REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

HC 537
SESSION 2013-14

10 JULY 2013

Department of Health

Managing the transition to the reformed health system

Key facts

£1.1bn	10,094	211
the reported cost of the reforms to 31 March 2013	the number of full-time equivalent NHS staff made redundant	the number of clinical commissioning groups

Over 170	the number of organisations that closed
Over 240	the number of new organisations that have been established
9 per cent	the level of vacancies across the health system on 1 April 2013
45,350	the total number of posts in the reformed health system on 1 April 2013
£43,095	the average redundancy payment
£95.6 billion	the money granted to NHS England in 2013-14
£2.4 billion	the Department's estimate of savings in administration costs as a result of the reforms to 31 March 2013

Summary

1 The Health and Social Care Act 2012 provided for widespread reform of the health system in England. Most of the changes came into effect on 1 April 2013, including new structures for commissioning healthcare. NHS England and 211 clinical commissioning groups were created, and responsibility for public health was transferred to local authorities. **Figure 1** overleaf shows the reformed health system.

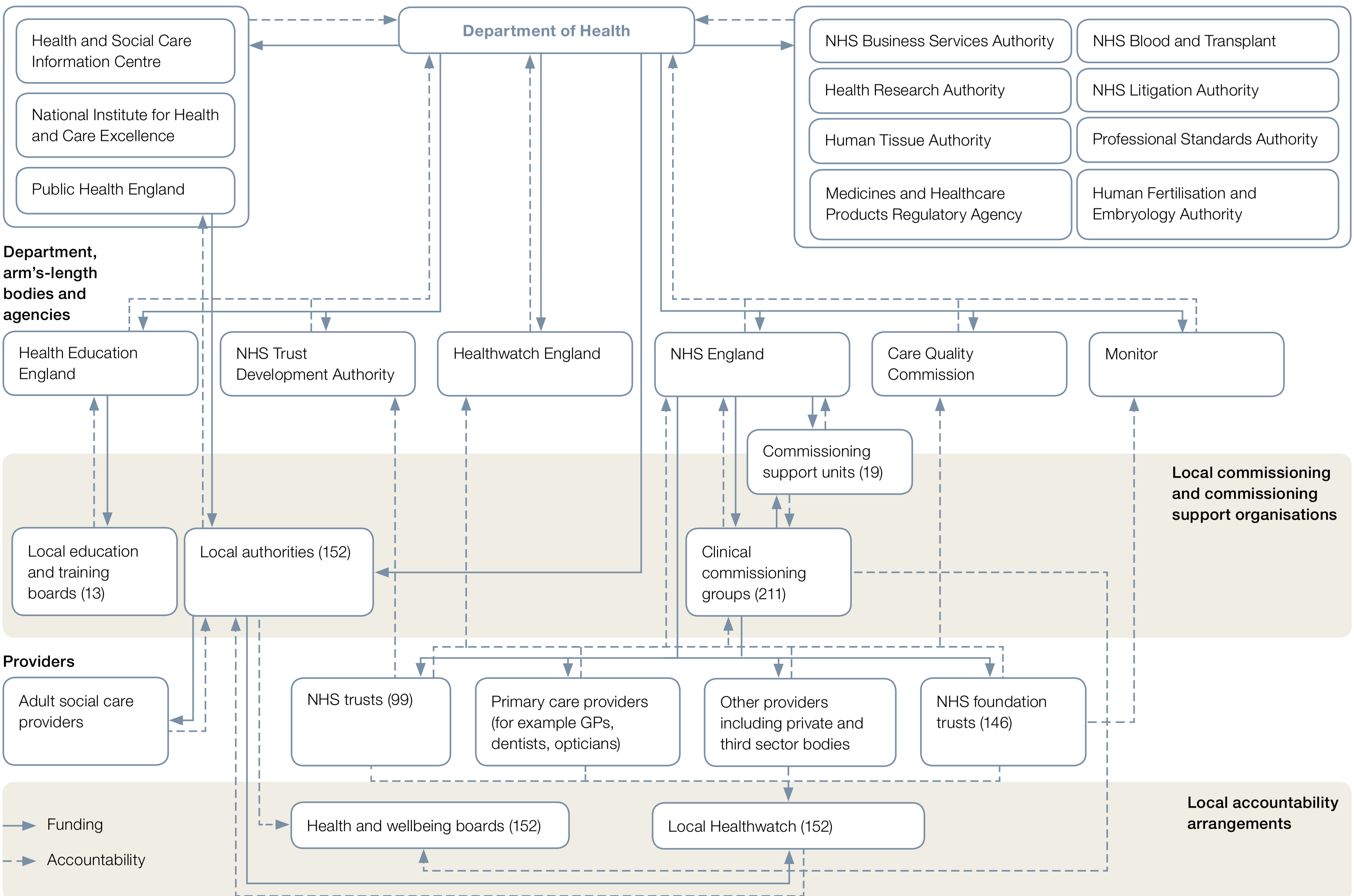
2 The reforms coincide with a period of financial restraint for the health system after a decade of sustained and significant growth. In the four years to 2014-15, there will be very little real terms growth in spending, and the NHS needs to make efficiency savings of up to £20 billion to keep pace with the growing demand for healthcare. While the reforms are generating savings in administration costs, the extent of change during the period has been demanding for NHS staff.

