair:** We are a major outlier in the amount that we spend on capital in the NHS.

Matt Hancock: We are an outlier in capex, and the fact that so much of it, especially in the previous decade, was in PFI and, therefore, is highly constrained capital. Our tech spend is much lower than the OECD average as well, which is part cap, part revenue. Absolutely. My enthusiasm for ensuring that the capital estate is as good as it needs to be needs no tempering. Since I managed to get the enthusiastic support of the new Prime Minister, we have spent an awful lot of time and effort over the past three months getting moving on this, after essentially being blocked by Treasury for a long time. Now we are getting cracking.



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Q102 **Chair:** But the thing is that we are just trying to recover from the position that we have had for five years of capital-to-revenue transfers. We have been artificially making it look as if we are spending more on the NHS by describing it just as NHS England, but some of that has been coming from other budgets.

Matt Hancock: I want to get away from that approach. I do not favour cap-rev switches at the end of the year in order to find a financial balance. I want to get away from all those approaches—the non-strategic approach to where capital expenditure goes, according to the legal status of the hospital trust. I want to get away from the hand-to-mouth approach—the “here’s another bit of manna from heaven” style solution to pressing problems. You can spend capital money, which is all taxpayers’ money, much more effectively if you have time to plan.

I got criticism for the HIP process being 40 hospitals over a decade, but part of the problem has been that people have not known that they are in the programme for several years’ time. Let’s take an example at random: Torbay hospital. They now know that they have the go-ahead to do the planning work, with the presumption, of course subject to business case, that they will get a new hospital in the second half of a 10-year period.

Q103 **Chair:** But how can they be guaranteed that when actually the track record, as we have heard, is that just 3% of money previously promised for capital projects has actually made it to the frontline? How confident can we be that this will actually be followed up with delivery?

Matt Hancock: That is what the whole HIP process is all about. It includes simplifying sign-off procedures. We have a single board that is now chaired by David Williams, including NHSE&I, so the Department is taking a much more strategic oversight, as opposed to just leaving it with the system. Specifically, on the STP capital, which I think is what you are referring to with the 3%, that is upgrades—not new hospitals. We have not really had a new hospital programme.

Q104 **Chair:** No, I realise that, but it is just giving you the point. You can understand why people are a bit cynical.

Matt Hancock: I want to fix it.

David Williams: We need to do better, but it is worth bearing in mind that the STP pipeline of around £2.5 billion was a multi-year settlement, and largely backloaded. In the first two years, we were looking to spend only about 5% of the total anyway, and we have spent about 3%. There is still room to improve, but the money ramps up this year, and the peak years of that programme are next year and the year after. Without wanting to be complacent, because there is more we need to do to improve the process, it is not surprising that we have not seen much spend so far.

Q105 **Chair:** But it is not just the STP programme, is it? That was the STP programme, as you say, but only £48 million of £325 million announced



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in the Budget in March 2017 for the first wave of NHS transformation projects actually made it to the frontline. Do you recognise that figure?

David Williams: There are 25 schemes and five are finished; 75% are at the final business case stage, so I expect the money will flow pretty quickly.

Q106 **Chair:** We are just seeking assurance that this will actually be followed up.

Matt Hancock: Absolutely. If there is one message that I could get across in this session, it is that the health infrastructure plan was received as an announcement of 40 new hospitals, and there was the debate over HIP 1 and HIP 2. That is just the start. The point of the health infrastructure plan is to turn the capital expenditure of the NHS into a strategic, organised plan and system, rather than the essentially piecemeal aftermath of a PFI-based approach. It is all part and parcel of getting rid of PFI, doing everything up front and on balance sheet, and being transparent with the finances as opposed to the financial implications of some of the decisions that were previously made, which you alluded to earlier. It is an attempt to turn the system into one of strategic planning from one of piecemeal decision making.

Chair: Thank you.

Q107 **Dr Williams:** Secretary of State, specifically on the mental health estate, which was described by the independent review of the Mental Health Act as being among the NHS's worst estates, we have seen proportionally less investment in mental health than in acute services. Mental health accounts for around 14% of revenue spend, but it had only 9% of capital investment in the financial year 2017-18. Would we expect to see that proportion continue, or would you like it to change?

