



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

**HC 708
SESSION 2010–2011
20 JANUARY 2011**

Department of Health

National Health Service Landscape Review

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National Audit Office

Department of Health

National Health Service Landscape Review

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Amyas Morse
Comptroller and
Auditor General

National Audit Office

19 January 2011

The NHS in England caters to a population of 51 million and employs more than 1.3 million people, just under half of whom are clinically qualified. On average, it deals with one million patients every 36 hours.

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Contents

Introduction **4**

Part One
Department of Health and
NHS funding **7**

Part Two
Proposed changes to
the NHS **10**

Part Three
Managing the transition **26**

Appendix
Key Department of Health
publications on the reform
proposals **32**

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This report can be found on the
National Audit Office website at
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Introduction

1 The National Health Service in England is the largest publicly-funded health service in the world. It is based on three core principles:

- It meets the needs of everyone.
- It is free at the point of delivery.
- It is based on clinical need, not ability to pay.¹

2 The NHS in England caters to a population of 51 million and employs more than 1.3 million people, just under half of whom are clinically qualified. On average, it deals with one million patients every 36 hours. Each of the 37,000 General Practitioners (GPs) (in more than 10,000 practices) sees an average of 140 patients a week. Most NHS funding is allocated by the Department of Health to Primary Care Trusts which purchase healthcare services from GPs, hospitals and other providers on behalf of their local population. In future this role and associated funding will fall to local consortia of GPs, as part of proposals for the reform of the NHS which we set out in this report.

3 The Government has embarked on a fundamental reform of the NHS in order to address what it sees as a number of long-standing issues with the operation and performance of the NHS compared to other health systems. These include: the relatively poor health outcomes for some conditions such as cancer; some failings in the management of health services, such as avoidable hospital admissions and healthcare-associated infections; and a lack of a “genuinely patient-centred approach” to services. These changes are being introduced at a time when the NHS, although ‘protected’ in the recent Spending Review, faces the tightest financial settlement in recent years. The Government also aims to deliver up to £20 billion of efficiency savings in the NHS by the end of 2014-15, including a 33 per cent saving in administrative costs across parts of the health sector during the period.

¹ With the exception of charges for some prescriptions and optical and dental services.

Current proposals for reform

4 The July 2010 NHS White Paper, *Equity and excellence: Liberating the NHS*, set out the Department of Health's long-term vision for the future of the NHS, which is to:

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to patients – the outcome of their healthcare; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

5 To achieve this vision, the White Paper proposed a number of reforms to the structure and operation of the NHS, which have since been refined and developed in the Command Paper *Liberating the NHS: Legislative framework and next steps*, published in December 2010. The Health and Social Care Bill creating the necessary legislative change was published on 19 January 2011. The Department has also issued a number of accompanying documents giving further details of how its reforms will be rolled out over the next two financial years, 2011-12 and 2012-13, and fully implemented within three years. The Appendix at the end of this report lists key references.

6 The Government considers that the changes proposed are a necessary and coherent framework of reforms, designed to help deliver the objective of a health service that is financially sustainable and achieves outcomes among the best in the world. The NHS reforms are part of a wider strategy for the health and social care system, which in turn is part of the Government's approach to reforming public services.

The purpose of this report

7 In this report we summarise the key changes proposed, although, given that they are at an early stage, we do not attempt to evaluate them or to draw conclusions on value for money. Translating the aspirations of the White Paper and the Bill into reality will involve a highly complex programme of linked activities, many of which are interdependent. Some pilot schemes, such as GP commissioning consortia 'pathfinders' are being introduced, but the detail of other aspects of the reform programme is yet to be determined. The full reforms will take several years to implement.

8 Given the scale of the reforms proposed, and the ongoing interest of the Committee of Public Accounts in the financial management of health spending and value for money in health delivery, we concluded it would be valuable, at this early stage, to provide an overview of the proposed reforms, to highlight key dependencies and establish an initial set of issues and benchmarks, against which the progress of the reforms can be assessed as they are rolled out. Questions framing this work, informed by both the current proposals and our past Value for Money reports on health topics, will be:

- How the proposed NHS Commissioning Board and GP consortia are achieving value for money in commissioning.
- How economies of scale can be achieved in a localised system of NHS commissioners and providers.
- Whether data and information systems meet the needs of decision-makers, Parliament and the public.
- How the emerging market in healthcare is regulated to deliver efficient and high quality services.
- How the Department will manage the transition in a way that controls costs and protects the quality of services during transition.

9 This report has been prepared to inform a hearing of the Committee of Public Accounts, on 25 January 2011, on the changes proposed in the White Paper, Command Paper and the Health and Social Care Bill. The report will enable the Committee to take stock of the proposals as they currently stand and to discuss their implementation with senior officials from the Department of Health and the NHS.

10 The report is in three parts:

- Department of Health and NHS funding.
- Proposed changes to the NHS.
- Managing the transition.

Part One

Department of Health and NHS funding

1.1 Health is the second largest area of public expenditure and has grown consistently at rates above inflation in recent years. This Part provides an outline of how health spending is used and the requirements for efficiency savings in the coming years, as background for our discussion of the planned reforms (Part Two) and the management of the transition process (Part Three).

