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to the report*

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The Committee of Public Accounts

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Summary

The financial sustainability of health and social care is a serious and ongoing concern of the Committee. The Department of Health and Social Care's 2017–18 Annual Report and Accounts suggests an improvement in fortunes when taken as a whole. But this masks the underlying deficits at a local level and the continued use of short term measures to reduce individual deficits, such as use of the sustainability and transformation fund and money to help with winter pressures. This overall figure also fails to show the regional variations and balancing act between the different health bodies. In 2017–18, 101 of 234 of NHS Providers were in deficit but this was largely off-set by a surplus in NHS England's finances. NHS England achieved this surplus despite 75 of the 207 Clinical Commissioning Groups (CCGs) reporting an overspend. Recent reports that around a fifth of hospital trusts and health boards across the UK have missed their A&E, cancer treatment, and non-emergency surgery waiting time targets, hammer home the concerns we hold about the reality of the financial pressures on trusts at local level.

As part of its long-term plan for the NHS, the Department intends to ensure that finances balance at the individual NHS Provider and Clinical Commissioning Group level, as well as the system overall, but this is still some way off. In addition, the continuing uncertainties surrounding the long term funding of social care, the funding of NHS staff pay awards and the UK's arrangements after leaving the European Union, with issues around workforce and medical supplies, highlight the challenges the Department continues to face. The 10 year plan must set out how these challenges will be met.

Introduction

The Department of Health and Social Care (the Department) is responsible for overseeing the health and care system in England. In 2017–18 the Department’s budget for day to day running costs (resource departmental expenditure limit) was £121.3 billion of which it spent £120.7 billion, it had a separate capital budget (capital departmental expenditure limit) of £5.6 billion of which it spent £5.2 billion. Its Annual Report and Accounts bring together the financial results for the Department and the national and local bodies which form part of the Departmental group. The group includes around 500 individual bodies including England’s 207 Clinical Commissioning Groups (CCGs), 154 National Health Service (NHS) Foundation Trusts and 80 NHS Trusts. In 2017–18 the Department reported that the NHS had achieved a broadly balanced position overall. However, 101 of the 234 NHS Providers (NHS Trusts and Foundation Trusts) were in deficit at the end of the financial year and in aggregate NHS Providers reported a deficit of £991 million. This was largely offset by a surplus of £970 million within NHS England’s (NHSE) finances.

The Comptroller and Auditor General did not qualify his opinion on the 2017–18 accounts but, as in previous years, included an emphasis of matter paragraph to draw attention to the uncertainties inherent in the amount of money the Department has estimated it may need to pay out in the future for clinical negligence claims against NHS Providers.

Conclusions and recommendations

1. **The Department's focus on health spending at a national level fails to take into account regional variations in funding and the impact this has on patient care.** In 2017–18, 101 of the 234 NHS Providers (NHS Trust and Foundation Trusts) were in deficit at the end of the financial year and NHS Providers reported a total deficit of £991 million. This deficit was largely offset by a surplus of £970 million within NHS England's (NHSE's) finances. NHSE achieved this surplus despite 75 of the 207 Clinical Commissioning Groups (CCGs) reporting an overspend, totalling £0.2 billion. At present the Department focuses on ensuring the whole NHS is in balance, but there is significant regional variation in the finances of individual organisations which we are concerned could pose a risk to patient care in areas with large deficits. The Department told us that it plans to address the regional imbalance in the finances of the NHS to ensure that all NHS Providers and CCGs balance their finances or achieve a surplus, but that it would be at least two to three years before this could be achieved and there is no certainty that this will be achieved.
2. **Recommendation: *The Department should, by 31 January 2019, write to the Committee to outline its assessment of the impact regional funding variations have on patient care.***
3. **The Department's lack of a clear plan for recruiting staff after Brexit risks exacerbating existing staff shortages in the health and social care workforce.** At the end of June 2018 there were 108,000 vacant posts in the NHS, which represents approximately 10% of the 1.1 million whole time equivalent staff employed by NHS Providers in England. The Department currently considers vacancy rates within the NHS at a national level. This hides underlying disparities in specific specialisms and local areas and does not allow them to fully understand the impact of staff shortages. We are concerned that existing shortages of staff could worsen depending on the UK's immigration policy following Brexit. We are not reassured by the Department's assertion that it has not seen a large exodus of staff since the referendum and that the number of people from the EU working in the NHS has increased. The Department told us it is committed to expanding the British workforce in the NHS both by training more staff and continuing to ensure that the NHS is somewhere that people want to come to work. It told us that it is working with the Home Office to ensure that the future immigration policy takes into account the need to recruit more permanent staff for the NHS.
4. **Recommendation: *The Department should, by 31 January 2019, write to the Committee to outline how it will address the workforce issues affecting specific specialisms and geographical regions.***
5. **Recommendation: *The Department should, as soon as the Home Office's immigration white paper has been published, write to the Committee setting out how it will respond to any changes in immigration policy arising from Brexit.***
6. **The Department has failed to assess the risk Brexit poses to the supply of medical equipment, risking patient care.** The NHS procures 56% of medical consumables, such as gloves, dressings and syringes from, or via, the European Union. The Department aims to build up a six-week stockpile of these goods, along

