Response to Queries on the 17-18 Supplementary Estimates Memorandum

Please find below responses to the follow up questions from the Health and Social Care Committee.

Capital Investment

1. **Question**:
   The Supplementary Estimate shows a net reduction of £0.5 billion in capital investment (from £6.1bn to £5.6bn) compared with the main estimate but at a level which is £1 billion higher than the prior year.

   - Is capital investment now at a level where we can expect to see the maintenance backlog across the NHS, which the latest data show increased to £5.5 billion in 2016-17, to start falling?

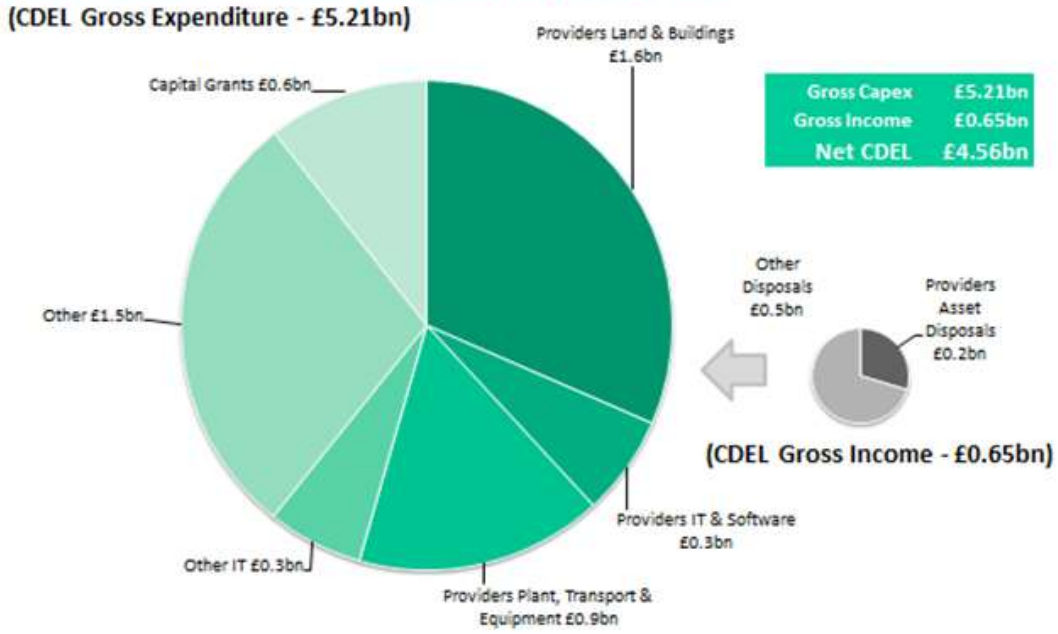
   - How much of the capital investment in 2017-18 is being spent on buildings and how much is spent on other items (equipment, IT, R&D)?

   Response:
   In the 2017 Autumn Budget the government took specific steps to tackle the increase in capital investment providing an additional £3.5 billion of new capital investment over 6 years to 2022-23, to transform its estate and drive further efficiency savings.

   - Within this funding, £700 million was provided to support turnaround plans in the individual trusts facing the biggest performance challenges, and to tackle the most urgent and critical maintenance issues that trusts are facing. This will enable some of the backlog maintenance issues to be reduced. However, it is too early to say when the overall level will start to fall.

   - The latest capital expenditure figures can be found in the 2016-17 DHSC Annual Report. Figure 6 below has been extracted from the 2016-17 DHSC Annual Report and shows the breakdown between the different types of capital expenditure for the Department.

Figure 6: Capital DEL - spending breakdown (also see SOPS 1.2)



The figures in the illustrations above detail the gross RDEL and CDEL expenditure and RDEL and CDEL income for the DH Group. This differs from the presentation in the Statement of Parliamentary Supply (SOPS) notes 1.1 and 1.2 as not all DH Group bodies are detailed on a gross expenditure and income basis.

2. **Question**:
The Estimates report that half-way through the financial year (April to September 2017) the Department had spent less than a third (27.5%) of its Capital DEL allocation compared to around half (49.6%) of its Resource DEL allocation.

Why did the November 2017 Budget announce a large increase of £506 million for Capital DEL even though this budget was on course for an underspend?

Response:

The £506 million received in the 2017 Autumn Budget equates to approximately 9% of the total Capital DEL allocated to the DHSC in 2017-18. The total Capital DEL for the DHSC in 2017-18 Supplementary Estimate is £5,597 million.

Given the late allocation of Capital DEL and the fact that it is not unusual for capital expenditure to be low during the first half of the financial year; it is not unexpected that the percentage spend is low in 2017-18.

