National Audit Office

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

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Department of Health

Managing the transition to the reformed health system

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National Audit Office

Department of Health

Managing the transition to the reformed health system

Report by the Comptroller and Auditor General

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Amyas Morse
Comptroller and Auditor General
National Audit Office

8 July 2013

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This report examines how the Department of Health and the NHS implemented the transition from the existing to the reformed health system. 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.

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Contents

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This report can be found on the National Audit Office website at www.nao.org.uk/nhs-reforms-2013

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Key facts

£1.1bn
the reported cost of the reforms to 31 March 2013

10,094
the number of full-time equivalent NHS staff made redundant

211
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.

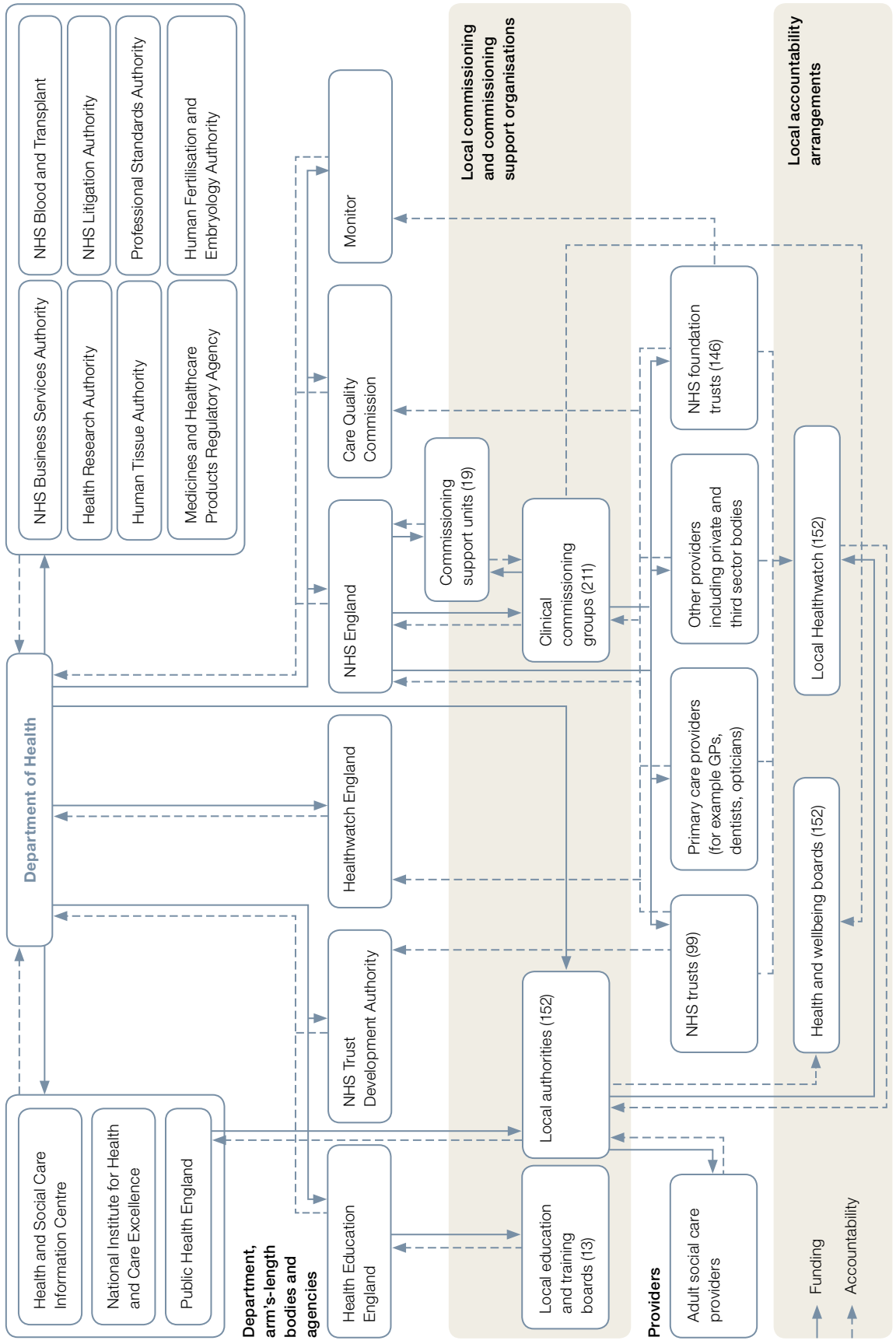
2 The reforms coincide with a period of financial restraint for the health system after a decade of sustained and significant growth. In the four years to 2014-15, there will be very little real terms growth in spending, and the NHS needs to make efficiency savings of up to £20 billion to keep pace with 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.

Part One

The reformed health system

1.1 The Health and Social Care Act 2012 provided for widespread reform to the health system in England, with the aim of improving the quality of care provided to patients. This part of the report sets out the main changes and the role of the Department of Health (the Department) in the reformed system.

The main changes

New structures for commissioning healthcare

1.2 The 2012 Act provided for the abolition of primary care trusts as the main commissioners of health services, and of strategic health authorities as the regional tier of the NHS. Responsibility for commissioning healthcare now rests with new bodies – NHS England (legally, and until 1 April 2013 known as, the NHS Commissioning Board)[3] and clinical commissioning groups, supported by commissioning support units (**Figure 2**).