Matt Hancock: I want to see more investment in the mental health estate. I also want to see more investment in the estate for supporting in-patients with severe learning difficulties and autism, which is a separate area that is sometimes seen within the same discussion but needs to be properly separated. Mental health services are proportionately more likely to be delivered in community settings. I would not automatically take a par proportion of revenue expenditure as the appropriate level for mental health investment. There were a lot of mental health investments in the STP programme, partly because of the scale of each individual investment.

Each individual mental health estate tends to be on a smaller scale, so it is not likely to be in the majors scheme in HIP. Having said that, one of the exciting things about some of the HIP projects is that they plan to be properly and fully integrated physical and mental health services, which we have never properly done. Some of the schemes that are now going ahead and starting their development for HIP 2 propose to bring community mental health services and acute secondary care services together, and I think some of those schemes will be world-class in how



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they do that. The very best are, essentially, taking the allocation as money to be spent at ICS level, and bringing in primary care community hospital approaches. I think that is very exciting, where it is working.

Q108 Anne Marie Morris: Secretary of State, I am delighted that Torbay has the opportunity to put forward its business case, but I am sure that along with other hospitals it will say, "Having put forward my business case, what are the chances of me having my case accepted?" You will probably say that it depends how good it is, and I will say that you still have to have a budget, because you have to agree it with the Chancellor. All things being equal, could all 100% of them get through? Do you have the budget for them?

Matt Hancock: Absolutely, yes.

Q109 Anne Marie Morris: And the Chancellor is happy with the sum of money that this is going to cost.

Matt Hancock: Yes. The commitment is for 40 new hospitals over the next decade, as you heard the Prime Minister say at conference. There are two reasons why we did HIP 2 in the way we did. One is that we of course want to make sure that the plans as they are developed are really good value for money, so it is entirely reasonable for the centre to reserve judgment on any given business case. The second is that funding in the second half of the next decade is not yet in the Treasury Red Book at all; it is to the right of the charts. It is the go-ahead to develop plans with the presumption that they will be taken forward, and I am fully confident that they will be built.

Q110 Anne Marie Morris: Excellent. I am pleased to hear it. When you develop this new strategy, I assume that it will take account of the fact that we are moving to a different way of delivering health and care. Some of it is in a community setting, as we have said before, and some will be at home. As you yourself always advocate, the use of technology and IT is a crucial piece of that. Is the strategy going to cover capital in its broadest sense, including IT equipment and the new structures and places for managed access provision?

Matt Hancock: Yes. To give a bit of colour to that, I first proposed to call it the hospital infrastructure plan. In fact, it was going to be the hospital infrastructure strategy, but we thought HIS was a bit of a funny acronym, so it became the hospital infrastructure plan. Then David suggested we call it the health infrastructure plan, precisely to indicate that it is about more than just hospitals; it is about delivering health and care in a locality.

Q111 Anne Marie Morris: In previous submissions to this Committee, much of what has been said related to a shortage of equipment—scanners and the like. It seems to me that, yes, they are expensive, but in the grand scheme, to try to resolve some of the issues, and to fast-track some of the technology so that cancer and other things can move forward, is that something you have in hand? Is it something you would like to see?



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Matt Hancock: Yes, we have announced £200 million for scanners across the country, to be spent this year and next year, £100 million in each, and we are shortly going to announce where we are proposing to fund those.

Q112 **Anne Marie Morris:** Scanners are one piece. There is lots of equipment. Do you have a broader strategy for an immediate resolution, as opposed to the big strategy that will take rather longer to arrive at?

Matt Hancock: A lot of individual equipment and IT will be paid for on a revenue basis—for instance, cloud data storage is now a revenue cost, not a capital cost—and from the retained surpluses of hospitals that are in good financial shape. But we will also have an approach that is capital from the centre, to be allocated strategically. Across technology and other equipment, it will be a combination of capital that comes from the centre top-down and capital that is generated locally.

Q113 **Anne Marie Morris:** Given that IT has always been the NHS's real problem, and you are such a fan, which is great, are we going to see a joined-up IT and technology strategy across the NHS?