3 This report examines how the Department of Health (the Department) and the NHS implemented the transition from the existing to the reformed health system. It builds on our *National Health Service Landscape Review*,[1] published in January 2011, which outlined the key changes that the government proposed to make.

4 For this report, we examined how the transition was managed, whether the new system was ready to start operating on 1 April 2013, and the costs and benefits of the reforms. While providing an overview of progress, our work focused particularly on the new structures for commissioning healthcare. We did not evaluate the value for money of the reformed system as it is too early to assess the impact of the changes. We set out our audit approach in Appendix One and our evidence base in Appendix Two.

1 Comptroller and Auditor General, *National Health Service Landscape Review*, Session 2010-11, HC 708, National Audit Office, January 2011.

Figure 1
The reformed health system



Source: National Audit Office

Key findings

Managing the transition

5 The Department and the NHS faced major challenges in implementing the reforms by 1 April 2013. The changes are regarded as the most wide-ranging and complex since the NHS was created in 1948. They included closing more than 170 organisations and creating more than 240 new bodies. The timetable for implementing the reforms was tighter than originally planned because of delays in securing Parliamentary approval for the legislation. The Health and Social Care Bill received Royal assent on 27 March 2012, just over a year before the reforms were due to take effect (paragraphs 2.2 to 2.4).

6 A number of key milestones were missed during 2012-13, meaning that tasks converged in the months leading up to 1 April 2013. Considerable planning and preparatory work was done in advance of the Bill being passed, but uncertainty over the final shape of the reforms and the need to wait for Parliamentary approval delayed some aspects of the transition. The new bodies also underestimated how long some activities would take, including organisational design and staff recruitment (paragraphs 2.4 and 3.6).

7 The Department's programme management demonstrated many elements of good practice. The Department put in place comprehensive governance structures to oversee the transition, supported by an integrated programme office. The senior staff leading the programme have been present throughout the transition process. The Department put in place ongoing monitoring arrangements for key aspects of the transition, such as staffing. It also used a variety of review mechanisms to assess the state-of-readiness of the new bodies and gain assurance about progress (paragraphs 2.6 to 2.11).

8 Assurance that care quality was maintained during the transition is limited because little data is available to track the quality of primary care. NHS staff stressed that maintaining the quality of care was paramount throughout the period. The transition was not expected to have a direct impact on the care provided, and the Department provided funding for locums to cover the time GPs spent setting up clinical commissioning groups. However, the Department's headline indicators of care quality focus on hospital services. Performance was maintained in most respects, with the exception of waiting times in accident and emergency departments (paragraphs 2.12 to 2.15).