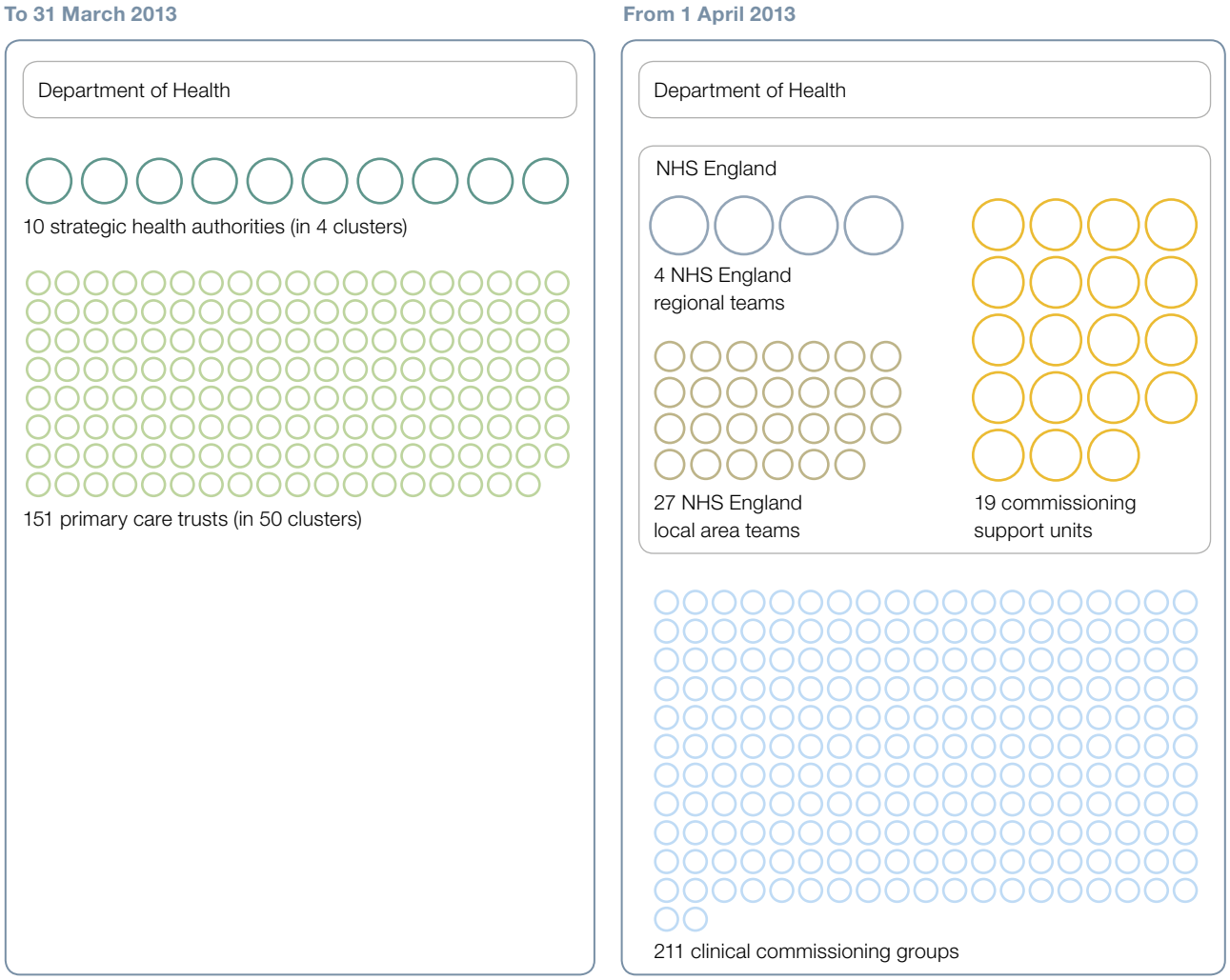
1.3 NHS England is an arm's-length body of the Department, but is operationally independent. The government sets objectives for the NHS through an annual mandate, which may be revised only if NHS England agrees, if there is a general election or if there are 'exceptional circumstances'. NHS England is free to decide how to meet these objectives. Its main responsibilities are to:

- ensure that the commissioning system as a whole functions properly;
- support, develop and hold to account clinical commissioning groups; and
- directly commission primary care services, specialised services and healthcare for those in prison or custody and in the armed forces.

3 We use the name 'NHS England' throughout this report for consistency, although the NHS Commissioning Board did not adopt this name until April 2013.

Figure 2

The organisations responsible for commissioning healthcare



NOTES

1 Commissioning support units are hosted by NHS England; there are currently 19 units though the number has not yet been finalised.

2 NHS England's London region does not have separate local area teams.

Source: National Audit Office adaptation of work © The Nuffield Trust (reproduced with permission). Available at: www.nuffieldtrust.org.uk/talks/slideshows/new-structure-nhs-england, accessed 29 May 2013.

1.4 For 2013-14, the Department has granted NHS England £95.6 billion, 68 per cent of which has been passed on to clinical commissioning groups. NHS England is accountable to the Department for the outcomes achieved by the NHS. The Health and Social Care Act 2012 designates the chief executive of NHS England as its accounting officer; this contrasts with the position in other arm's-length bodies, whose accounting officers are appointed by the Department's accounting officer.

1.5 Responsibility for commissioning most health services now rests with 211 **clinical commissioning groups**. These are independent, statutory bodies. Every GP practice is required to be a member of a clinical commissioning group. Clinical commissioning groups are supported and held to account by NHS England. Each group is required to have an 'accountable officer', responsible for the stewardship of resources and the performance achieved, and a clinical leader.

1.6 Clinical commissioning groups are supported by 19 **commissioning support units** which provide a range of services such as procurement, contract management and service redesign. The units will also provide support to NHS England and other commissioners, including local authorities. The governance of the units is complex – they have no separate legal status and are hosted by NHS England, which grants them a licence to operate, although their staff are employed by the NHS Business Services Authority. Commissioning support units are expected to operate on commercial lines and NHS England expects them to become independent bodies by April 2016 at the latest.

New arrangements for public health

1.7 **Local authorities** (county councils and unitary authorities) now have a statutory duty to improve the health of their populations and are responsible for commissioning public health services. The Department provides ring-fenced funding to local authorities to carry out this role, which previously rested with the NHS. The Department intends to gain assurance about how this funding has been used by reviewing data on public health outcomes.

1.8 Local authorities will discharge their public health role in conjunction with a new executive agency of the Department, **Public Health England**. The agency will support local authorities by providing evidence and advice on how to improve health. It also takes the lead on wider threats to the health of the population, such as emergencies and pandemics.