Matt Hancock: Yes.

Q114 **Anne Marie Morris:** How long will it take to deliver that?

Matt Hancock: I created NHSX to be able to deliver that strategy. NHSX is a hybrid organisation that is both part of the Department and part of the NHS, precisely to be able to deliver within the NHS, but also to fit within the wider health and social care responsibilities that I have as Secretary of State outside the NHS—for instance, to make sure that it links up with social care, hospices and other parts of the health and care system. NHSX is working on that and doing an absolutely brilliant job.

Q115 **Anne Marie Morris:** Timescale?

Matt Hancock: The strategy is delivery, if you like. But if you think that they need to write that down in a clearer format in a document, that is something we are able to do.

Q116 **Anne Marie Morris:** I think that would be a good idea, not least, it seems to me, because it is your passion. Not to document it or publish how successful it has been or not to publish when we are going to have a proper strategy that we can all share would seem to be a lost opportunity for you, Minister.

Matt Hancock: The Department wrote the tech vision, as it was called, and published it, I think in November last year. It is based on standards of interoperability, cyber-security and privacy, to make sure that the systems can talk to each other. The idea within technology is that we say, "You must fit within these standards, so that the systems can talk to each other, but, within that, you can buy what works for you locally." The vision document sets out the strategy and plan. A year on, a huge amount of work has been done, so it may be time to publish an update.



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Q117 Anne Marie Morris: Thank you. I am very pleased that you are going to change this dreadful system of capex and top-down and bottom-up, the problem being, as you say, that some trusts can spend because they are in surplus, and others cannot, so because of your limited envelope you are always trying to get that balance with a limited amount of cash. If you are getting rid of that system, will you then be able to take a proper look at trusts that are in deficit through no fault of their own? They are historically in deficit not because they have always been set up to fail but because they have peculiar problems, whether their rurality or being in areas of deprivation—

Matt Hancock: Or PFI.

Q118 Anne Marie Morris: It would be instead of the current system, whereby, if you are in deficit, it is hard to get any more money and you are actually told to save more, which seems counter-intuitive if the reason is that they cannot help being where they are. It is not that they have been profligate.

Matt Hancock: In a way, the control totals process, whereby a trust has to live within a control total, which brings them back to balance, is a recognition that some have costs that are outside their control—for instance, expensive PFI, bad deals that were struck a decade ago that make it much more difficult. We plan to bring people back to balance, as David was saying.

Another proposal that the NHS has put forward as part of the long-term plan Bill is to ensure that all trusts have to live within a total that can be afforded by the system. I do not want to take away the autonomy of foundation trusts to run their organisations well, but at the same time we need to balance that with the ability of all trusts to live within a capital envelope that the system as a whole can afford, so that we avoid the problem we reached this summer. That has been proposed by the NHS for the NHS Bill, and I want to do that carefully, in a way that works, in the same way that at the moment the control total works, and make sure that we can have a strategic approach.

Q119 Anne Marie Morris: The first answer to my question was that you would ensure that those who were not of their own fault in deficit because of historical issues—you said yes. Now you are talking about going back to a constrained envelope. I am a little confused as to where you are. I understand that people have to live within their means. I get that.

Matt Hancock: The first half of my answer was essentially about revenue and the second half was essentially about capital.

David Williams: On the first half, it is part of the financial test in the long-term plan about providers getting back to balance. NHSE&I are specifically looking at a plan for the most challenged, alongside making sure that the new regime continues to incentivise good and strong financial performance by those who are already doing well. Getting that balance right is important, but part of the diagnosis of the problem for



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the most challenged trusts is looking at the challenges for those in local management control, those with a system issue and those where there is a structural deficit, which could be an expensive PFI or something else. Depending on the balance of those factors, your response or your plan for that organisation will be different.

Q120 Anne Marie Morris: When will the new system be in place? I think it will make quite a bit of difference.

David Williams: On the back of the publication of the long-term plan, we had a sort of interim or transitional financial framework for this year. There will be detailed planning guidance produced by NHSE&I around the turn of the year for next year. Whether we get there all in one go or there is one more phased transition remains to be seen.