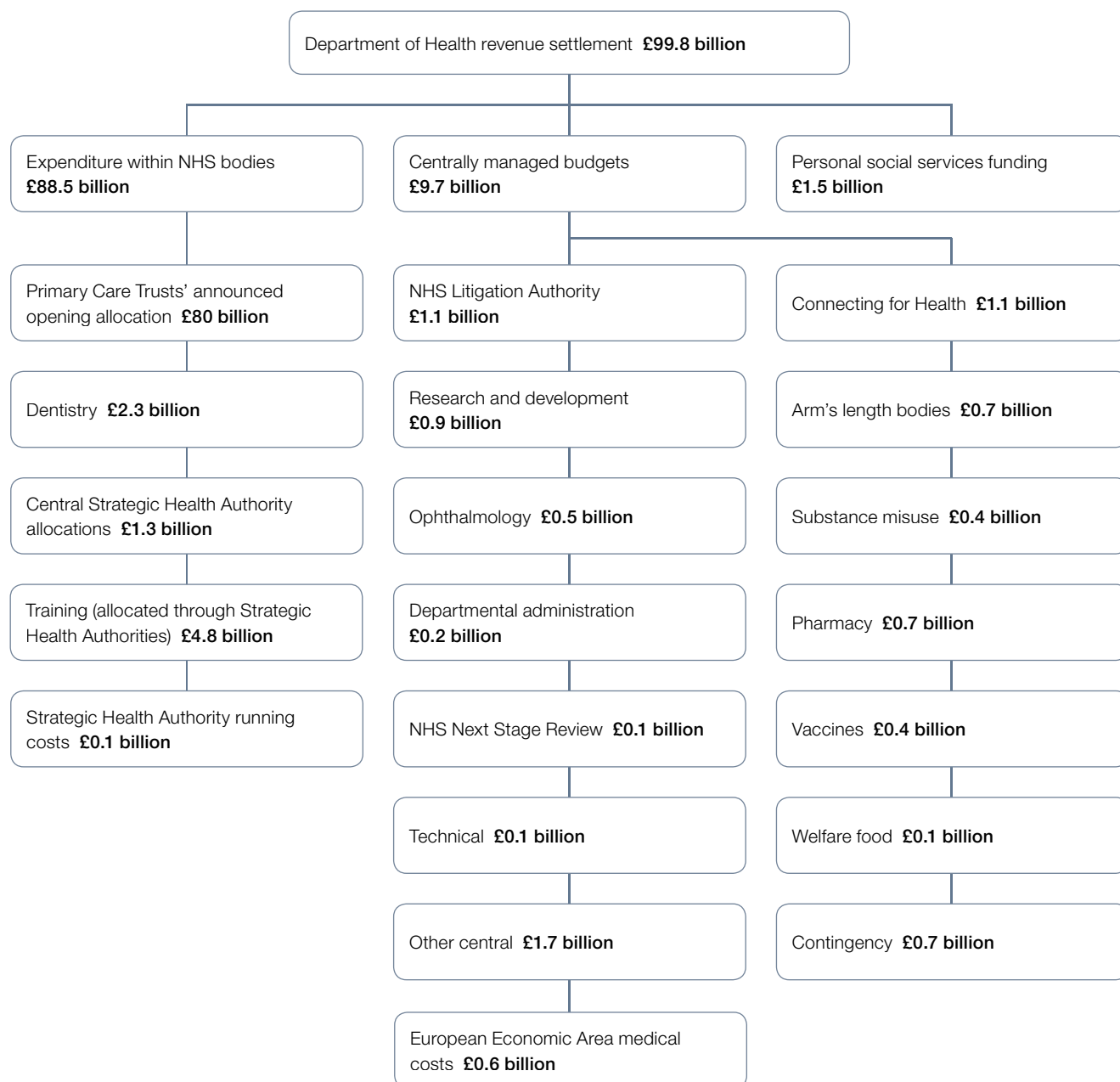
Current funding

1.2 The Department of Health's revenue budget, which covers the day-to-day costs of the health service, was £99.8 billion in the financial year 2009-10 (**Figure 1** overleaf). The majority of the money provided to the Department is spent within the NHS, which accounted for 89 per cent of the overall budget in 2009-10. One hundred and fifty-two Primary Care Trusts spend this money to commission healthcare services for their local populations. Centrally managed budgets, for activities carried out directly by the Department and its arm's length bodies such as the National Patient Safety Agency, account for almost 10 per cent of the total budget. The remaining balance of £1.5 billion contributes to the funding of adult personal social services, which is mainly provided by the Department for Communities and Local Government.

1.3 In addition to its day-to-day running costs, the NHS also invests in capital assets such as buildings and higher value medical equipment. In 2009-10, the NHS's capital budget was £5.5 billion, of which providers of NHS services such as hospital trusts spent 53 per cent (£2.9 billion) and Primary Care Trusts 14 per cent (£0.8 billion). Central budgets, such as the NHS Connecting for Health programme to improve IT, made up 33 per cent (£1.8 billion).

1.4 Primary Care Trusts are currently responsible for commissioning healthcare services for their local population, controlling over 80 per cent of the NHS revenue budget, although this responsibility will pass to local consortia of GPs under the proposed reforms (Part Two). The Department allocates resources to each Primary Care Trust on the basis of local needs, aiming to ensure equal access to healthcare and to help reduce avoidable health inequalities. Primary Care Trusts commission services from a range of providers including hospital trusts – either NHS acute trusts or Foundation Trusts, which are independent of the Department of Health – GPs, dentists, opticians, pharmacies and private sector and voluntary sector organisations.

Figure 1
The distribution of the Department of Health's resources (2009-10)



Source: Department of Health

Future funding

1.5 Over the last ten years, real-terms growth in health spending has averaged around 5.5 per cent per annum, well above general inflation over the same period. The NHS was protected from real-terms cuts in the Spending Review covering the financial years 2011-12 to 2014-15. During this period the Department's total budget will rise to some £114.5 billion, which means broadly flat (0.1 per cent annual growth) in real terms. The settlement includes a 33 per cent real terms reduction in administrative costs over four years.

1.6 Demand for NHS services is expected to continue to increase, above the rate of budget increases, due to demographic changes such as an ageing population, rising public expectations and medical advances. The long run growth in NHS activity is about 2.7 per cent a year.² The Department is aiming to bridge the gap between flat real-terms growth in resources and increasing demand, by achieving efficiency savings and productivity improvements of around £20 billion over the next four years under the Quality, Innovation, Productivity and Prevention (QIPP) programme. In our report on the *Management of NHS hospital productivity* (HC491), published in December 2010, we highlighted the risk associated with QIPP's timetable coinciding with the period of transformation of the NHS.

² This is the growth over the ten-year period 1998-2008 in the Cost Weighted Activity Index, measuring patient treatment activity, which was included in the recent Spending Review.

Part Two

Proposed changes to the NHS

2.1 This Part describes the key reforms which the Government initially proposed in the White Paper on health, *Equity and Excellence: Liberating the NHS* (July 2010) and developed in the Command Paper of December 2010 and the Health and Social Care Bill published on 19 January 2011.

The reforms outlined in the White Paper

2.2 The White Paper set out the Government's aim of "putting patients at the heart of the NHS" through more choice and control. It focuses on outcomes for patients, measured through a set of quality standards, with local professionals and providers given greater autonomy but with more local accountability. Meanwhile, the NHS must also secure efficiency gains of up to £20 billion by 2014-2015 (as discussed in Part One).

2.3 The proposed reforms involve fundamental changes to the way health and social care services are commissioned and delivered in England. The reforms build upon past changes to the health service, including the separation of commissioning from provision (known as the 'purchaser/provider split') GP fundholding, Payment by Results (under which hospitals are paid at a set tariff rate per procedure carried out), Foundation Trust status (offering greater independence for hospitals) and Practice Based Commissioning (Primary Care Trusts engaging GPs in commissioning of services while retaining budgetary control).

How the new arrangements will work

2.4 The proposals involve major changes to the role of the Department of Health and many parts of the NHS, with new organisational structures and relationships (**Figure 2** overleaf). The timeline for the key changes is shown in **Figure 3** on pages 14 and 15. The changes can be summarised as follows:

- The Secretary of State for Health currently has general powers of delegation and direction, which carries the potential for actual or perceived political interference in the day-to-day operation of the NHS. The Health and Social Care Bill aims to give **greater freedom to the NHS**, conferring powers directly on new organisations. The Government believes that it will **constrain the powers of the Secretary of State** and make these more transparent, while retaining overall political accountability to Parliament.