with medicines, to mitigate potential supply issues during the weeks immediately following 29 March 2019. It told us that potential disruption to the supply of large medical equipment, such as X-ray machines, was not on its radar. The Department similarly told us that it had not communicated with NHS Providers to establish the impact this potential disruption could have on patient care. The Department informed us that it had however, at the start of October, issued advice to NHS Trusts to perform a review of contracts held with the aim of identifying the potential consequences of Brexit. The Department was unable to tell us what level of risk this poses to NHS Providers, services or patient care and has since written to us confirming that it is not putting specific contingency measures in place in relating to the stockpiling of equipment.

7. **Recommendation:** *The Department should write to the Committee by 31 January 2019 with details of its assessment of the impact of Brexit on the supply of medical equipment and, where necessary, what contingencies it has put in place.*
8. **We are concerned that the Department's decision to fund pay awards through the National Tariff risks the funding not being distributed to the intended NHS Providers.** For 2018–19, the Department has decided to fund the Agenda for Change pay award, covering NHS staff on standard terms and conditions, using one off payments separate to the National Tariff as this had already been agreed. However, the Department did not provide any detail as to how it had allocated the one-off payments to ensure they were only made to cover Agenda for Change employees rather than private healthcare providers or those not on standard NHS pay terms. The Department told us that it plans for the 2019–20 pay award to be incorporated into the National Tariff. The National Tariff includes adjustments to account for the cost of operating in different geographical locations. We are therefore concerned that some NHS Providers in affluent areas will receive a disproportionately higher share of funding even though there is a national pay system in place for NHS staff. Funding through the tariff will also increase payments made to private healthcare providers, whose employees are not on Agenda for Change terms. We are similarly concerned that NHS Providers using wholly-owned subsidiaries, who employ non-clinical staff outside of the Agenda for Change terms, could also benefit disproportionately when pay awards are funded through the tariff.
9. **Recommendation:** *The Department should, by 31 January 2019, write to the Committee to explain how funding for the pay award has been allocated.*
10. **The recently launched consultation on the NHS' regulation of wholly-owned subsidiaries and pause of existing proposals is welcome but must address concerns about the use of these companies.** We have previously raised concerns about the NHS' use of wholly-owned subsidiaries and that trusts were increasingly looking to form subsidiary companies, partly to remove NHS contractual terms and conditions from any new non-clinical staff and thus make savings from lower salaries and pension contributions. We also raised concerns that these subsidiaries may benefit from reduced tax liabilities. The Department and NHS Improvement previously told us that it had not been tracking these arrangements, and neither the Department nor NHS Improvement appeared aware of this trend. NHS Improvement

committed to us that it would review its regulatory oversight of these subsidiaries and we will be interested in the results of the recently launched consultation on regulating the use of these bodies.

11. **Recommendation:** *The Department should update the Committee on the timeline for and outcome of NHS I's consultation on the oversight and use of wholly-owned subsidiaries by the NHS.*
12. **We are concerned that the Department's preparations for winter, and the decision to allocate additional winter funding solely to social care services, may not be sufficient to meet demand.** The Department has a record of implementing annual short-term fixes to deal with the additional demand placed on NHS services during the winter, for example cancelling elective procedures in January 2018. The Department told us that it plans to reduce the need to make cancellations at short notice this winter by scheduling fewer elective procedures. Despite this, it would not provide a guarantee to us that a blanket postponement would not occur again. The Department has provided an additional £240 million of social care funding to local authorities to help reduce delayed transfers of care and increase the availability of hospital beds during the winter. However, if this amount were divided equally between local authorities this would only be equivalent to £1.6 million per authority, despite them suffering significantly larger funding cuts. In addition, the Department told us that it does not plan to seek any assurances that the £240 million has been spent as intended, putting accountability for taxpayers' money at risk.
13. **Recommendation:** *The Department should put in place long term solutions for winter through the integration of health and social care. This should be achieved by the time of its Government's costed 10-year social care plan, due in April 2019.*
14. **The Department's current estimate of fraud within the NHS isn't yet robust enough to enable it to target specific areas to prevent loss.** The Department created the NHS Counter Fraud Authority (NHS CFA), which is responsible for identifying, investigating and preventing fraud within the NHS and the wider health service, on 1 November 2017. NHS CFA subsequently published its 2018 Strategic Intelligence Assessment (SIA) which estimated that the level of fraud within the NHS was £1.29 billion during 2016–17. The Department explained that elements of the estimate are based on dated and non-specific information. It confirmed, however, that the estimate nonetheless provides a starting point for estimating fraud to help identify areas where targeted intervention would be beneficial. As part of its work to combat patient prescription charge fraud the Department issued 1 million Penalty Charge Notices (PCNs) in 2017–18. However, these notices are often overturned on appeal as large numbers are issued as a result of patient administrative error as opposed to patient ineligibility to receive free prescriptions.
15. **Recommendation:** *The Department should, by January 2019, provide the Committee with details of how it will improve its ability to target interventions at specific areas and better prevent loss. The Department must ensure that it distinguishes between what is fraud and what is error.*
16. **The Department's inability to accurately forecast its exposure to clinical negligence costs in advance of the end of the financial year resulted in a £14.8**