The readiness of the reformed system

9 All the new organisations had enough staff to start operating on 1 April 2013, with 9 per cent of posts across the system remaining vacant. However, vacancy rates were over 10 per cent in some bodies, including NHS England, local commissioning bodies and Public Health England. The most important front-line shortfall was in Public Health England's immunisation and screening staff (paragraphs 3.2 to 3.5).

10 Just over 10,000 full-time equivalent staff were made redundant in the three years to 31 March 2013, around 19 per cent of the total employed at the start of the period. The Department's aim was to minimise redundancies and most posts were filled by transferring staff from the bodies that were closing. Considerable numbers of staff carried out dual roles during the transition, continuing with their existing role while helping to set up one of the new bodies (paragraphs 2.5, 3.2 and 4.12).

11 Further changes will be needed before the right number of staff with the right skills are in place across the system. Nearly 40 per cent of staff were moved in bulk transfers to the new organisations in order to mitigate the risk of posts being left vacant due to delays in recruitment, and to provide stability. Other staff were transferred on the basis of a matching exercise where more than half of an existing post matched a new role. The new organisations now need to assess whether the staff they have inherited are affordable and whether they have the right skills. Further redundancies are expected to be made (paragraphs 3.7 and 3.8).

12 All 211 clinical commissioning groups have been authorised as statutory bodies, although some cannot yet operate completely independently. By April 2013, half the groups were fully authorised; the remainder still had conditions attached to their authorisation. Fourteen groups also had directions; this means they have to work with NHS England or another group in relation to certain functions (paragraphs 3.20 to 3.26).

13 Many clinical commissioning groups began operations in an atmosphere of financial uncertainty, which has hampered their ability to plan and budget:

- Shortcomings in commissioning and financial plans were the most common reasons for clinical commissioning groups having conditions attached to their authorisation. This raises concerns about their ability to make savings and remain financially sustainable in the coming years (paragraphs 3.23 and 3.24).

- The budget allocations to clinical commissioning groups (and to local authorities for public health) relied heavily on data supplied by primary care trusts. Limitations in the accuracy of this data mean that budget allocations for 2013-14 may not reflect previous spending patterns as closely as intended (paragraphs 3.29 to 3.33).

- NHS England was still adjusting budgets for clinical commissioning groups after 1 April 2013, causing delays in the groups agreeing contracts with providers. There was particular uncertainty about adjustments to clinical commissioning groups' budgets relating to 'specialised services' (worth around £12 billion), which NHS England is responsible for commissioning (paragraphs 3.34 to 3.37).

14 Indicators had not been developed to track performance against all the specified NHS outcomes from April 2013. Information is crucial for oversight and accountability in the reformed system. However, of the 67 indicators in the NHS outcomes framework – which the Department will use to hold NHS England to account, and NHS England will use to hold clinical commissioning groups to account – eight were still being developed at the time of our work (paragraphs 3.38 to 3.40).

15 A considerable amount of work remains to complete the transition. This work is expected to continue throughout 2013-14. Priorities will include due diligence work on property and other assets transferred from the bodies that closed and completing the implementation of IT systems (paragraphs 3.12 to 3.19, 3.44 and 3.45).

Costs and benefits of the reforms

16 The Department is confident that the total costs of the reforms will not exceed £1.7 billion, which is £215 million above the business case estimate. Its current best estimate is that the total costs will be £1.51 billion, comprising reported costs of £1.1 billion to 31 March 2013 plus future costs of £411 million. However, the Department does not have robust up-to-date data on the costs that are expected to be incurred in 2013-14 and beyond. The estimate for future costs was made in December 2011. At the time of our work, the Department was collecting data from arm's-length bodies to produce a more reliable estimate of future costs (paragraphs 4.6 to 4.9).

17 The cost of making staff redundant accounted for 40 per cent of costs to 31 March 2013, an average of £43,095 per person. The redundancies included 44 staff who were board-level managers in strategic health authorities or chief executives of primary care trusts. They each received an average of £277,273. The Department estimates that 2,200 staff made redundant between May 2010 and September 2012 were subsequently re-employed in the NHS; and, at the time of our work, was reviewing data to assess whether any staff made redundant from October 2012 onwards had been re-employed. Redundancy payments can be reclaimed only if the individual concerned rejoins the NHS within four weeks of leaving (paragraphs 4.12 to 4.17).