- The Department and the ten Strategic Health Authorities currently oversee both NHS commissioning bodies (Primary Care Trusts) and providers (hospital trusts, apart from Foundation Trusts, and the parts of Primary Care Trusts involved in service provision). In the new system **commissioning and provision will be separated**, between the new NHS Commissioning Board and the two main regulators (Monitor and the Care Quality Commission) respectively.
- Primary Care Trusts are responsible for commissioning services, but they are not directly responsible for the decisions that incur much expenditure, such as referrals and prescribing. In the new system Primary Care Trusts will be abolished and **commissioning responsibilities will move to the NHS Commissioning Board and GP-led consortia**. The Department believes this will create incentives for clinicians to ensure commissioning decisions provide value for money and improve quality of care, through more efficient prescribing and referral patterns.
- The role of the regulatory body Monitor, currently responsible for the regulation of Foundation Trusts, will change. Monitor will gradually withdraw from its current role **to become an economic regulator** with a responsibility to set prices, promote competition and safeguard continuity of any provider's services which have been 'designated' by local commissioners as requiring continuation at their current level.

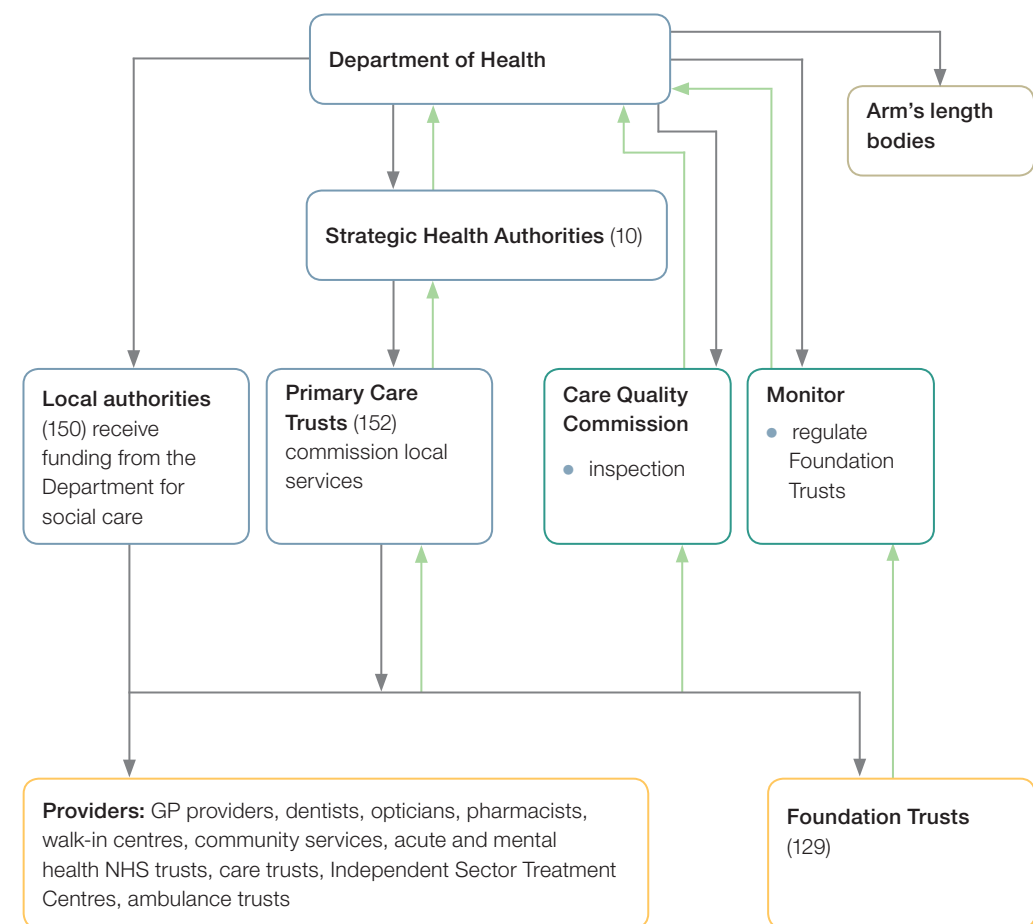
Changes to national and regional NHS leadership functions

2.5 The new model for health envisages that the current NHS leadership functions – in which the Permanent Secretary of the NHS and the Chief Executive of the NHS both hold Accounting Officer roles – will either no longer be necessary or will move out to other organisations, principally the NHS Commissioning Board. In the future, the day-to-day operation of the NHS will be more at arms-length from the Department, which, in addition to leadership responsibilities for public health, will principally be responsible for setting strategic direction, securing resources, establishing the legislative framework, holding the NHS Commissioning Board to account for improving outcomes and ensuring that the different elements of the system work together. The Department will also retain ultimate financial accountability to Parliament.

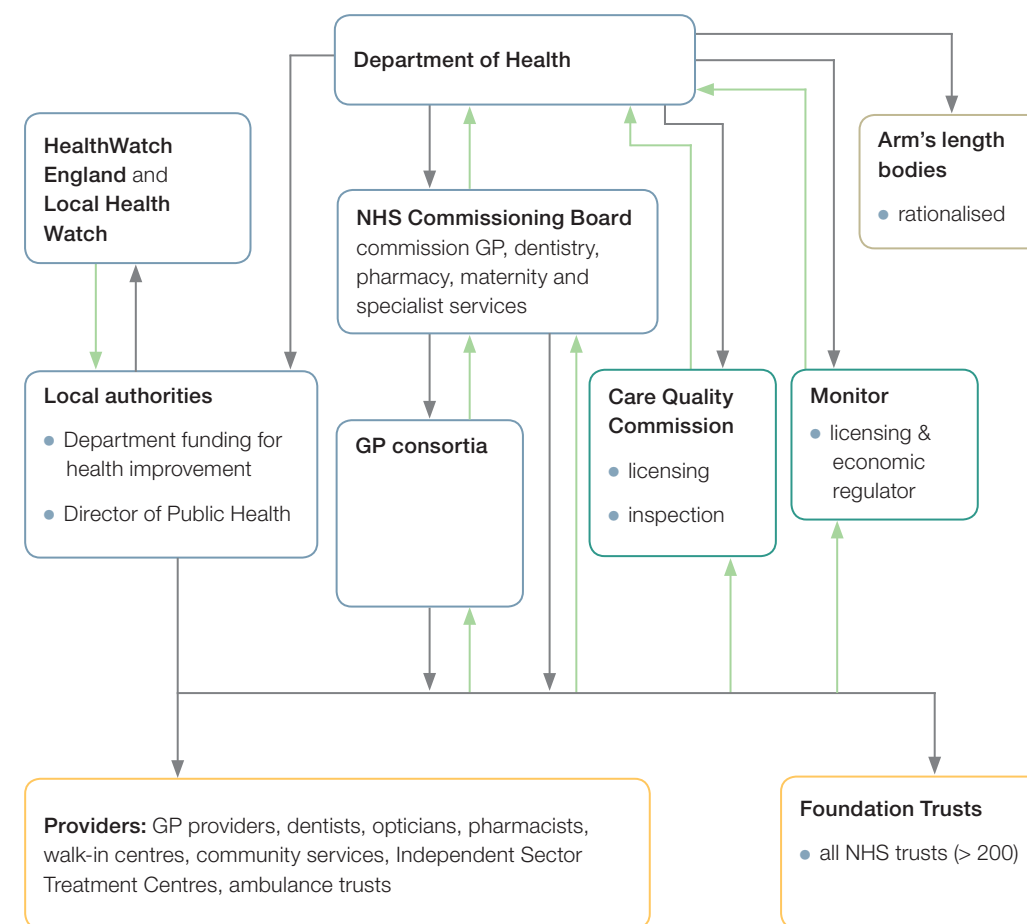
2.6 The ten Strategic Health Authorities will be abolished in April 2012. The responsibility for performance management of commissioning will pass to the NHS Commissioning Board, albeit in a different form. Their responsibilities for health improvement and protection will be consolidated within the Department or transferred to local government.