billion underspend. The Department gained approval from Parliament to increase its Annually Managed Expenditure (AME) budget by £13.6 billion from £14.7 billion to £27.9 billion in February 2018. This budget relates almost entirely to the amount the Department may pay out in the future when setting clinical negligence cases and could not be spent on the day to day running of the NHS. However, in its 2017–18 accounts, the Department reported that it had underspent this budget by £14.8 billion, more than 50% of the money available. The Department’s estimate of how much these cases might cost relies on an assessment by actuaries that is performed at the end of the financial year. While we recognise that it is difficult to reliably estimate it earlier, we are nonetheless concerned that the extent of the Department’s underestimate suggests it is unaware of its exposure to clinical negligence cases when setting its budget. The Department told us it had taken a cautious and prudent approach to avoid it exceeding the amount agreed by Parliament, but stated that it was not happy with this level of underspend.

17. **Recommendation:** *The Department should create a more accurate forecast of its exposure to future clinical negligence costs. The Committee expects this to be in place in time for the supplementary estimate to avoid a similar underspend against the Department’s budget in 2018–19.*

1 National Health Service finances

1. We took evidence from the Department of Health and Social Care (the Department) on its 2017–18 Annual Report and Accounts, audited by the Comptroller and Auditor General.
2. The Department is responsible for overseeing the health and care system in England and funding the bodies responsible for commissioning healthcare. The Department's spending is financed through a combination of funding voted on by Parliament and a share of national insurance contributions (non-voted) collected by HM Revenue and Customs. The Department is expected to contain its expenditure within these limits. In 2017–18, total funding for the Department's day to day running costs (resource departmental expenditure limit) was budgeted at £121.3 billion, this included a transfer of £1 billion from the capital budget made part way through the year. The Department spent £120.7 billion of the available budget. The Department's capital budget, following the transfer, (capital departmental expenditure limit) was set at £5.6 billion for 2017–18, of which it spent £5.2 billion.¹
3. The Department's Annual Report and Accounts bring together the financial results of the Department and the national and local bodies which form part of the Departmental group. The group includes around 500 individual bodies including England's 207 Clinical Commissioning Groups (CCGs), 154 NHS Foundation Trusts and 80 NHS Trusts. The majority of the Department's resource departmental expenditure limit funding provided to NHS England (NHSE), who, via CCGs, commission healthcare from both NHS and private providers.²

Regional variations in financial performance

4. In 2017–18 the Department reported that the NHS had achieved a broadly balanced position overall. However, 101 of the 234 NHS Providers (NHS Foundation Trusts and NHS Trusts) were in deficit at the end of the financial year and all together NHS Providers reported a total deficit of £991 million. This deficit was largely offset by a surplus of £970 million within NHSE's overall finances. NHSE achieved this surplus despite CCGs collectively reporting an overspend, totalling £0.2 billion, with 75 of the 207 individual CCG's in deficit.³ It also told us that the 31 CCG's with an overspend of over 2% have developed financial recovery plans which will be scrutinised by NHS England before implementation.⁴
5. The Department told us that, since 2016, it has focused on the finances of the health system as a whole to ensure the Department remained within its budget voted by Parliament. However, it admitted that to achieve this it had created perverse incentives at a local level. For example, providers in financial special measures as well as those who have not agreed their budget are charged higher interest rates on the loans they have with the Department. In addition, in 2016–17 the Department, via NHS Improvement (NHSI), introduced the Sustainability and Transformation Fund (STF) which aimed to incentivise

1 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, p 107

2 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, p 67

3 Qq21, 23, [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, pp 1, 5, 35, 198, 200

4 [Letter from Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care](#), 30 October 2018

NHS Providers to improve their financial position and give the NHS the financial stability needed to improve and transform services. NHSI determined the eligibility criteria for accessing this fund, and the amount each NHS Provider received if they met the criteria. In 2017–18, access to the fund was dependent on NHS Providers accepting, and subsequently achieving, a set budget. Therefore, the majority of the fund was distributed to those NHS Providers who were already performing well, rather than those in significant financial difficulty.⁵ The Department told us that the current application of funding encouraged the best to do better rather than helping the most financially challenged NHS Providers gain a more sustainable position.⁶