Greater public engagement and local accountability

1.9 The reforms are intended to secure greater public engagement with the running of the health system. A new body, **Healthwatch England**, has been set up to enable the collective views of people who use health and social care services to influence national policy, advice and guidance. Healthwatch England is a committee of the Care Quality Commission. There are also **local Healthwatch** bodies, which provide a forum for people to influence and challenge how health and social care services are provided in their local area. Local Healthwatch are funded and held to account by local authorities.

1.10 Health and wellbeing boards have been established in each county council and unitary local authority to bring together key players in the local health and care system. The boards are responsible for encouraging integrated working, with the aim of improving the health and wellbeing of their local population and reducing health inequalities.

The role of the Department

1.11 One of the aims of the government in reforming the health system was to remove day-to-day strategic management of the NHS from the direct control of the Department. The Department remains responsible for stewardship of the system as a whole. The Department has defined its responsibilities as to:

- lead the health and care system;
- support the integrity of the system, including accounting to Parliament; and
- champion innovation and improvement.

1.12 The Department's 'accounting officer system statement',[4] published in August 2012, set out how accountabilities should work in the reformed health system. The permanent secretary has sole accounting officer responsibility for the proper and effective use of resources voted by Parliament for health and adult social care services. With reduced departmental involvement in operational matters, the accounting officer relies on a system of assurance around the commissioning, provision and regulation of healthcare. The Department is developing its approach to stewardship of the system, and has set up a sponsorship unit to oversee its relationships with its arm's-length bodies.

4 Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/126966/Accounting-Officer-system-statement.pdf.pdf

Part Two

Managing the transition

2.1 This part of the report covers the scale of the challenge the Department faced in implementing the reforms and how it managed the transition programme.

The scale of the challenge

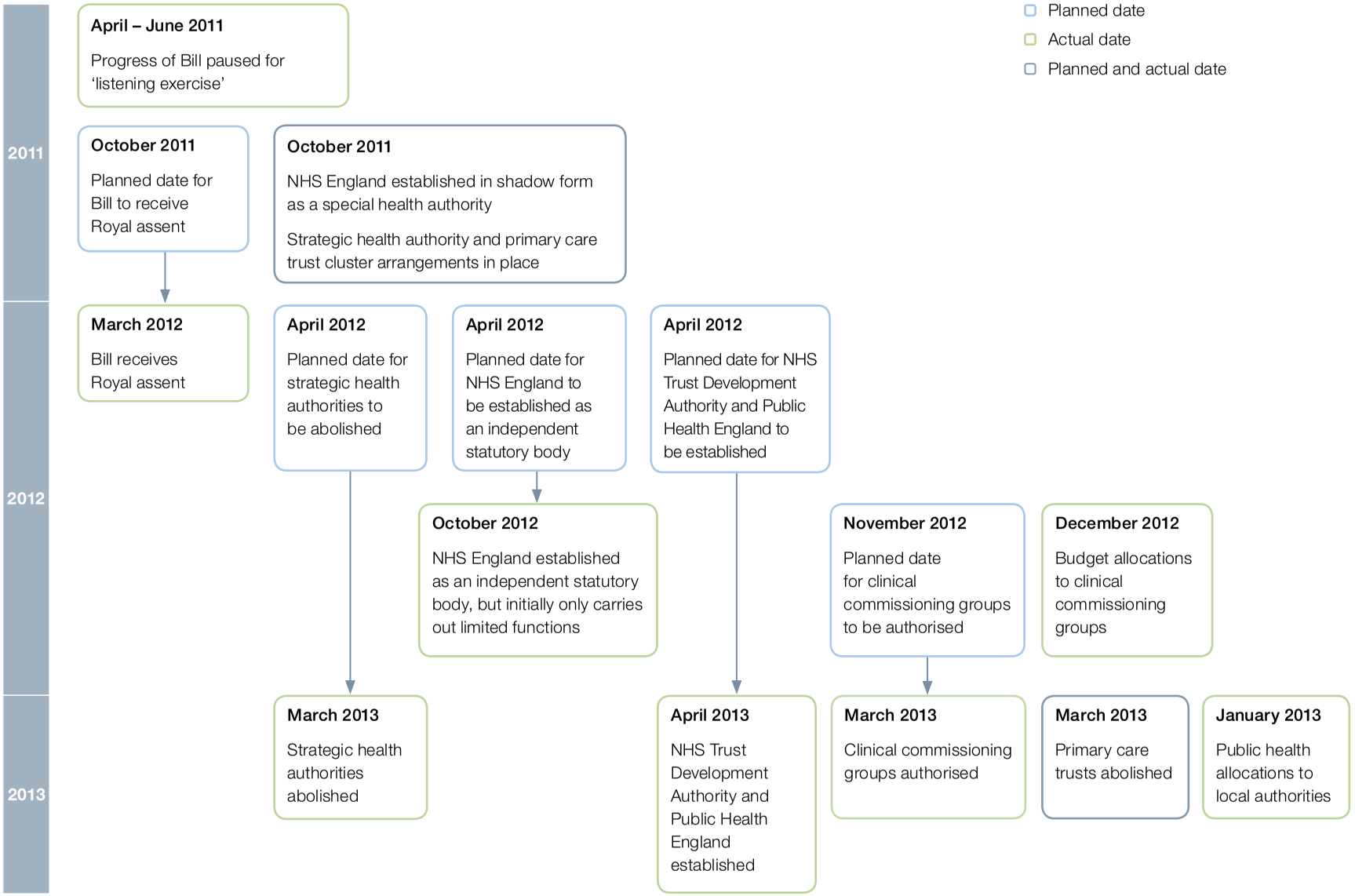
2.2 The reforms to the health system are regarded as the most wide-ranging and complex since the NHS was created in 1948. More than 170 organisations have been closed and more than 240 new bodies established, with others having their functions changed.

2.3 The timetable for implementing the reforms was tighter than originally envisaged because of the time it took to secure Parliamentary approval for the legislation. The Health and Social Care Bill was published in January 2011. The proposals proved controversial and attracted opposition in Parliament and from professional bodies. In April 2011, the government announced a break in the passage of the Bill to 'pause, listen and reflect' on the areas that had caused the most debate. In the light of the pause, the government amended aspects of the proposed reforms; further changes to the legislation were made in the House of Lords. The Bill received Royal assent on 27 March 2012, some five months later than originally planned and just over a year before most of the changes were due to take effect.