Figure 2
Current and proposed NHS structure

Current structure

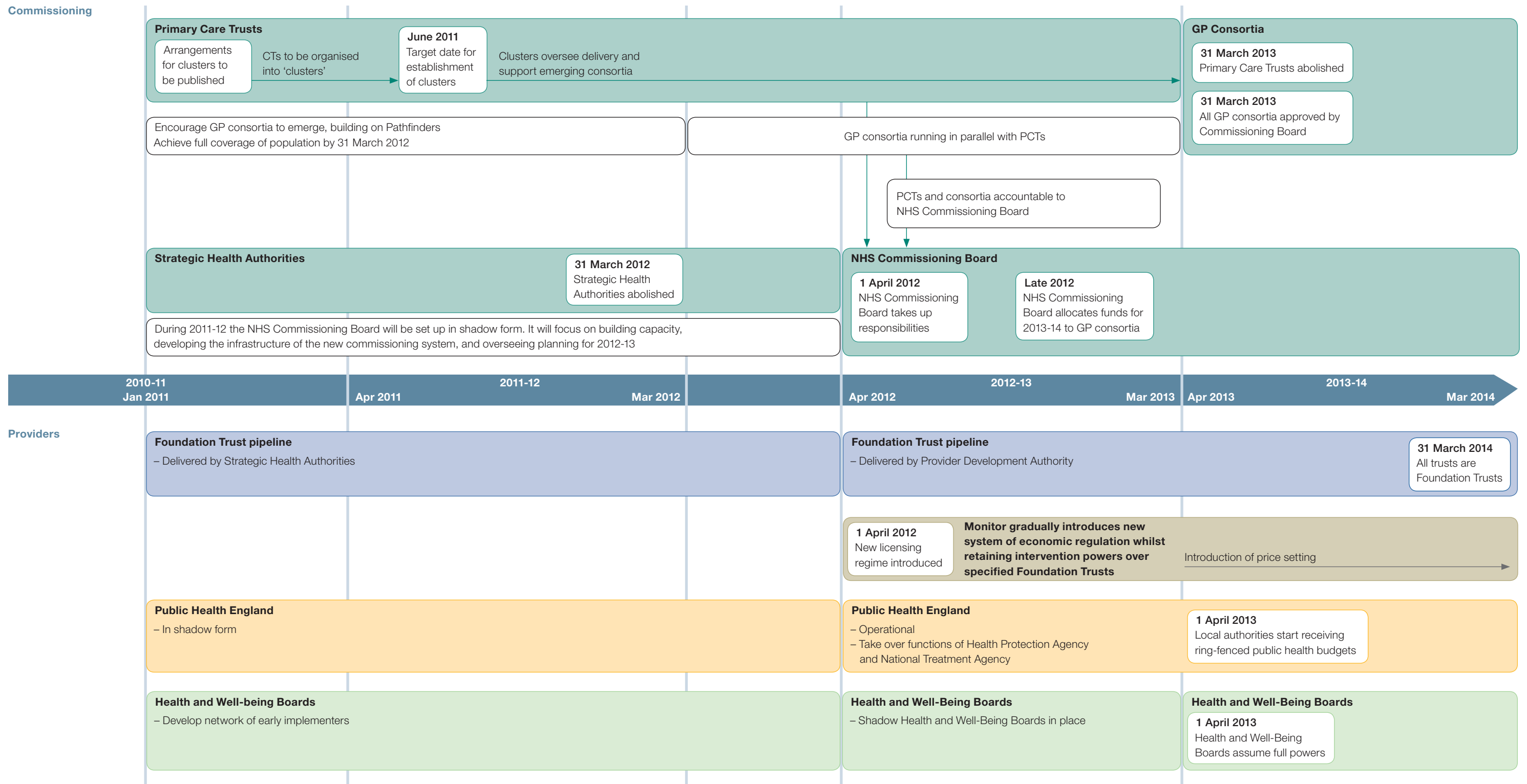


Proposed structure



→ Funding → Accountability

Figure 3
Timeline for the new arrangements



Source: Department of Health

The NHS Commissioning Board: role and accountability

2.7 The NHS Commissioning Board will be established as a non-departmental public body from April 2012. While details of the Board's role remain to be determined, the Government proposes that it will be responsible for:

- supporting continuous improvements in the quality and outcomes of NHS funded services;
- promoting and extending public and patient involvement and choice;
- ensuring a comprehensive system of GP consortia, supporting them and holding them to account;
- directly commissioning primary medical care, some specialised services and services for those in prison or custody;
- allocating and accounting for NHS resources; and
- promoting equality and reducing inequalities in access to healthcare.

2.8 The relationship between the Department and the NHS Commissioning Board will be set out in a framework document and an annual mandate. The Secretary of State will hold the NHS Commissioning Board to account for performance against a set of health outcomes consisting of around 50 indicators grouped into five 'domains':

- Preventing people from dying prematurely.
- Enhancing the quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill-health or following injury.
- Ensuring people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.9 The NHS Commissioning Board will meet its accountability obligations by publishing a business plan setting out how it intends to achieve its statutory duties and its objectives or requirements set by the Secretary of State, plus an annual report setting out progress against its business plan. The Commissioning Board will be audited by the National Audit Office.

2.10 Sir David Nicholson, the current chief executive of the NHS, has already been appointed chief executive of the NHS Commissioning Board. The appointment of the rest of the board is expected later in 2011.