6. The Department told us that it judged whether a NHS Provider was financially well managed against the NHS Provider’s control total (the budget agreed with the NHSI) rather than whether the NHS Provider broke even at the end of the financial year. The budgets agreed for some NHS Providers mean that they are expected to be in deficit at the end of the year, rather than it being a sign of poor financial management during the year or a lack of financial controls. The Department told us that it wanted to return to a position where the two measures are the same and all NHS Providers would be expected to break even at the end of the financial year.⁷ The Department explained two incentives it is using this year to encourage NHS Providers to improve their financial position. The first will make available additional sustainability funding for NHS Providers who commit now to improving how they manage their finances, with a view to either reducing their deficit or achieving a balanced financial position. The second encourages NHS Providers to sell their assets by allowing them to retain the profits from the sale on disposal. We are concerned that these incentives are based on a short-term view as opposed to addressing the long term financial sustainability of the NHS.⁸

7. We raised concerns over the significant level of variation in the financial performance of NHS Providers across the country and the impact it could have on the quality of patient care in regions with the highest deficits. The Department told us that NHSE and NHSI have launched a consultation on the National Tariff for 2019–20, which sets the amount of money NHS Providers receive from CCGs based on agreed prices for performing health care activities and delivering services. The Department’s intention is that going forward NHS Providers are able to generate, through their activities, the income that they need to cover the cost of delivering those activities. It admitted, however, that it would be at least two to three years before this could be achieved.⁹

Funding pay awards for NHS staff

8. NHS staff are paid based on Agenda for Change (AfC), the national pay system for all NHS staff, with the exception of doctors, dentists and most senior managers. AfC sets the pay bands for staff based on agreed national job profiles. In 2018–19, the Department decided to fund pay increases for staff included in AfC using one-off payments which were separate to the National Tariff. The Department told us that it made this decision so that the prices set within the tariff did not need to be re-calculated as the pay award was agreed part-way through the financial year. We asked the Department how it had

5 Qq 25, 27–28

6 Q140

7 Q22

8 Qq146–153

9 Qq26, 28

gained assurance that the one-off payments made only covered AfC employees, rather than funding NHS staff not covered by the AfC, or private providers, but the Department did not provide any detail to explain this.¹⁰

9. The Department informed us that it intends to incorporate the AfC pay award for 2019–20 into the National Tariff so in future NHS Providers would not receive any additional one-off payments to fund pay awards. We raised concerns that, given the nature of the National Tariff, which uses a Market Forces Factor (MFF) to account for variation in the cost of providing activities and services across the country, this would mean the more affluent areas would receive a disproportionately higher share of the funding.¹¹ The Department informed us that NHSE and NHSI are reviewing the MFF as part of their long-term plan but expect geographical adjustments to remain in place.¹²

10. Funding the pay award through the National Tariff could also mean that private healthcare providers and NHS Providers who use wholly-owned subsidiaries to employ staff outside of the AfC terms and conditions will receive additional funding. Since 2006, NHS Foundation Trusts have been able to establish subsidiary companies. Wholly-owned subsidiary companies have been set up across the country, most notably to generate additional income to support the clinical work of hospitals. When we examined Sustainability and Transformation in the NHS in March 2018, we were concerned that wholly-owned subsidiaries were being used to reduce salaries and pension contributions by removing NHS contractual terms and conditions from new non-clinical staff. We also raised concerns that wholly-owned subsidiary companies were set up to reduce tax liabilities. The Department told us that it was not aware of these concerns, and that it had not looked into the tax status of wholly-owned subsidiaries.¹³ NHS Improvement wrote to us after our evidence session to confirm that there were 42 subsidiary companies included in the 2016–17 accounts of foundation trusts, but that it did not hold information on the number subsidiary companies in the trust sector as a whole. It told us that there was no requirement for trusts to notify NHS Improvement when they establish subsidiaries. It accepted that it had no oversight over this area and committed to ensuring that it had greater visibility of subsidiary companies.¹⁴ We will be interested in the results of the recently launched NHSI consultation on regulating the use of these bodies.

Preventing fraud within the NHS

11. The Department created the NHS Counter Fraud Authority (NHS CFA), an arms length body (ALB) responsible for identifying, investigating and preventing fraud within the NHS and the wider health service, on 1 November 2017. The NHS CFA published its 2018 Strategic Intelligence Assessment (SIA) in July 2018 which estimated that the NHS had lost £1.29 billion to fraud in 2016–17, an increase on its estimate of £1.25 billion for 2015–16. For the purpose of this assessment the word ‘fraud’ is used to include fraud, bribery, corruption and other relevant unlawful activity. The CFA’s estimate assesses 13

10 Qq58, 63, 66

11 Qq59, 64

12 [Letter from Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, 30 October 2018](#)

13 Q1; Committee of Public Accounts, Twenty-Ninth Report of Session 2017–19: [Sustainability and transformation in the NHS](#), HC 793, Q129–136

14 [Correspondence with NHS Improvement: subsidiary companies in the NHS, 15 March 2018](#); [Correspondence with NHS Improvement: subsidiary companies in the NHS, 27 April 2018](#)

thematic areas, including prescription, contractor and procurement fraud. It uses both specific information provided by those working locally in the NHS to tackle fraud, and non-specific information from outside the health service.¹⁵