2.4 The slippage in the Parliamentary timetable was not reflected in any change in the deadline of 1 April 2013 for the new system to be operational. The Department had enough contingency in its original plans to accommodate the delay in passing the legislation. However, a number of key milestones were missed during 2012-13 and many tasks had to run concurrently, reaching a peak in the early months of 2013 (**Figure 3**).

2.5 The people we interviewed from across the health system consistently emphasised the significant additional effort that many NHS staff had made during the course of the transition. During 2012-13, considerable numbers of staff effectively carried out more than one job at the same time, continuing with their existing role while helping to set up one of the new bodies. At 31 December 2012, 97 per cent of those appointed to a new organisation had not yet left their previous role.

Figure 3
The timeline for the transition



Source: National Audit Office analysis of Department of Health and NHS England documents

Programme management

2.6 The Department put in place comprehensive programme management arrangements to oversee the transition. These proved effective in ensuring that the reformed system was ready to start operating on 1 April 2013. Governance structures and lines of accountability were clear, although they evolved over time. In particular, changes were made in October 2012 when governance for the NHS-specific aspects of the reforms, including NHS England, was moved to a separate portfolio overseen by its own board (**Figure 4**).

2.7 At the highest level, the Department treated the reforms as a single programme and the senior staff leading the programme remained present throughout the transition period. The transition director became the senior responsible owner for the programme in April 2012, taking over from the director-general for finance. The overall programme comprised a series of component programmes, each with its own senior responsible owner. The Department also established an integrated programme office, which tracked the progress of the various constituent programmes against the plans. To provide independent challenge, the Department's accounting officer appointed an external senior representative with specific responsibility for the transition.

2.8 The Department's programme management demonstrated many elements of good practice. For example:

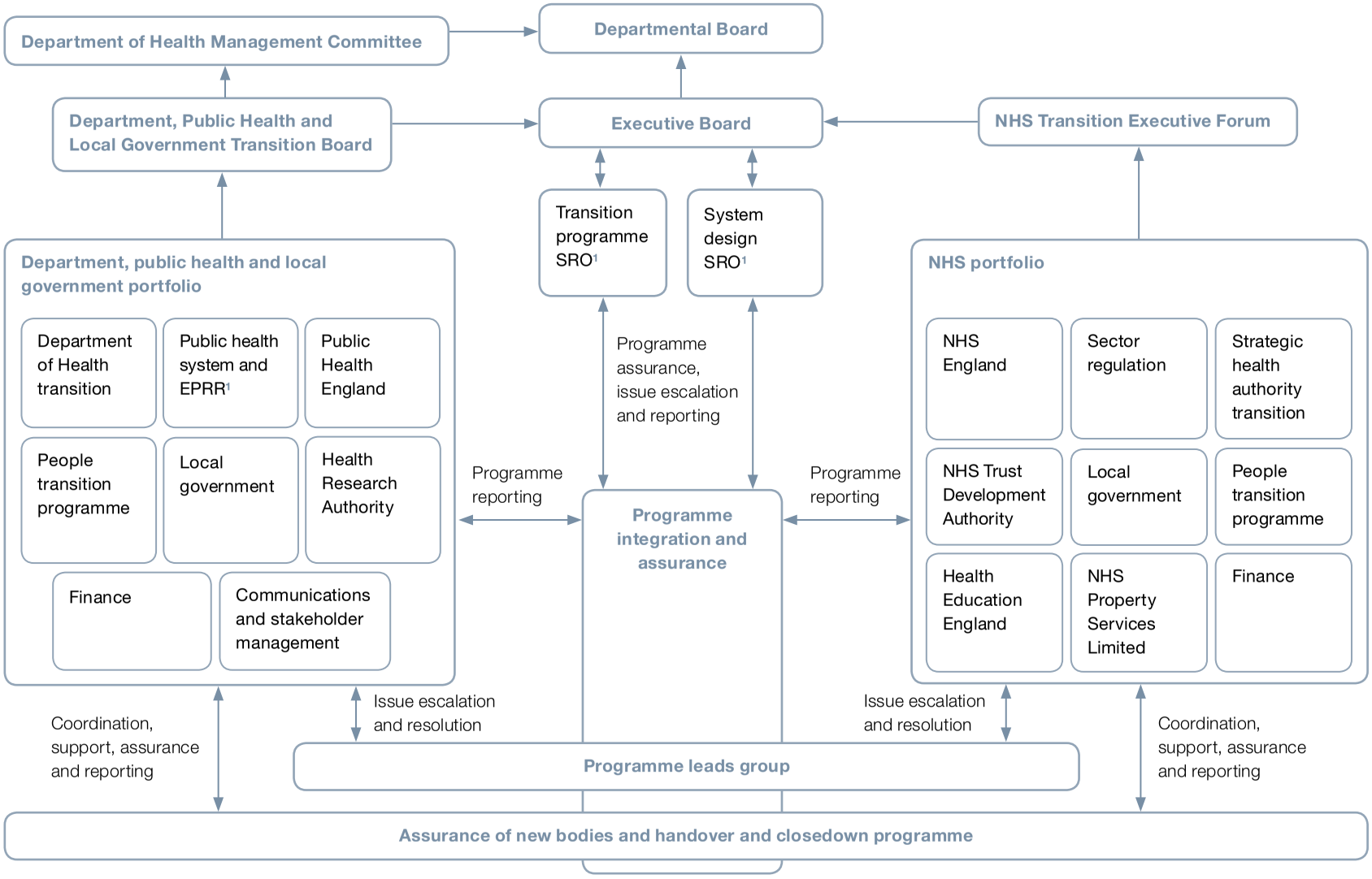
- The programme had clear overarching objectives and measures of success were defined.
- The Department developed a comprehensive stakeholder engagement strategy, with individual strategies for different stakeholders.
- Some aspects of the reforms, including clinical commissioning groups, were formally piloted and evaluated. In addition, in many parts of the country, the new bodies, including commissioning support units, operated in shadow form during 2012-13.
- The Department tracked and managed risks across the programme, and the highest priority risks were integrated into the departmental risk register for the attention of the Department's board.