GP commissioning consortia: role and accountability

2.11 The majority of commissioning will be undertaken by GP consortia, from budgets allocated to them by the NHS Commissioning Board using a needs-based formula. All GP holders of primary medical care contracts will have a duty to be a member of a consortium. Consortia will be statutory bodies with a designated accountable officer, who will be responsible for ensuring that a consortium complies with its financial duties, promotes continuous improvements in the quality of services it commissions and provides good value for money.

2.12 The Government has not stipulated the size of consortia nor their detailed governance arrangements, nor will they have a statutory requirement for a management board. Each consortium will be required to submit a written constitution to the NHS Commissioning Board for approval. The constitution must include:

- the names and members;
- geographical coverage;
- arrangements for discharging statutory functions;
- procedures for decision-making and managing conflicts of interest; and
- arrangements for the effective participation of members.

2.13 Consortia will be accountable to the NHS Commissioning Board for their finances and will have a duty to achieve financial balance. Each consortium will have to provide accounting information, in a format specified by the Department, to the NHS Commissioning Board. The Board will prepare a consolidated annual account covering all the consortia, which will be incorporated into the Department's resource account.

2.14 All GP consortia and the NHS Commissioning Board will have a statutory obligation to reduce inequalities in healthcare provision. Consortia will prepare commissioning plans before the start of each year and will discuss these with local Health and Well-Being Boards set up by local authorities, with the aim of ensuring that the plans reflect joint views of local need.

2.15 So far, the Department has announced the formation of 141 'pathfinder' consortia which will be established in shadow form from April 2011. Pathfinders are made up of groups of GP practices from the same geographical area. The pathfinders range in size from 1 to 105 practices, covering populations of between 14,000 and 672,000. Findings from the pathfinders will be used by other emerging consortia as they develop during 2011-12. The emerging consortia will work with Primary Care Trusts to develop transition plans, including staffing, requirements for external commissioning support, information and IT systems, partnership arrangements with local authorities and relationships with emerging Health and Well-Being Boards. The Department is seeking to clarify other issues, including, for example, the handling of legacy debts and liabilities from Primary Care Trusts.

2.16 The Health and Social Care Bill, published on 19 January, proposes a statutory failure regime for commissioners, which will include powers for the NHS Commissioning Board to establish and maintain a risk pool with consortia, to issue guidance to consortia on financial risk management and to intervene where there is a significant risk of financial failure.

Healthcare provision

2.17 To deliver its goal of an NHS which achieves results that are among the best in the world, the Government plans to give more autonomy to NHS providers, supported by effective regulation of the quality of services and the functioning of provider markets. The Government believes that this approach will ensure that patients know services are safe, the taxpayer gets value for money and new providers can enter the market. Provision of services to the NHS, both primary and acute, will be on the basis of 'any willing provider' – all providers, whether NHS or non-NHS providers such as charities and private organisations, will be given an equal opportunity to provide services and NHS providers will compete with each other and with non-NHS providers.

The provision of acute care

2.18 In the acute (hospital) sector, hospital trusts are being given more autonomy through attaining Foundation Trust status. The majority of hospital trusts in England are now Foundation Trusts (94 of 167) and have much more financial and operational freedom than other NHS trusts. To achieve this they have met a range of criteria set by the regulator, Monitor. The Government wants all hospitals to become Foundation Trusts by 2014. Under the proposed reforms, Foundation Trusts will be granted even greater freedom, including the removal of the current cap on non-NHS income and statutory borrowing controls. They will not be privatised.

2.19 A new Provider Development Authority will work with the remaining acute trusts to get them ready for Foundation Trust status. The Government intends that all NHS trusts which have not yet achieved such status, for various reasons such as financial issues arising from Private Finance Initiative and other legacy debts, will either do so by April 2014, or cease to exist as a separate body. In the latter case they may merge with existing Foundation Trusts.

2.20 Foundation Trusts will face increased pressure to improve their cost-effectiveness, through a wider adoption of the practice of reimbursing hospitals for treatment given to patients according to the costs incurred by the most efficient hospitals, rather than the average. The Department will provide an 'operationally independent banking function' to Foundation Trusts, including making repayable loans to Foundation Trusts when there is a reasonable expectation that they will be repaid.

2.21 Due to changes in government accounting rules under HM Treasury's 'Alignment Project', the Secretary of State will need accounting information from Foundation Trusts to consolidate into the Department's accounts and to discharge his responsibilities to Parliament and HM Treasury in reporting and managing resources against financial and other controls. The Department of Health's Accounting Officer will therefore become responsible for accounting to Parliament for Foundation Trusts' financial affairs because Foundation Trusts' financial accounts will be amalgamated into the Department of Health resource account. The Secretary of State will have power to define accounting and reporting requirements for Foundation Trusts.

2.22 The Health and Social Care Bill, published on 19 January, contains measures to address the risk of financial failure by key health providers such as Foundation Trusts. It will give Monitor "a broad set of legislative intervention powers to ensure the continuity of designated healthcare services". This includes "powers in extreme circumstances to enable Monitor to direct an organisation to take specific actions in order to prevent failure."

The provision of primary care

2.23 The NHS Commissioning Board will commission primary care services (including dentistry, pharmacy and ophthalmic services) and hold GP contracts. GP consortia will have a statutory duty to help the Board drive up the quality of primary care. The Care Quality Commission will be expected to register primary care providers during 2011 and 2012.

Regulators: existing and new roles

2.24 Regulators will be of increasing importance in exercising oversight of commissioners and providers. The performance of the NHS in terms of the quality of service is currently monitored by the **Care Quality Commission**. The Commission licenses and monitors health and adult social care services in England. It will continue this role and will adopt a more inspection-based regime, with less emphasis on self-regulation by providers.

2.25 Monitor, which currently regulates Foundation Trusts, will have a change of role to become the economic regulator of the NHS and will also work jointly with the Care Quality Commission to license providers. It will:

- apply competition law to enforce competition, including regulation of prices, acting against both providers and commissioners;
- act against anti-competitive behaviour by providers or commissioners; and
- support the continuity of designated essential services in local communities.

2.26 Setting the prices of NHS services (tariff) will be a joint responsibility of Monitor and the NHS Commissioning Board. The Board will be primarily responsible for designing the pricing structure, while Monitor will have primary responsibility for setting the price levels.

2.27 Monitor currently has intervention powers to remove the board members and governors of a Foundation Trust and issue 'directions' when necessary. In the future, Monitor will need to treat all providers of NHS services equally and so these powers will be removed. The Department proposed in the White Paper to remove these controls from April 2012 onwards, but will now retain intervention powers temporarily for new Foundation Trusts (authorised after April 2012 and for a defined subset of existing Foundation Trusts), until March 2014 or two years after the individual Foundation Trusts authorisation date, whichever is later.