12. We asked the Department how much of the £1.29 billion estimated fraud loss could have been prevented. The Department explained that elements of the estimate are based on dated and non-specific information. For example, the SIA calculates loss due to payroll and identity fraud using an assessment made by the National Fraud Authority in 2013 which suggested to the Department that 0.2% was a reasonable proxy for fraud within payroll. The Department told us that this assessment did not focus on the public sector and that it was published at the start of the decade. The Department asserted that the estimate was therefore a starting point for identifying where fraud prevention programmes should be targeted, rather than an accurate description of fraud.¹⁶

13. As part of combating fraud in health and social care, the NHS Business Services Authority (NHS BSA), on behalf of the Department, undertake detailed checking of prescription and dental exemptions. Where potentially fraudulent claims are detected by NHS BSA, Penalty Charge Notices (PCNs) are issued. Since the inception of this checking service, NHS BSA has issued 2.71 million PCNs (of which 1 million were issued in 2017–18).¹⁷ We raised concerns over the level of PCNs issued which are subsequently overturned on appeal due to patient administrative error rather than patient ineligibility. For example, when a patient is eligible to receive their prescription free of charge but ticks the incorrect eligibility criteria on the form. The Department told us that the roll-out of electronic prescriptions would allow it to use modern data analytics to address prescription fraud in the future.¹⁸

15 [The 2018 Strategic Intelligence Assessment](#), Period: 2016–17, pp 5–6

16 Qq154–155; NHS Counter Fraud Authority, [The 2018 Strategic Intelligence Assessment](#), Period: 2016–17, pages 5–6, 11

17 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, pages 82–83

18 Qq156–158

2 Planning for the future

The Department's exposure to clinical negligence claims

14. The Department is responsible for paying the costs of damages for the effects of clinical negligence where it is the defendant in legal proceedings brought by claimants where it is the defendant. The Department states how much it estimates these cases might cost in its Annual Report and Accounts, which reflects the likely value of future costs of known reported claims. This was £77 billion at 31 March 2018. The Department also identified a further £46 billion of potential expenditure which related to cases with greater uncertainty over the Department's liability.¹⁹

15. The Comptroller and Auditor General did not qualify his opinion on the Department's 2017–18 accounts but, as in previous years, included an emphasis of matter paragraph to draw attention to the uncertainties inherent in the amount of money the Department has estimated it may need to pay out in the future for clinical negligence claims against NHS Providers.²⁰ The Department gained approval from Parliament to increase its Annually Managed Expenditure (AME) budget by £13.6 billion from £14.7 billion to £27.9 billion in February 2018.²¹ This budget relates almost entirely to the amount the Department may pay out in the future when settling clinical negligence cases and could not be spent on the day to day running of the NHS. Although the estimate in its Annual Report and Accounts is sufficiently accurate, the Department has in recent years been unable to accurately forecast its exposure to clinical negligence costs in advance of the end of the financial year. In 2017–18 this resulted in a £14.8 billion underspend, (2016–17 £6.6 billion²²) which was more than 50% of the available budget.²³

16. The Department told us that estimating its exposure to the costs of clinical negligence cases is particularly difficult due to the long-term nature of the Department's liabilities and the sensitivity of the assumptions on which the estimate is based. As a result, the Department relies on an assessment performed at the end of the financial year by the Government Actuary's Department (GAD) to estimate how much clinical negligence cases might cost to settle in the future. Whilst we recognise that it is difficult to reliably estimate it earlier, we are nonetheless concerned that the extent of the Department's underestimate suggests it is unaware of its exposure to clinical negligence cases when setting its budget. The Department told us it had taken a cautious and prudent approach to avoid exceeding the amount agreed by Parliament, but stated that it wanted its estimate to be more accurate. The Department told us that it is committed to exploring ways to improve forecasting in this area.²⁴

19 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, pp 178, 184

20 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, p 118

21 [Central Government Supply Estimates 2017–18: Supplementary Estimates](#), HC 808, 2017–18, HM Treasury, 7 February 2018, p 145

22 [Department of Health Annual Report and Accounts 2016–17](#), 18 July 2017, p 84

23 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, p 107, Q13

24 Qq13–15; [Letter from Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care](#), 30 October 2018

Preparations for winter

17. Demand for NHS services increases significantly with the onset of cold weather and outbreak of flu, respiratory and gastrointestinal illnesses. The British Medical Association (BMA) described the winter of 2017–18 as the most pressurised in recent history for the NHS with 81,000 trolley waits in January 2018, the most ever recorded in a single month.²⁵ When we examined the Department’s Annual Report and Accounts for 2016–17, the Department told us that it thought its plan was very strong and that the NHS was better prepared for winter than it had been before.²⁶ However, the Department’s National Emergency Pressures Panel recommended hospitals defer all non-urgent inpatient elective care in January 2018, with the exception of cancer operations and time-critical procedures, to ease ‘winter pressures’. This resulted in 22,800 fewer elective admissions to hospital in January 2018 compared to January 2017. The Department estimated that these deferred elective cases freed up the equivalent of 1,400 beds in January 2018.²⁷ The Department told us that it plans to reduce the need to make cancellations at short notice this winter by scheduling fewer elective procedures. Despite this, it would not provide a guarantee to us that a blanket postponement would not occur again.²⁸ The BMA told us that it is deeply concerned that the NHS will experience high rates of admissions, bed shortages and cancelled operations this winter.²⁹