Assurance about progress

2.9 The Department put in place ongoing monitoring arrangements for key aspects of the transition programme, such as staffing. Primary care trusts and strategic health authorities had to provide the Department with monthly data on staff numbers, redundancies and transfers. Clinical commissioning groups reported their staffing data to NHS England. However, although the groups were encouraged to report data each month, they were not required to do so. Therefore, the Department and NHS England did not have complete assurance about the progress of the groups in appointing staff until March 2013 when all groups provided data.

Figure 4

Governance structures from October 2012



NOTE

1 EPRR = emergency preparedness, resilience and response. SRO = senior responsible owner.

Source: National Audit Office analysis of Department of Health information

2.10 In addition to the monthly monitoring, the Department used a variety of review mechanisms to gain assurance on progress:

- At an early stage, the Department commissioned a series of 'Gateway reviews' for individual programmes, carried out by teams independent of the bodies concerned. The reviews assessed the likelihood that the programmes would be delivered successfully, and made recommendations for improvement.
- In late 2012, the Department initiated a series of 'state-of-readiness' reviews on the new arm's-length bodies and those taking on significant new functions. The reviews involved an element of self-assessment by the bodies concerned. Most of the reviews were followed by a 'board-to-board' meeting between the Department and the arm's-length body to discuss the findings and ensure they were taken forward. The Department held two such meetings with NHS England, in January and March 2013, to discuss the actions being taken in each area of concern, which included staffing, IT and financial readiness.
- The Major Projects Review Group produced three programme-wide reports, which considered the deliverability and state-of-readiness of the transition programme, cost and risk management, and the impact on benefits of changes in the programme.

2.11 During the lead-up to transition and for the month afterwards, the Department carried out daily monitoring to assure itself that the reformed system was operating effectively and to have early warning of any significant issues. The possibility that staff would not be paid correctly in April 2013 because of inaccuracies in staff records was identified as a key risk. The new bodies put contingency arrangements in place to mitigate this risk.

Assurance about care quality

2.12 The NHS Operating Framework for 2012-13 stated that maintaining strong day-to-day performance remained the overriding priority. The NHS staff we interviewed confirmed that maintaining the quality of the care provided to patients was paramount throughout the transition. The NHS Operations Executive continued to monitor care quality as part of 'business as usual', independent of transition management. Primary care trust clusters were responsible for ensuring the quality of primary care was maintained during the transition.

2.13 The focus of the transition was on implementing new structures for commissioning healthcare. The transition was therefore not expected to have a significant impact on the quality of care provided. The most likely potential impact related to GPs being diverted to set up clinical commissioning groups and thereby having less time to spend with their patients. The Department sought to mitigate this risk by providing funding for locum GPs.

2.14 No particular concerns about care quality were raised with the Department. However, assurance that quality was maintained is limited by the fact that little data is available to track the quality of primary care, community services and mental health services. The headline indicators that the Department uses to monitor care quality focus on the quality of hospital care provided by NHS trusts and NHS foundation trusts. These organisations were not directly affected by the restructuring.

2.15 Our review of the headline indicators showed that performance was maintained in most respects during the transition period, including in relation to 'referral to treatment' waiting times (the 18-week target) and healthcare associated infection rates. During most of the transition period performance was above the target that 95 per cent of patients attending an accident and emergency department should be seen, treated, admitted or discharged within four hours. However, performance in the three months to March 2013 was below the 95 per cent target. NHS England is currently reviewing urgent and emergency care in the light of growing pressure on accident and emergency departments.

Part Three

Was the reformed system ready?

3.1 This part of the report covers whether the reformed system was ready to start operating on 1 April 2013, and what remained to be done. Our work focused on areas that were key to the transition, in particular setting up the new arrangements for commissioning healthcare.

Were staff in place?

Vacancy rates

3.2 Getting staff in place was the biggest challenge facing the new organisations. The Department's aim was to minimise the level of redundancies so most posts were filled by transferring staff from the organisations that were closing, including strategic health authorities and primary care trusts. At 1 April 2013, over 41,000 posts had been filled, leaving nearly 4,000 vacancies (9 per cent of total posts) (**Figure 5**).

3.3 The vacancies were concentrated in the new commissioning bodies and Public Health England (Figure 5). NHS England had an overall vacancy rate of 11 per cent, but the unfilled posts were not spread evenly across the organisation. NHS England prioritised recruitment to its regional and local teams and vacancies were concentrated in back-office functions. Seventy-five per cent of posts in its national support centre were filled, with the lowest rate in the policy directorate (67 per cent).

3.4 Vacancy rates among the 211 clinical commissioning groups ranged from 0 to 37 per cent at 1 April 2013. Three groups had recruited less than three-quarters of their staff by this date. Senior staff from clinical commissioning groups told us that they had lost key staff to NHS England. They had appointed staff in advance of NHS England, but when NHS England started to recruit in earnest, local commissioners found that they were unable to compete financially.

Figure 5
Staffing position at 1 April 2013

	Filled posts	Vacant posts	Total posts	Percentage of total posts vacant at 1 April 2013
NHS England	6,017	719	6,736	11
Public Health England	4,678	658	5,336	12
Clinical commissioning groups	9,010	1,080	10,090	11
Commissioning support units	8,102	1,094	9,196	11
Other	13,616	376	13,992	3
Total	**41,423**	**3,927**	**45,350**	**9**

NOTES

1 All figures are full-time equivalents.

2 Excludes posts not affected by the transition.

Sources: NHS England for NHS England and clinical commissioning groups; Public Health England for Public Health England; otherwise Department of Health

3.5 Despite the vacancies, evidence indicates that the commissioning bodies and Public Health England had enough staff to carry out their functions from 1 April 2013. The front-line area that caused most concern was Public Health England's immunisation and screening services. These posts were regarded as essential and a failure to recruit staff quickly was highlighted as a serious risk in summer 2012. However, a third of these posts remained vacant in early April 2013 (including 10 per cent of clinical consultant-level posts). The shortfall arose because newly created full-time immunisation and screening posts could not be easily matched to existing staff roles, leaving around half of these posts to be filled later through competitive recruitment.