One of the reasons capital expenditure is low during the first 6 months of the financial year relates to the way capital expenditure is recorded in individual bodies.

The capital expenditure profiling tends to reflect the Provider sector, where the higher proportion of expenditure lies. The table below compares the percentage of capital expenditure in the Provider sector to the Supplementary Estimate figures for the Financial Years 2017-18 and 2016-17.

Provider Quarterly Performance Report	17-18	16-17
	£m	£m
Year to date at Q2	1,079	1,111
Full year 2017-18 Forecast at Q3 and 2016-17 Actual at Q4	3,376	2,902
Year to date as a Percentage of Full Year Actual	32%	38%
Supplementary Estimate figures for the Financial Year	27%	39%

The Provider figures are as per the Quarterly Performance reports from NHS Improvement which can be found on the NHS Improvement website at https://imprkovement.nhs.uk/search/?q=quarterly+performance.

The DHSC is forecasting a balanced position on Capital DEL for 2017-18.

The funding received in the 2017 Autumn Budget was specifically for the NHS to deliver transformation that improves ability to meet demand for services, tackle the most urgent and critical maintenance issues and support efficiency programmes.

Costs of reciprocal healthcare arrangements within the European Economic Area

3. **Question**:
The Estimate provided £267 million of extra funds for higher than anticipated costs of reciprocal healthcare arrangements within the EEA. How much have these costs increased compared to the prior year and the forecast at the start of the year? The memorandum says that the average cost and number of claims are increasing. Can you provide more detail on these increases and explain why this is occurring?

Response:
The net budget for 2017-18 was set at £630 million. The net outturn position for 2017-18 will be published in the 2017-18 financial statements and remains subject to audit but is expected to be in the region of £920 million, compared to the net outturn position of £739 million for 2016-17.

The original spending plan for 2017-18 was set at the time of the last spending review, SR15 and increases in average cost of healthcare and volume of claims that occur in future periods could not reasonably be predicted as they are demand led, and valued at the prevailing foreign exchange rate when final cash payments are made.

There are two primary mechanisms in place for the reimbursement of healthcare costs between EEA countries for healthcare provided to their insured persons:

- The first is reimbursement based on actual healthcare costs. Anything within the temporary visitor category (EHICs and planned treatment) is usually billed on the basis of actual healthcare use.

- The second is reimbursement based on an average, fixed, cost per person per month resident in the member state. Anything within the temporary visitor category (EHICs and planned treatment) is usually billed on the basis of actual healthcare use. However, with regard to pensioners and their dependants, exportable benefit recipients and dependants in the home state of a worker, billing methods will vary by country – either actual costs or an average cost. For these categories, Spain and

Ireland bill other countries on the basis of an average cost per person and France bill on the basis of actual healthcare usage. Average costs are produced 2-3 years in arrears and are ratified by the European Commission.

The majority of costs incurred by the UK, circa 75%, relate to healthcare provided to UK pensioners living within the EEA and of this, the majority is billed on the basis of average costs. In 2017-18 the rules governing the calculation of average costs changed, the EU introduced segmentation by age bands and Member States increased their average costs by more than expected (they had been, on average, trending downwards). EU rules provide a legal framework for payment mechanisms for healthcare, including payment timescales, methods of calculating and agreeing those payments and arrangements for settling disputes between countries. The Department checks all claims for validity and disputes those where validity is not clear however the average costs, on which bills are calculated, are imposed without scope to challenge. Expenditure is particularly sensitive to changes in Spain's average cost as there are almost 70,000 pensioners and dependents resident in Spain that the UK is liable for, the largest number of any member state. Spain's average cost for pensioners increased by €682.85 for claim year 2015 and then a further €89.29 for claim year 2016, we were notified of both of these changes in 2017-18.

Another factor that has increased costs is greater number of UK visitors abroad which has the consequence of greater EHIC usage and therefore increased costs.

Personal Injury Discount Rate

4. **Question**:
The increase of the Personal Injury Discount rate resulted in an additional cost of £394 million in 2017-18. The Civil Liability Bill is proposing changes to the discount rate which will reduce these additional costs – can you estimate what impact these proposed changes will have and when they will come into effect?

Response:
The Civil Liability Bill is led by the Ministry of Justice, at this point in time no estimates of the impact of the proposed changes have been calculated by DHSC. The PIDR impacts only some aspects of clinical negligent claims, which by their nature are difficult to estimate, as there are a number of variables that can impact the cost.

DHSC will, therefore, estimate the impact of any PIDR changes when there is further clarity on what the rate will be and the associated timings. DHSC did comment on the consultation, setting out that any changes to the PIDR rate would have a financial impact, the exact value of which would depend on the rate.