18. In September 2018, the Government announced that the Department has provided an additional £240 million of social care funding to local authorities to help reduce delayed transfers of care and increase the availability of hospital beds during winter. However, if this amount were divided equally between local authorities in England this would only be equivalent to £1.6 million per authority, despite them facing significantly larger funding cuts.³⁰ We examined the pressures on local authority funding in May 2018. We found that after seven years of government funding reductions totalling nearly 50% and rising demand for services, local authorities are under real strain putting key services under enormous pressure.³¹ The Department told us that no additional funding is going directly to NHS Providers to manage winter pressures. It also told us that it does not plan to seek any specific assurances that the £240 million given to local authorities has been spent as intended increasing their capacity to deliver social care services during the winter rather than plug existing gaps in funding.³²

19. When we examined the interface between health and adult social care in July 2018, we found that the government still lacks an effective overall strategy or plan to achieve its long-held aim to integrate health and social care. We recognise that the renaming of the Department to the Department of Health and Social Care in January 2018 was a sign of intent to integrate health and social care provision, but with local authorities squeezed financially progress in achieving this integration has been limited. However, without progress, people are at risk of not getting the joined-up, co-ordinated care they need,

25 British Medical Association ([PDH0001](#))

26 Q1

27 [NHS review of winter 2017–18](#), NHS Improvement, 7 September 2018, p 15

28 Q132

29 British Medical Association ([PDH0001](#))

30 Qq119–120

31 Committee of Public Accounts, Fiftieth Report of Session 2017–19, [Financial Sustainability of Local Authorities](#), HC 970, p 3

32 Qq117, 121

which could lead to poorer outcomes. The Department has set out a high-level vision for what integrated health and social care should look like, secured additional NHS funding and committed to a 10-year plan for the NHS.³³

33 Committee of Public Accounts, Sixty-Third Report of Session 2017–19, [Interface between health and adult social care](#), HC 1376, pp 3, 5

3 Impact of Exiting the European Union

20. The Department has established an EU Exit Programme which aims to deliver a smooth and orderly exit from the European Union so that the delivery of healthcare to UK citizens is maintained and that the health and social care system continues to focus on improving outcomes and achieving efficiencies.³⁴ In evidence to the Exiting the European Union Committee in October 2018, the Department confirmed that the three main issues it faces as a result of Brexit are; securing the supply of medicines, workforce capacity and reciprocal healthcare arrangements.³⁵

The NHS workforce

21. At the end of June 2018 there were 108,000 vacant posts in the NHS, which represents approximately 10% of the 1.1 million whole time equivalent staff employed by NHS Providers in England.³⁶ We asked what impact the vacancy level was having on the Department's use of temporary staff. The Department assured us that its use of expensive agency staff had continued to decline as it works towards having vacancies covered by more cost-effective bank staff. Despite this, we were concerned by the increased use of bank staff as it often results in the Department asking the same NHS employees to do more work, which is unsustainable. We also asked the Department about the differing vacancy rates in particular specialisms and regions. The Department told us that it currently considers vacancy rates within the NHS at a national level, but that it was planning to review geographical areas and specialisms to identify where the impact of vacancies may be greater. We were concerned that this might not be sufficient given that the issues in geographical areas are long-standing and the time needed to ensure an adequate pipeline for some specialisms.³⁷

22. The Department told us that it would prefer to fill posts with more permanent staff rather than using flexible staffing models, and that where it did need flexibility, for these posts to be covered by bank staff rather than agency staff. The Department told us that its long-term plan would include a workforce strategy to try to address these issues. It recognised that this would need to include training (and retraining) more staff, introducing different routes into the health profession and addressing some of the reasons why people leave the NHS, while ensuring those members of staff who want to work flexibly are still able to.³⁸

23. We asked the Department how much more difficult it was to manage the NHS workforce and staff vacancies in the light of uncertainty over staffing that arises from Brexit. There are currently over 155,000 staff from EU27 countries making an important and valued contribution to the health and care system. The Department stated in its Annual Report and Accounts that securing their position has been made a priority in negotiations on exiting the European Union.³⁹ The Department told us that it had not seen

34 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, pp 12–13

35 [Exiting the European Union Committee, Oral evidence: The progress of the UK's negotiations on EU withdrawal](#), HC 372, 17 October 2018, Q 28, 48

36 NHS Improvement, [Performance of the NHS provider sector for the quarter ended 30 June 2018](#), 11 September 2018, 2.5 NHS Provider Vacancies