Q121 Anne Marie Morris: The Government have renegotiated some PFI contracts successfully. Can I plead with you to have a go at some of the others, because it would make a big difference if some of the PFI contracts were renegotiated? They are a real weight on the financial balance sheet.

Finally, before the Chairman gets cross with me, on ICSs, and their status going forward, which I know has been discussed by the Committee long before my time, if this is the future and they are to try to look at the local health system and own it, run it and manage it, how close are you to thinking about making them a legal entity? I appreciate that there are pluses and minuses to that, but, if you are in the process of looking at property and new build, and where it is going to vest, if it vests in the trusts, in a sense you are creating a problem for the future, if you ultimately decide that, in an integrated system, ICSs are what are going to drive it.

Matt Hancock: Of course, there needs to be a legal form, which is proposed by the NHS in its long-term plan proposals. The question of exactly what legal form comes down to what you do with CCGs. Having the commissioner and provider within a legal committee is one important step forward. If you merge the provider and the commissioner, it makes a material difference to how things operate on the ground. The NHS has proposed that we do the former and give them legal form as a system.

I would expect decisions about local capital projects and proposals up for funding from the centre on capital very much to be driven by ICSs. I see the role of the regions as essentially consultative and being helpful—potentially, for instance, championing their region's bids as the regions did when we put together the 40 in HIP 1 and 2. The decision making, when it is a national decision, will be with the new joint committee of NHSE&I and the Department, so that we have one decision-making process, rather than having to go through a whole series of layers, as at the moment. ICSs will play an absolutely critical part in that in future, and they will have a legal form.



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Q122 **Andrew Selous:** Can I touch on capital for primary care, particularly in areas of very high housing growth, like my own? I have a lot of GP surgeries that are extremely cramped. We have proposals for hubs coming along, but quite slowly. Is sufficient capital allocated for primary care in areas of particularly high housing growth? Are hubs where it is all going? What is the vision for capital in the primary care estate?

Matt Hancock: That is a great question, and very important. I would expect that, as the work on HIP extends, we will want to ensure that we take a strategic approach across primary as well as secondary care. Primary care capital rests with NHSE at the moment, because it is tied to commissioning GP services. As I said, we are bringing the linkages between decisions made by NHSE&I and the Department, which previously have been done in three separate spaces, all together under David's leadership to try to ensure that we have a more co-ordinated approach between the different parts of the health service.

Q123 **Andrew Selous:** Have you taken into account the fact that younger GPs looking to make a career in general practice may well not want to have to own part of the buildings they operate in?

Matt Hancock: Yes.

Q124 **Andrew Selous:** We do not expect hospital consultants to have to buy part of the hospital in order to work there. It is perhaps a bit of an outdated model in some cases. Has the capital allocation taken into account the fact that new, up-and-coming GPs will not necessarily want to buy into the model, as they have in the past?

Matt Hancock: Yes. The partnership review earlier this year addressed that central challenge. In a way, if you step back, over a generation, primary care has benefited from the fact that many GPs who had a financial stake in their property have had an uplift over a career, as property prices have gone up. Now that is more likely to present a barrier than an opportunity, which is one of the challenges in primary care.

There are already some incredibly exciting structures being developed to solve this, through the use of mutuals and community interest companies to hold the property for a GP practice, and through the use of federations. GPs may want to become salaried, with the assets held by an organisation that is essentially their employer and who holds the contract with NHSE. That is why primary care capital is deeply entwined with the GP contract, and the whole thing needs to be looked at in the round. Of course, GPs are, in the main, private providers in the NHS system, a fact that should not be lost on those who want to abolish private provision in the NHS.

Andrew Selous: Indeed.

Q125 **Chair:** Secretary of State, if you have time, could I quickly touch on some issues that were raised in the "State of Care" report?

Matt Hancock: Yes, of course.



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Chair: One issue that they raise is that A&E and the four-hour targets are a barometer for pressures for the whole system. As you know, the issue last summer was that we have not had a let-up in the NHS. Usually, we talk about winter pressures, but we are now having to talk about summer pressures as well. It has been a particularly difficult summer across the NHS in terms of pressures on the whole system. Would you accept that?