2.28 The National Institute for Health and Clinical Excellence's main role under the new model will be to provide advice to the NHS Commissioning Board and the Secretary of State, with the aim of enabling them to carry out their quality improvement functions effectively. NICE will produce, on behalf of the NHS Commissioning Board, around 150 quality standards by 2015. These will provide guidance to commissioners that is intended to identify and standardise best practice on the processes required to achieve particular outcomes. NICE quality standards will not be mandatory.

2.29 The National Institute for Health and Clinical Excellence will also work with the NHS Commissioning Board and the Department on value-based pricing of medicines, which will be introduced from 2014. This national system is intended to ensure that the price of a medicine is based on assessment of its value; currently, pharmaceutical companies are free to set whatever price they choose, within boundaries set by the Pharmaceutical Price Regulation Scheme. The Department's Command Paper states that "Like [Primary Care Trusts] now, GP consortia will be expected to fund services and interventions that are clinically-[effective] and cost-effective."

Local authorities and public health

2.30 The Department's Public Health White Paper, published in December 2010, proposed the establishment of Public Health England from 2012, based within the Department of Health. Early estimates of baseline spend on public health could be over £4 billion. This is a first step in determining future budgets for public health, including a new ring-fenced public health grant to local authorities, under section 31 of the Local Government Act 2003, in order to commission services to improve and protect the health of their local population. The Department of Health will be undertaking work in 2011-12 to provide the basis for 'shadow' public health allocations to local authorities in 2012-13. Shadow budgets will provide an opportunity for further work and planning before actual grant allocations are made in 2013-14. A proportion of this will go to local authorities, who will assume responsibility for public health under the reforms. Public Health England will allocate funds to local authorities, including a 'premium' for progress

in key activities under the new public health outcomes framework. Public Health England's management costs will also be counted as part of the targeted reduction in administrative costs. It will also incorporate the current functions of the Health Protection Agency. It will coordinate commissioning of some public health activities with the NHS Commissioning Board.

2.31 Directors of Public Health in local authorities, appointed jointly by the authorities and Public Health England, will be responsible for coordinating public health activities in their authority and for liaison with other health organisations such as the NHS Commissioning Board, which also has a role in promoting public health.

2.32 New statutory **Health and Well-Being Boards** in each upper-tier local authority³ will bring together local leaders in the NHS, public health and social care to produce joint strategic needs assessments and joint health and well-being strategies for their communities, and encourage partnership working. The Boards will play a key role in collaboration between GP consortia and local authorities.

Review and reform of arm's length bodies

2.33 As stand alone national organisations sponsored by the Department of Health, arm's length bodies work closely with the local NHS, social care services, and other arm's length bodies to carry out specific functions including regulating the system, improving standards, protecting public welfare and supporting local services.

2.34 Following a review in 2010, the number of arm's length bodies is being reduced from 18 to between 8 and 10 bodies, with some bodies being completely abolished and others absorbed or merged. The changes to arm's length bodies are aimed at reducing duplication and overlap, reducing bureaucracy and supporting the aims of the new system. The reductions and other changes are intended to deliver savings of more than £180 million by 2014-15.

Financial duties and accountabilities of the Department of Health and the NHS

2.35 The changes outlined in the sections above lead in some cases to changes in organisational financial accountabilities, both in terms of their statutory financial duties and their wider accountabilities for use of resources. In other cases they lead to the establishment of new accountable organisations. **Figures 4 and 5** overleaf set out the current and future financial duties and accountabilities of health bodies.

³ Where two tiers of local government exist (e.g. county councils and borough or district councils). Where there is only one tier, the unitary authority (e.g. metropolitan borough councils) will be responsible for the Health and Well-Being Board.

Figure 4

Current financial duties and financial accountability arrangements for NHS bodies

Organisation	Accountability of chief executive	Who they are accountable to and for what
Department of Health	Permanent Secretary is the Principal Accounting Officer NHS Chief Executive is an Additional Accounting Officer	<ul style="list-style-type: none"> Secretary of State and Parliament 	<ul style="list-style-type: none"> Remain within limits set through Parliamentary supply process and expenditure controls set by HM Treasury
Strategic Health Authority	Accountable Officer	<ul style="list-style-type: none"> Department of Health and Secretary of State Strategic Health Authority board 	<ul style="list-style-type: none"> Remain within capital and revenue resource limits, and cash limits
Primary Care Trust	Accountable Officer	<ul style="list-style-type: none"> Strategic Health Authority, Department and Secretary of State Primary Care Trust board 	<ul style="list-style-type: none"> Remain within capital and revenue resource limits, and cash limits
NHS trust	Accountable Officer	<ul style="list-style-type: none"> Strategic Health Authority, Department and Secretary of State NHS trust board 	<ul style="list-style-type: none"> Break even taking one year with another, usually over a three year period
NHS Foundation Trust	Accounting Officer	<ul style="list-style-type: none"> Parliament Monitor Also accountable to the board of governors and the members of the Foundation Trust 	<ul style="list-style-type: none"> Remain a going concern Operate efficiently, effectively and economically Contain borrowing within limits set by Monitor Contain private patient income within a pre-determined limit set by its terms of authorisation
Arm's length body	Accounting Officer	<ul style="list-style-type: none"> Parliament Department of Health and Secretary of State 	<ul style="list-style-type: none"> Where funded by the Department, to remain within capital and revenue resource limits, and cash limits

Source: *Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08*

Figure 5

Future financial duties and financial accountability arrangements for NHS bodies

Type of organisation	Who is accountable within the organisation?	Who are they accountable to?	Statutory financial duties
Department of Health	Permanent Secretary is the Principal Accounting Officer	<ul style="list-style-type: none"> Secretary of State and Parliament 	<ul style="list-style-type: none"> Remain within limits set through Parliamentary supply process and spending limits set by HM Treasury
NHS Commissioning Board	Accounting Officer – a Departmental appointment	<ul style="list-style-type: none"> Secretary of State, and Department of Health Parliament 	<ul style="list-style-type: none"> Remain within resource limits
GP consortia	Accountable Officer – nominated locally, appointed by NHS Commissioning Board	<ul style="list-style-type: none"> NHS Commissioning Board Local stakeholders 	<ul style="list-style-type: none"> Remain within resource limits
NHS Foundation Trust	Accounting Officer	<ul style="list-style-type: none"> Parliament Also accountable to the board of governors and the members of the Foundation Trust Local stakeholders 	<ul style="list-style-type: none"> Remain a going concern Operate efficiently, effectively and economically
Arm's length body	Accounting Officer	<ul style="list-style-type: none"> Parliament Secretary of State and Department of Health 	<ul style="list-style-type: none"> Where funded by the Department, to remain within capital and revenue resource limits, and cash limits