Approach to recruitment

3.6 The process of recruiting staff took longer than planned and was not complete by the end of December 2012 as intended:

- Recruitment was held up because work to design the new organisations continued beyond the planned completion date of May 2012. This affected NHS England in particular. Its organisational design developed between July 2011 and April 2013, reflecting in part greater clarity about the functions it would inherit and the budget it would receive. The number of new posts increased from an initial estimate of 3,500 to 4,463, and the balance between different types of staff changed. NHS England expects to complete its design work during 2013-14, including finalising how many staff it will need in the long term.
- Recruitment of 'very senior managers' to the new organisations, which the Department regarded as vital to driving forward wider recruitment, was not substantially completed until the end of January 2013, compared with the expected date of June 2012. Recruitment to senior posts in the Health and Social Care Information Centre and NHS Property Services was continuing at 1 April 2013. In the meantime interim senior staff were in place.
- Competition for posts did not begin in earnest until November 2012. In order to minimise redundancies, the new bodies could only make posts available for open competition if they could not be filled from among existing staff.

3.7 The way in which many staff were transferred to the new organisations means that further changes will be needed before the staffing position is stable. To mitigate the risk of posts being left vacant and to provide stability during the transition, certain groups of staff whose functions were continuing were 'lifted and shifted' in bulk transfers to the new organisations. The Department's intention was to minimise use of this approach. However, partly due to delays in recruitment and partly to minimise disruption among clinical and front-line staff (such as in Public Health England), over 17,000 staff (39 per cent of those affected by the transition) were transferred in this way. Over 80 per cent of posts in Public Health England and 34 per cent of posts in NHS England were filled through this route. The new organisations now need to determine how many of the staff concerned should be retained. Further redundancies are expected to be needed to reduce staff numbers to affordable levels.

3.8 The new organisations also need to assess whether the staff they have inherited have the right skills. As well as the bulk transfers, some staff were moved in one-to-one transfers, which involved matching posts in the bodies that were closing to jobs in the new organisations. A match was achieved if 51 per cent or more of an existing post matched a new job in terms of function and grade. It remains to be seen whether the staff concerned will have the skills required to carry out their new roles effectively, particularly where a relatively low proportion of the two jobs matched.

Was the supporting infrastructure in place?

3.9 Our review of the evidence indicated that the new organisations had the necessary supporting infrastructure in place by 1 April 2013. In some cases, however, 'workarounds' or interim arrangements had to be put in place as a contingency and further work will be needed in the coming months (paragraphs 3.10 to 3.19).

Property services

3.10 A new company, NHS Property Services Limited, started work on 1 April 2013. However, the Department decided in early 2012 that the company would not be expected to operate on a fully commercial basis for a further two years.

3.11 The new organisation is responsible for managing some 4,000 buildings previously occupied by strategic health authorities and primary care trusts, together with surplus properties from other departmental bodies. It faced a number of challenges, including compiling a complete list of NHS properties and identifying existing tenants, up to 40 per cent of whom did not have leases. It also needs to integrate staff inherited from 161 organisations that closed.

Transfer of assets and liabilities

3.12 Due diligence work to finalise the transfer of assets from the organisations that closed to the new bodies was not complete by 1 April 2013. Further work will be needed to identify and reassign assets that have been allocated incorrectly and to resolve disputes.

3.13 The transition involved approximately 340 separate schemes involving the transfer of considerable volumes of assets, ranging from basic equipment to contracts for health services with NHS providers. It became apparent in late 2012 that the Department's legal service, provided through an arrangement with the Department for Work and Pensions, had insufficient capacity to process all the transfer schemes by 1 April 2013. The legal service therefore took on additional temporary staff and used external lawyers to help process the schemes.

3.14 The Department and the NHS faced a particular challenge in ensuring that responsibility for all continuing liabilities was transferred to one of the new bodies, including claims for continuing care (paragraph 3.37). Another set of liabilities without an automatic recipient concerned potential claims by patients for harm suffered as a result of care provided by primary care trusts. The NHS Litigation Authority is responsible for funding and managing these liabilities during 2013-14. At the time of our work, the Department and NHS England were discussing who should take responsibility for these liabilities beyond this date.

IT systems

3.15 The Department planned to implement a new corporate IT system to support its own operations and most of the new arm's-length bodies. At 1 April 2013, however, the system was not operating as intended. The Department's data showed that, by early June 2013, just over 30 per cent of the expected users were using the new system.

3.16 The largest group of users who were not using the new system were NHS England staff. Although the Department signed a contract with its system supplier, Atos, in January 2012 to cover itself and all of its arm's-length bodies, NHS England did not exist at the time and only formally agreed to this arrangement in September 2012. In November 2012, NHS England concluded that seeking to implement the system across the organisation on 1 April 2013 would not allow sufficient time for proper testing and phased deployment across over 40 locations, and would present an unacceptable risk to business continuity. NHS England therefore implemented contingency arrangements, with most staff using legacy systems inherited from predecessor bodies. NHS England expects the new system to be implemented across its regional and local teams by October 2013.

Access to data

3.17 Given the sensitivity of 'patient identifiable data', organisations need legal permission to access it. The Health and Social Care Act 2012 limited access to the Health and Social Care Information Centre, and temporary measures had to be put in place to allow the new commissioning bodies to access the data. Commissioners need access to this data, for example to analyse outcomes for patients with a particular condition or to monitor the performance of providers.

3.18 NHS England did not seek permission for local commissioning bodies to access patient identifiable data from the Health Research Authority Confidentiality Advisory Group until March 2013. The Group granted temporary permission, for three months, on 5 April 2013. In parallel, a temporary solution has been put in place for 2013-14 to provide commissioners with the analysis they need by arranging for around 200 commissioning support unit staff to be seconded to the Health and Social Care Information Centre. The bodies concerned are working together to develop a permanent solution during 2013-14.

3.19 More limited arrangements have also been put in place to allow public health staff in local authorities access to certain data for analysis. Anonymised national data sets will be available through the Health and Social Care Information Centre, and for specific queries through an enquiry service run by Public Health England.