37 Qq67–68, 73–75

38 Q68

39 [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, p 25, para 104

a large exodus of staff since the EU referendum and that the number of people from the EU employed by the NHS had gone up. The Department recognised that in the number of nurses registered with the Nursing and Midwifery Council had fallen substantially since the referendum.⁴⁰ It told us, however, that this was as a result of the new language test implemented at the same time as the referendum and that it had seen the same results when the language test had been changed for doctors. The Department asserted that the risk to the NHS in relation to staff from overseas going forward is more about the future immigration policy than about Brexit specifically as it expects to continue to have more staff from non-EU countries than from EU-countries. It told us that it was in close discussions with the Home Office about its forthcoming immigration White Paper and the impact this may have on various medical workforces.⁴¹

24. The Department told us that it wanted the NHS to continue to be somewhere that staff from overseas wanted to work, but that it was also committed to expanding the British workforce so that it was not so reliant on overseas staff. In March 2018, the Secretary of State announced 1,000 new undergraduate medical school places, including places at five brand new medical schools, in addition to the 500 new places already allocated to existing schools.⁴² Since our evidence session, the Department has written to us outlining the current schemes to recruit nurses post Brexit. These include a 25% increase in the number of nurse training places available during 2018 (equivalent to 5,170 extra places) as well as incentives worth £10,000 to postgraduate students to take up nursing in certain disciplines (learning and stability, mental health and district) once they finish university.⁴³

Procurement of medicines, consumables and equipment

25. We asked the Department what capital investment or other spending had been required so far in advance of the UK's exit from the European Union, and what potential costs might arise in the event of a no deal. The Department told the only money that it had spent so far had been on the supply of non-medicine supplies, the specific cost of which was commercially confidential but was in the region of tens of millions. The Department told us that it was currently building up a six-week stockpile of medical consumables, such as gloves, syringes and dressings. It told us that the NHS currently procures around 56 per cent of its medical consumables, either from or through the EU. The Department is aiming to build up a six-week stockpile of these goods, along with medicines, to mitigate potential supply issues during the weeks immediately following 29 March 2019.⁴⁴

26. We asked whether the Department intended to stockpile any bigger items of medical equipment, for example X-ray machines. The Department confirmed that the purchase of such items was not on its radar. The Department was unable to answer further questions on the level of risk any disruption to the supply of such big ticket medical equipment posed to NHS Providers, services or patient care.⁴⁵ The Department told us that they had written to NHS Trusts on 12 October 2018 requesting that they review the contracts for goods and services they hold to consider the Brexit consequences associated with each, with high impact areas to be reported back to the Department by 30 November 2018. However,

40 Qq69–70

41 Qq70–72

42 Q72; [Department of Health and Social Care Annual Report and Accounts 2017–18](#), 12 July 2018, p 25, para 105

43 [Letter from Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care](#), 30 October 2018

44 Qq 37–39, 41

45 Qq46–47

this communication did not specifically cover the supply of medical equipment. The Department has since written to us confirming that it is not putting specific contingency measures in place in relating to the stockpiling of equipment.⁴⁶

46 Q43; [Letter from Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, 30 October 2018](#)

Formal Minutes

Monday 10 December 2018

Members present:

Meg Hillier, in the Chair

Douglas Chapman

Nigel Mills

Sir Geoffrey Clifton-Brown

Bridget Phillipson

Draft Report (*Department of Health and Social Care accounts*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 26 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Seventy-First of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 12 December at 2:00pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 17 October 2018

Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, and **David Williams**, Director General Finance, Department of Health and Social Care

[Q1-158](#)

List of Reports from the Committee during the current Parliaments

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Tackling online VAT fraud and error	HC 312 (Cm 9549)
Second Report	Brexit and the future of Customs	HC 401 (Cm 9565)
Third Report	Hinkley Point C	HC 393 (Cm 9565)
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396 (Cm 9575)
Fifth Report	Managing the costs of clinical negligence in hospital trusts	HC 397 (Cm 9575)
Sixth Report	The growing threat of online fraud	HC 399 (Cm 9575)
Seventh Report	Brexit and the UK border	HC 558 (Cm 9575)
Eighth Report	Mental health in prisons	HC 400 (Cm 9575) (Cm 9596)
Ninth Report	Sheffield to Rotherham tram-trains	HC 453 (Cm 9575)
Tenth Report	High Speed 2 Annual Report and Accounts	HC 454 (Cm 9575)
Eleventh Report	Homeless households	HC 462 (Cm 9575) (Cm 9618)
Twelfth Report	HMRC's Performance in 2016–17	HC 456 (Cm 9596)
Thirteenth Report	NHS continuing healthcare funding	HC 455 (Cm 9596)
Fourteenth Report	Delivering Carrier Strike	HC 394 (Cm 9596)
Fifteenth Report	Offender-monitoring tags	HC 458 (Cm 9596)
Sixteenth Report	Government borrowing and the Whole of Government Accounts	HC 463 (Cm 9596)
Seventeenth Report	Retaining and developing the teaching workforce	HC 460 (Cm 9596)