Source: National Audit Office

New ways for local people to hold the NHS to account

2.36 The reforms include proposals for strengthening the influence of patients, carers and the public over the NHS, as follows:

- A new body, HealthWatch England, will be kept independent from government by being established as a committee of the Care Quality Commission. The Committee will be represented on the Commission's board by its chair, who will be appointed by the Secretary of State for Health. The HealthWatch England committee will have powers to provide advice to the NHS Commissioning Board, Secretary of State for Health, the Care Quality Commission and Monitor.
- At the local level, the existing system of Local Involvement Networks will evolve into a new system of local HealthWatch bodies, commissioned by local authorities, to provide local intelligence for HealthWatch England.
- Local authorities will have a new freedom and flexibility to discharge their health scrutiny powers in the way they deem to be most suitable – whether through continuing to have a specific health overview and scrutiny committee, or through a suitable alternative arrangement. Health and Well-Being boards in every upper tier local authority will have a proposed minimum membership including elected representatives, GP consortia, Directors of Public Health, Directors of Adult Social Services, Directors of Children's Services, local HealthWatch and where appropriate, the participation of the NHS Commissioning Board, as well as at least one local elected representative.

Holding the NHS to account following the abolition of the Audit Commission

2.37 On 13 August 2010, the Secretary of State for Communities and Local Government announced plans to disband the Audit Commission. This is significant for NHS bodies as many have auditors appointed by the Audit Commission or, in the case of Foundation Trusts who appoint their own auditors, choose to use the Audit Commission's audit practice. The intention is to have new arrangements in place for auditing England's local public bodies by 2012-13.

2.38 The Audit Commission's responsibilities for overseeing and delivering local audit and inspections will stop, as will their research activities. The audit work will move to the private sector. The Audit Commission is responsible for the 2011-12 audit of local public bodies and is expected to close in December 2012. This timetable has yet to be confirmed and depends on the necessary legislation being passed. To help the National Audit Office provide assurance to Parliament on NHS bodies' use of public money, the Department of Health and the Department for Communities and Local Government are working together with the National Audit Office to develop effective arrangements for independent external audit. These arrangements will need to address both financial and value for money audit within the planned new health structures.

The new role for the NHS Information Centre

2.39 The **NHS Information Centre** will become the single, national repository for data collected from NHS and social care organisations taking over data collection responsibilities from other arm's length bodies and central data collectors such as the Department of Health itself. Central to this will be to ensure that accurate and timely information flows to local decision-makers, the public and health regulators, moving away from the existing emphasis on information that allows central monitoring by the Department.

Areas for discussion

- Accountability to Parliament for health and social care expenditure, when there is no single national headquarters for the NHS.
 - Governance and accountability arrangements of organisations in the new system.
 - Audit arrangements.
 - The changing roles and responsibilities of regulators.
 - Protecting the public purse in the event of financial failure of Foundation Trusts.
-

Part Three

Managing the transition

3.1 The proposed changes are complex with many inter-related elements. More than 500 organisations are likely to be abolished, created or have their functions changed. Over 90,000 staff will be directly affected by the changes and many more will experience some indirect effects. The transition takes place over a number of years, starting now but not concluding until 2014-15.

3.2 This Part of the report discusses the Department's approach to managing the transition, the financial costs and benefits of the reorganisation and plans for maintaining the quality of NHS services during the transition.

The Department's approach to managing the transition

3.3 Given the scale of the proposed reforms and the number of inter-dependencies between different parts of the system, the Department faces a major challenge in ensuring coherence during the transition period, so that different rates of progress in different parts of the system do not adversely affect each other. Effective risk management will also be crucial to the success of the reforms, as it is to any such large-scale, complex transformation programme. Our work⁴ has identified a number of undesirable results which follow from poor risk management: poorly thought-through plans, unrealistic timetables, weak controls, delays in delivery and wasted money.

3.4 The Department has put a management structure and processes in place to manage the risks of the reform programme. The Department is treating the reforms as a single programme, with one Senior Responsible Officer responsible for overall system design and coherence, supported by an Integrated Programme Office which manages and tracks the progress of the reforms against the Department's plans. Other elements of the Department's approach are:

- a senior management governance structure;
- challenge and assurance processes, including a Gateway Review led by the Office of Government Commerce;

4 See, for example, 2004 National Audit Office report *Managing Risks to Improve Public Services* (HC 1078).

- timelines, with dated milestones for the overall programme and for each main element of it. These elements are: changes affecting the Department, other national bodies and their interaction with local government; changes to the commissioning of health services; changes to the provision of health services, and overall project management work such as communication and engagement with staff;
- documentation determining the scope of the overall programme and its main elements. These scoping documents include the objectives and scope of the work, structure, roles and responsibilities, governance and decision-making, deliverables and cost estimates;
- a transition assurance process led by the NHS leadership team, which is tasked with identifying and managing risks regionally; and
- a risk management approach in which the main transitional risks across the programme, reported with ‘traffic light’ ratings are tracked, escalated and managed by named individuals. The highest priority risks are integrated into the overall Departmental risk register for the attention of the Department’s board.

3.5 In determining the approach to the change programme, the Department believes that previous NHS reforms have shown that it is important to get the right balance between progress on commissioning and on provision. The Department is therefore prioritising the development of GP commissioning consortia, through the programme of pathfinder consortia. It is also developing a parallel programme of ‘early implementer’ Health and Well-being Boards and HealthWatch pathfinders, to enable GP consortia to work effectively with local government.

The financial costs and benefits of the transition

3.6 The reforms proposed will in the short term mean extra costs to the NHS from staff redundancies and reorganisations, but in the long run the Department expects that they will produce a major (33 per cent) reduction in the administration costs of the health sector⁵.

3.7 Where the 33 per cent saving in administration costs relate to the NHS (Strategic Health Authorities and Primary Care Trusts) they form one of several component parts of the £20 billion savings which the NHS is expected to achieve under the Quality, Innovation, Productivity and Prevention programme, over the same time period, the four years to the end of 2014-15. This programme pre-dates the reforms proposed in the White Paper and will be achieved by a combination of quality and productivity improvements and efficiency savings.

⁵ i.e. the Department of Health, its arm’s length bodies and NHS organisations, excluding Foundation Trusts.

3.8 The Department currently estimates that the direct cost of the changes will be £1.4 billion, including redundancy costs in a range of £0.8 billion – 1.3 billion (depending on the extent to which staff from former NHS organisations transfer to the new organisations), and £0.4 billion for other costs, mainly IT and ‘double running’ of organisations during the transition process. GP consortia will be given £2 per patient to cover initial set-up costs. The Department describes these figures as ‘top-down’ estimates which will be refined as the reforms progress.

3.9 The Department expects the reforms to deliver a 33 per cent reduction in administration costs by 2014-15. Over ten years, the Department estimates that the direct benefits of the reforms will be £11.8 billion and direct costs £2 billion, as detailed in the Department’s impact assessment, published alongside the Health and Social Care Bill.