Were clinical commissioning groups ready?

3.20 NHS England authorised all 211 clinical commissioning groups as statutory bodies in time to take up their responsibilities on 1 April 2013. All groups had operated in 'shadow form' during 2012-13, and some for longer, which helped the transition process.

3.21 Authorisation took place in four waves between December 2012 and March 2013. NHS England reviewed documentary evidence, including feedback from other NHS bodies and local authorities, and carried out site visits. The NHS staff we interviewed generally considered that the process had been rigorous and transparent.

3.22 In assessing applications, NHS England sought assurance that clinical commissioning groups could safely discharge their responsibilities for commissioning healthcare. Applicants were assessed against 119 criteria. Where NHS England concluded that groups had not met all the criteria, it authorised them 'with conditions' or, where the concerns were more serious, 'with directions'.

3.23 In total, 168 clinical commissioning groups were initially authorised with conditions, including 25 with more than 10 conditions (**Figure 6** overleaf). Failure to satisfy the following two criteria generated far more conditions than any others:

- The clinical commissioning group has a clear and credible integrated plan, which includes an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15 (122 initial failures reduced to 80 by 1 April 2013).
- The clinical commissioning group has detailed a financial plan that shows how it will achieve financial balance, sets out how it will manage within its management allowance and any other requirements set by NHS England, and is integrated with the commissioning plan (100 initial failures reduced to 71 by 1 April 2013).

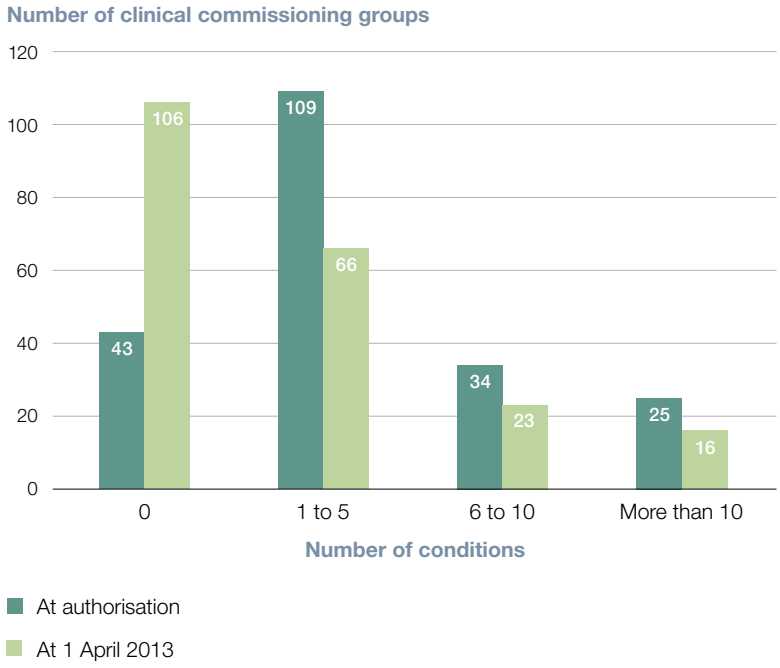
3.24 The number of clinical commissioning groups that lacked detailed, credible plans raises concerns that they will not be well placed to make the necessary efficiency savings. In the coming years, NHS commissioners will need to manage resources carefully and work closely with local providers to make savings and ensure that the health system remains financially sustainable. In particular, some clinical commissioning groups are working within local health economies with long-standing financial difficulties.

3.25 The conditions set out the actions the clinical commissioning groups needed to take, and the support NHS England would provide, to meet the criteria in question. By 1 April 2013, 63 groups had had their conditions lifted, meaning that 106 groups were fully authorised (Figure 6). All groups with remaining conditions have a plan to move towards full authorisation.

Figure 6

Clinical commissioning group authorisation outcomes

In total, 168 clinical commissioning groups were authorised with conditions, falling to 105 by 1 April 2013



Source: National Audit Office analysis of NHS England data

3.26 Fifteen clinical commissioning groups were authorised with between one and five legal directions as well as conditions. This meant that the groups concerned were required to work with NHS England or with a neighbouring clinical commissioning group in carrying out those functions covered by the direction. By 1 April 2013, two of these groups had had their directions removed and one group had directions added, meaning there were 14 with directions. All groups with directions had to agree by the end of May 2013 plans for addressing the areas of concern.

Authorising other bodies

3.27 Although not statutory bodies in their own right, other local bodies also went through an authorisation process:

- NHS England assessed commissioning support units in a five-stage process; four of the stages had been completed by 1 April 2013. As the units are intended to operate as free-standing commercial entities, the process has focused on financial viability and business planning.
- Health Education England (the new national body responsible for the training of NHS staff) authorised local education and training boards, which are new bodies responsible for the training of NHS staff in their areas. All 13 boards were authorised in March 2013, although nine had between one and four 'conditions' relating to areas where direct involvement by Health Education England is required.

Were budgets allocated to clinical commissioning groups and local authorities?

3.28 Clinical commissioning groups and local authorities (for public health) were notified of their budget allocations for 2013-14 in December 2012 and January 2013 respectively. However, ongoing adjustments meant that the budgets for clinical commissioning groups had not been finalised at the time of our work, hampering their ability to plan and budget. Good financial management is particularly important given the financial challenges facing the NHS.

Budget allocations

3.29 The Department originally intended that budget allocations would be made using new formulae that would better reflect need. It asked the independent Advisory Committee on Resource Allocation to develop proposals.

3.30 In January 2013, the Department accepted the Advisory Committee's recommended formula for allocating funds to local authorities for public health. It plans to move local authorities from current funding levels to the amount recommended by the formula over several years. For 2013-14, 89 of the 152 local authorities received more than 10 per cent above or below the amount calculated using the formula.

3.31 In December 2012, NHS England decided not to rely on the Advisory Committee's recommended formula for allocating funds to clinical commissioning groups. NHS England considered that the proposed formula, used in isolation, risked increasing health inequalities by awarding more money to areas with better health outcomes. There was insufficient time to resolve these concerns so for 2013-14 NHS England simply increased each group's estimated allocation for 2012-13 by 2.3 per cent. This is intended to be a temporary approach for 2013-14 only. NHS England is currently reviewing how funds should be allocated in future. The review includes designing a new formula for distributing funds and assessing how quickly clinical commissioning groups can move from current allocations to the amount calculated using the new formula.