18 The estimated administration cost savings outweigh the costs of the reforms, and are contributing to the efficiency savings that the NHS needs to make. The Department estimates that the savings total £2.4 billion to 31 March 2013. However, our work indicated that the baseline of administration costs in 2010-11 is likely to have included some elements that were not attributable to the reforms. Applying a lower baseline would make the total savings for each subsequent year lower than reported (paragraphs 4.18 to 4.23).

19 The Department has identified wider benefits that it expects the reforms to achieve but does not yet have arrangements in place to track these benefits. The expected benefits are wide-ranging and long term. They include improved health outcomes and reduced inequalities. At the time of our work, the Department was developing plans for tracking the impact of the reforms. Responsibility for achieving the benefits will in the main rest with arm's-length bodies (paragraphs 4.24 and 4.25).

Conclusion

20 The transition to the reformed health system was successfully implemented in that the new organisations were ready to start functioning on 1 April 2013, although not all were operating as intended. Given the scale of the challenge that the Department and the NHS faced, this was a considerable achievement. It could not have been accomplished without the commitment and effort of many NHS staff, supported by the Department's effective programme management and monitoring.

21 Some parts of the system were less ready than others, and much remains to be done to complete the transition. Each individual organisation needs to reach a stable footing, and ensure in particular that they are financially sustainable. The reformed health system is complex. The Department, NHS England and Public Health England therefore need to provide a lead in helping to knit together the various components of the system so that it can achieve the intended benefits for patients.

Key challenges

22 The Department and the other bodies that make up the health system face significant challenges in making the reformed system work effectively. At this point, we highlight the following overarching areas:

a **Understanding roles and relationships.** The Department needs to develop its view of what its role of 'stewardship of the system' means in practice and how it can exercise effective oversight of its arm's-length bodies. In addition, a feature of the reformed system is that there are more organisations involved. Commissioners, providers and regulators need to establish new ways of working, respecting their distinct independent roles but recognising the need to work together for the benefit of the system as a whole.

b **Maintaining financial sustainability.** The administration costs of the new organisations are on average one third below those of their predecessor bodies. These reductions are part of the £20 billion of efficiency savings that the NHS is seeking to make. The new bodies need to establish quickly whether their chosen organisational design and staffing levels are sustainable within these tighter budgets, and adapt accordingly. Continuing to make savings, without a detrimental impact on services, will need close monitoring and an ongoing focus on cost control.

c **Providing effective incentives.** The new health system comprises hundreds of autonomous bodies. The design of the system creates a risk that bodies may be incentivised to act in a way that benefits their individual organisation rather than the NHS as a whole. For example, it may be cheaper for an organisation to rent a new building than to take on an existing lease, even though this will cost the NHS more overall. NHS England is now responsible for ensuring clinical commissioning groups collaborate when necessary for the benefit of local health economies as a whole, but it is not yet clear how it will exercise this role in practice or the circumstances in which it will seek to exert influence more widely across the health system.

d **Ensuring effective accountability.** Accountability through the devolved delivery chain must be underpinned by sound information systems. This is essential for the Department to discharge its accountability to Parliament for the money spent on healthcare. The same information is needed for effective oversight of local performance and for local bodies to be held to account. The Department needs to complete work on the framework of outcomes indicators and make sure that the supporting data flows are comparable and robust.

e **Delivering the benefits of the reforms.** The Department expects the reforms to bring significant wider benefits, but these benefits will not be realised by changing organisational structures alone. Behavioural and cultural change, as recommended by the Francis report,[2] will be needed to make the reformed system work effectively through greater collaboration and devolved decision-making. Senior managers across the system need to lead this change and demonstrate new ways of working.

2 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry,* chaired by Robert Francis QC, HC 947, Session 2012-13, February 2013.