3.10 The National Audit Office has previously examined other major reorganisations of government and found recurring issues of weak cost control. Our 2010 report *Reorganising Central Government* (HC 452) examined over 90 reorganisations of central government departments and their arm’s length bodies which occurred between May 2005 and June 2009. Key issues included the lack of business cases or budgets for reorganisations, weak identification of the benefits of reorganisation and poor project management. The report’s key recommendations included specific identification and presentation to Parliament of the costs of significant reorganisations, and separate management and reporting of such costs within departments’ financial accounting systems.

3.11 The Department is taking various measures to control the costs of the reform proposals, including:

- the production of a full business case for the changes, which will reflect ‘bottom-up’ costings and any changes emerging as the Bill goes through Parliament;
- projects around each of the key elements of the changes and cross-cutting project leads in areas such as human resources, premises and IT to ensure costs are monitored and minimised; and
- administration cost limits for each organisation in the new system.

Maintaining the quality of NHS services during the transition

3.12 A key objective of the proposed reforms is to improve the quality of service which the NHS offers to patients. However, during the transition process, there are a number of risks to service quality – for example, the risk that GP services to patients may decline as GPs focus on establishing commissioning consortia and getting to grips with their new commissioning role, and the risk of Primary Care Trusts ceasing to function effectively if key staff leave before their organisations are abolished. The Department's transition plans include:

- the introduction of a new NHS Outcomes Framework, intended to drive quality improvement in the NHS;
- the continuation of the main existing quality programme, Quality, Innovation, Productivity and Prevention, during the transition; and
- measures to maintain the functions and capability of Primary Care Trusts until the new GP consortia are ready to take over their commissioning role.

The new NHS Outcomes Framework

3.13 A new approach to measuring the performance of the NHS is a key pillar of the reform proposals. The new *NHS Outcomes Framework*, published in December 2010, is based on the principle of measuring performance through the health outcomes for patients – for example, premature mortality rates or recovery from injuries. This contrasts with the previous government's approach, which focused on targets for NHS processes, such as waiting times in accident and emergency departments or the length of time between a GP referral and the patient's first appointment with a hospital consultant.

3.14 The Outcomes Framework is not yet fully developed; many of the indicators which it includes have yet to be defined, and 'levels of ambition' for each indicator to reach are not yet set. The Framework is intended to evolve over the next two years as the new NHS architecture emerges. Key stages will be as follows:

- 2011-12 will be a transition year during which the NHS will not be held to account for progress against the Framework's indicators, but will be held to account against priorities and performance indicators in the Operating Framework 2011-12. The Department and the NHS will refine the indicators and finalise their definitions, as well as negotiating levels of ambition with the shadow NHS Commissioning Board.
- In 2012-13 the Framework will be used by the Secretary of State for Health to hold the NHS Commissioning Board to account, including achieving levels of ambition where they have been agreed.

Continuing the Quality, Innovation, Productivity and Prevention quality improvement programme during the transition

3.15 The Department has existing programmes in train to improve service quality in the NHS and there is a risk that these efforts may be diluted or lost as services undergo wholesale reorganisation. The main programme is the Quality, Innovation, Productivity and Prevention (QIPP) initiative, which consists of 12 national workstreams covering the areas of ‘commissioning and pathways’, ‘provider efficiency’ and ‘system enablers’ such as technology, supported by regional and local plans. In our recent report on the *Management of NHS hospital productivity* (HC 491), published in December 2010, we highlighted the risk associated with QIPP’s timetable coinciding with the period of transformation of the NHS.

3.16 The Department has recognised the risk that QIPP might be undermined by the transition process and has addressed it in the recent Command Paper *Liberating the NHS: legislative framework and next steps*. The Chief Executive of the NHS, Sir David Nicholson, has also stressed that “... meeting the quality and productivity challenge remains the most important priority for the NHS over the coming period” and that “... the reforms will support the achievement of QIPP” in a letter to all NHS chief executives in December. Specifically, Sir David stated that:

- there will be a legal duty for the Secretary of State and commissioners to carry out their functions with a view to securing continuous quality improvement, covering safety, effectiveness and patient experience; and
- the new economic regulator (Monitor) must also have regard to this legal duty.

Maintaining Primary Care Trusts in the short term

3.17 Primary Care Trusts will be abolished by April 2013 and their commissioning role taken over by the new GP consortia. The Department has decided to keep existing accountability arrangements and central controls in place, during the first year of the transition process, the financial year 2011-12. It will do this in a number of ways:

- Primary Care Trusts are to be formed into clusters “to secure essential capacity and capability of the system”.
- Primary Care Trusts will be required to invest 2 per cent of their budgets non-recurrently to create financial flexibility.
- Primary Care Trusts will be held to account against a list of indicators including efficiencies achieved under the Quality, Innovation, Productivity and Prevention programme (discussed above), progress on reform and “clinically relevant quality indicators”.

- The National Quality Board, which brings together all the key national bodies currently responsible for overseeing the NHS system, will review how best to maintain quality and safety during the transition and once the new system architecture is in place, building on its earlier *Review of Early Warning Systems in the NHS* (February 2010).
- To retain key staff, the Department has developed a human resources framework that will cover all staff affected, and has launched a “mutually agreed resignation” scheme to help retain key staff while they are still needed.

Areas for discussion

- The extent to which sound programme and project management principles are being applied to the reorganisation.
 - The robustness of the cost and benefits estimates currently being used by the Department and the length of time until cost certainty is achieved.
 - How the Department and the NHS will minimise the transitional costs.
 - How the Department and the NHS are maintaining quality of service and financial performance during transition.
 - Commissioning effectively during the transition.
 - The development of a regulated market of healthcare providers.
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Appendix

Key Department of Health publications on the reform proposals

The Department has published a number of documents on its proposals. The key documents giving an overview are:

- White Paper: *Equity and excellence: Liberating the NHS*, Department of Health, 12 July 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
- Command Paper: *Liberating the NHS: Legislative framework and next steps*, Department of Health, 15 December 2010
http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
- The Health and Social Care Bill 2011, 19 January 2011
<http://services.parliament.uk/bills/2010-11/healthandsocialcare/documents.html>
- An impact assessment of the proposals was published alongside the Bill
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123583

Additional detail, particularly on the transition to the new model, can be gained from:

- *The Operating Framework for the NHS in England 2011/12*, Department of Health, 15 December 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738
- *NHS Outcomes Framework*, Department of Health, 20 December 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944
- Letter from the Chief Executive of the NHS, Sir David Nicholson, to all NHS chief executives: *Equity and excellence: Liberating the NHS – Managing the transition and the 2011/12 Operating Framework*, Department of Health, 15 December 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_122740



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