Matt Hancock: Yes. Attendances have been up around 10% across the system, which of course puts on pressure.

Q126 **Chair:** People turn up in EDs when there is nowhere else to go, very often. If there is poor social care, people end up in emergency departments; if they cannot access their GP services, they end up there. It is the place where the lights are on and where people tend to go, and then they often end up in more expensive care settings, because they are more likely to be admitted to an expensive care setting, which might not be the most appropriate place. It is a barometer for pressure across the entire NHS and social care system.

Matt Hancock: Well, up to a point. If we think that people would be more likely to go to A&E if there was pressure on getting an appointment with a GP, you would expect the average acuity of attendance at A&Es to fall, and we have not actually seen that. The reasons for the rise in attendance are complicated, and not immediately obvious. We are doing some work on why, obviously. At the same time, we have the clinical review of standards across 14 test sites, because the four-hour target is not regarded by clinicians as the best way to measure performance of an A&E.

Q127 **Chair:** If we track performance across several years, you can just change the goalposts and make things look better. If we look at performance in EDs now compared with how it has been over the past five years, we can see that it is getting worse. Would you accept that?

Matt Hancock: I accept that there are very significant pressures, and I also accept that attendances have gone up, but I do not accept that—

Q128 **Chair:** The complexity is higher, too.

Matt Hancock: The complexity is also higher in many cases, but I do not accept that performance has declined. Performance in terms of how many people are seen within four hours has been incredibly positive. Performance as measured by the capability of our A&Es across the country to take patients and treat them has been very positive.

Q129 **Chair:** It is relentless, though. Would you accept that? They are having to work under enormous pressure. The number of people turning up at the door has increased.

Matt Hancock: Exactly. The attendance has gone up very sharply, yes.

Q130 **Chair:** Would you accept that it is a barometer for pressures across the



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wider system?

Matt Hancock: I think that a lot of weight has been put on the four-hour target, and I agree with clinicians who say that it is not necessarily a good clinical incentive.

Q131 **Chair:** I understand the rationale for changing the way they are measured, but if you take it as a marker for how the entire system is under much greater pressure than it was five years ago, for example, it is the best barometer for system pressure.

Matt Hancock: What I am trying to steer away from in my answer is the idea that there is a single measure that describes pressure in the system. For instance, the growth of attendance is a really good measure of pressure, and it is at 10%, which is higher than I think anybody expected this time last year. The word "performance" is important. If you say that A&E performance has gone down, it implies that people working in A&Es have not done so well, when they have.

Q132 **Chair:** I am sorry, but I do not accept that. That is not what I am saying at all. I am not implying any criticism of them. In fact, they are having to work under extreme pressure. That is what I am saying.

Matt Hancock: That is why I am very careful to use the language—

Q133 **Chair:** It is a term that is used, but you and I know that it is not a reflection on the staff themselves. That is never intended.

One thing that came out of the "State of Care" report is that at the moment the CQC operates in different silos. You have the inspectorate for hospitals, the inspectorate for social care and so on. What they cannot do at the moment is themselves set up system reviews. They have established that there are some areas where they have much more effective co-ordinated join-up of care, but they have to come to you separately if they want to do a system review. Do you think there is a case for allowing them independently to say that they want to carry out system reviews of how well they are working together in a particular local area?

Matt Hancock: There is certainly a case that could be made for that, but every time I have been asked, I have said yes, so the system can be made to work at the moment.

Q134 **Chair:** Yes, it can be made to work, but do you think that there is a case for saying that they can independently decide for that to happen?

Matt Hancock: Yes; as I say, I think there is a case that can be made for it, but there are many priorities and this one could be easily resolved by the CQC asking my permission—and I have always said yes.

Q135 **Chair:** Thank you. Are there any other points that you would like to make today, before you leave?

Matt Hancock: No, I don't think so.



HOUSE OF COMMONS

Q136 **Chair:** Could I catch you on the way out about a report that we are publishing at midnight tonight?

Matt Hancock: Yes, please.

Chair: Thank you.