Eighteenth Report	Exiting the European Union	HC 467 (Cm 9596)
Nineteenth Report	Excess Votes 2016–17	HC 806 (Cm 9596)
Twentieth Report	Update on the Thameslink Programme	HC 466 (Cm 9618)
Twenty-First Report	The Nuclear Decommissioning Authority's Magnox	HC 461 (Cm 9618)
Twenty-Second Report	The monitoring, inspection and funding of Learndirect Ltd.	HC 875 (Cm 9618)
Twenty-Third Report	Alternative Higher Education Providers	HC 736 (Cm 9618)
Twenty-Fourth Report	Care Quality Commission: regulating health and social care	HC 468 (Cm 9618)
Twenty-Fifth Report	The sale of the Green Investment Bank	HC 468 (Cm 9618)
Twenty-Sixth Report	Governance and departmental oversight of the Greater Cambridge Greater Peterborough Local Enterprise Partnership	HC 896 (Cm 9618)
Twenty-Seventh Report	Government contracts for Community Rehabilitation Companies	HC 897 (Cm 9618)
Twenty-Eighth Report	Ministry of Defence: Acquisition and support of defence equipment	HC 724 (Cm 9618)
Twenty-Ninth Report	Sustainability and transformation in the NHS	HC 793 (Cm 9618)
Thirtieth Report	Academy schools' finances	HC 760 (Cm 9618)
Thirty-First Report	The future of the National Lottery	HC 898 (Cm 9643)
Thirty-Second Report	Cyber-attack on the NHS	HC 787 (Cm 9643)
Thirty-Third Report	Research and Development funding across government	HC 668 (Cm 9643)
Thirty-Fourth Report	Exiting the European Union: The Department for Business, Energy and Industrial Strategy	HC 687 (Cm 9643)
Thirty-Fifth Report	Rail franchising in the UK	HC 689 (Cm 9643)
Thirty-Sixth Report	Reducing modern slavery	HC 886 (Cm 9643)
Thirty-Seventh Report	Exiting the European Union: The Department for Environment, Food & Rural Affairs and the Department for International Trade	HC 699 (Cm 9643)
Thirty-Eighth Report	The adult social care workforce in England	HC 690 (Cm 9667)
Thirty-Ninth Report	The Defence Equipment Plan 2017–2027	HC 880 (Cm 9667)

Fortieth Report	Renewable Heat Incentive in Great Britain	HC 696 (Cm 9667)
Forty-First Report	Government risk assessments relating to Carillion	HC 1045 (Cm 9667)
Forty-Second Report	Modernising the Disclosure and Barring Service	HC 695 (Cm 9667)
Forty-Third Report	Clinical correspondence handling in the NHS	HC 929
Forty-Fourth Report	Reducing emergency admissions	HC 795
Forty-Fifth Report	The higher education market	HC 693
Forty-Sixth Report	Private Finance Initiatives	HC 894
Forty-Seventh Report	Delivering STEM skills for the economy	HC 691
Forty-Eighth Report	Exiting the EU: The financial settlement	HC 973
Forty-Ninth Report	Progress in tackling online VAT fraud	HC 1304
Fiftieth Report	Financial sustainability of local authorities	HC 970
Fifty-First Report	BBC commercial activities	HC 670
Fifty-Second Report	Converting schools to academies	HC 697
Fifty-Third Report	Ministry of Defence's contract with Annington Property Limited	HC 974
Fifty-Fourth Report	Visit to Washington DC	HC 1404
Fifty-Fifth Report	Employment and Support Allowance	HC 975
Fifty-Sixth Report	Transforming courts and tribunals	HC 976
Fifty-Seventh Report	Supporting Primary Care Services: NHS England's contract with Capita	HC 698
Fifty-Eighth Report	Strategic Suppliers	HC 1031
Fifty-Ninth Report	Skill shortages in the Armed Forces	HC 1027
Sixtieth Report	Ofsted's inspection of schools	HC1029
Sixty-First Report	Ministry of Defence nuclear programme	HC 1028
Sixty-Second Report	Price increases for generic medications	HC 1184

Sixty-Third Report	Interface between health and social care	HC 1376
Sixty-Fourth Report	Universal Credit	HC 1375
Sixty-Fifth Report	Nuclear Decommissioning Authority	HC 1375
Sixty-Sixth Report	HMRC's performance in 2017–18	HC 1526
Sixty-Seventh Report	Financial Sustainability of police forces in England and Wales	HC 1513
Sixty-Eighth Report	Defra's progress towards Brexit	HC 1514
Sixty-Ninth Report	Sale of student loans	HC 1527
Seventieth Report	Department for Transport's implementation of Brexit	HC 1657
First Special Report	Chair of the Public Accounts Committee's Second Annual Report	HC 347
Second Special Report	Third Annual Report of the Chair of the Committee of Public Accounts	HC 1399