3.32 The estimated allocations for 2012-13 relied on spending data provided by primary care trusts between April 2011 and July 2012. The Department asked the trusts to divide their spending to reflect the fact that, in the reformed health system, responsibility for commissioning would be split between several organisations: NHS England, clinical commissioning groups and local authorities.

3.33 Primary care trusts faced a number of challenges in providing spending data. For example, they were asked to divide some categories of spending at GP practice level. Data did not exist to do this in many cases and the trusts therefore had to make assumptions. NHS England and the Department recognise that this will have affected the accuracy of the data and therefore the extent to which the budget allocations for 2013-14 reflect previous spending patterns.

Specialised services

3.34 Clinical commissioning groups have been particularly concerned about the budgets for 'specialised services'. NHS England is responsible for commissioning these services directly, which include treatment for less common cancers and care for people with rare conditions.

3.35 The Department had not set a firm definition of specialised services at the time primary care trusts provided spending data, so NHS England had to adjust the budgets initially allocated to its local area teams and clinical commissioning groups. These adjustments were continuing at the time of our work, meaning that final budgets were still not certain. NHS England has identified around £11.8 billion of specialised activity in hospitals which it will commission itself. Our interviews with clinical commissioning group staff in March and April 2013 indicated that most were not confident that the money transferred from them to NHS England for specialised commissioning was matched by a corresponding reduction in the level of hospital activity for which they were responsible.

3.36 This uncertainty made it more difficult for clinical commissioning groups to plan and commit resources. A consultation exercise conducted for us by the Foundation Trust Network in April 2013 indicated that some trusts were finding it difficult to develop plans because their local commissioners did not have final budgets; this was causing an unusual level of delay in the signing of contracts. NHS England recognises that there have been some difficulties in finalising some contracts. It met the NHS Trust Development Authority in May 2013 to discuss outstanding issues.

Other financial uncertainties

3.37 At the time of our work, clinical commissioning groups also faced other significant financial uncertainties:

- There was uncertainty over the charges NHS Property Services Limited would levy. Clinical commissioning groups were notified of the charges for the first six months of 2013-14 in May 2013. These amounts were based on estimates made by strategic health authorities and primary care trusts during 2012-13. The charges will be refined from October 2013, when NHS Property Services Limited expects to understand better the costs relating to each building.
- Clinical commissioning groups face uncertain liabilities relating to outstanding claims from patients. These liabilities were inherited from primary care trusts and relate to claims for reimbursement of 'continuing care' when a patient paid privately for care which should have been funded by the NHS. Not all claims had been processed by April 2013 so it was not clear what the final cost would be, or whether clinical commissioning groups or the Department would cover that cost. The amounts involved are expected to become clearer when primary care trusts' accounts for 2012-13 have been audited.

Was the information needed for oversight and accountability available?

3.38 Information is critical for the devolved delivery arrangements of the reformed health system to work effectively. However, indicators were not in place at 1 April 2013 to track performance against all of the outcomes that the Department had specified.

3.39 The Department's accounting officer system statement (paragraph 1.12) outlines the information flows needed to evaluate performance and support accountability. A key document is the mandate[5] issued by the government to NHS England. The mandate sets out the government's priorities for the NHS and the areas where it expects to see improvements. The mandate for April 2013 to March 2015, which was published in November 2012, identified five priorities (**Figure 7** overleaf).

5 Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/127193/mandate.pdf.pdf

Figure 7
The government's priorities for the NHS

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

Source: Mandate to NHS England, April 2013 to March 2015

3.40 NHS England is legally required to pursue the objectives in the mandate. The Department will measure progress and hold NHS England to account using the NHS outcomes framework. The framework comprises 67 indicators, of which eight were still in development at 1 April 2013. In turn, NHS England will hold clinical commissioning groups to account using a subset of these indicators. The subset comprises those measures where data is available at clinical commissioning group level.

3.41 The government also sets the strategic direction for public health. The Department will monitor progress through the public health outcomes framework. The framework focuses on two long-term outcomes: increasing healthy life expectancy, and reducing differences in life expectancy and healthy life expectancy between communities. It includes 66 indicators to assess progress towards these goals, of which 12 were still in development at 1 April 2013.

3.42 The Department worked with its arm's-length bodies and HM Treasury during 2012-13 to develop framework agreements for each body, setting out respective roles, responsibilities and lines of accountability. The system is more complex than it was, and NHS England in particular is much larger than any previous arm's-length body.

3.43 The Department intended that framework agreements would be in place by 1 April 2013. At the time of our work, however, the Department and HM Treasury were continuing to discuss the detail of the agreements. In the meantime, the Department is holding arm's-length bodies to account through other mechanisms, including quarterly accountability meetings (monthly in the case of NHS England given its scale and complexity).

What is left to be done to complete the closure of organisations?

3.44 Work remains to complete the closure of strategic health authorities and primary care trusts. The Department has set up a 'legacy management' team to carry out this work.

3.45 The Department intends that the legacy management team will operate for a year, until April 2014. The team is expected to employ some 600 staff on specific time-limited activities at a cost of £34 million. The main tasks will be:

- closing down the financial affairs of strategic health authorities and primary care trusts, including preparing the final accounts;
- completing the transfer of assets and liabilities from the organisations that have closed to the new bodies (paragraph 3.12);
- managing the records of the organisations that have closed, including destroying what does not need to be retained and putting the remaining records into storage; and
- dealing with outstanding issues relating to staff previously employed by the organisations that have closed.

Part Four

Costs and benefits of the reforms

4.1 This part of the report covers the costs and benefits of the reforms.[6]

Costs of the reforms

Estimated costs

4.2 The Department's estimate for the total direct cost of the reforms evolved over time as the changes became more certain and better data became available:

- In January 2011, in the impact assessment accompanying the Health and Social Care Bill, the Department reported that the reforms would cost approximately £1.4 billion.
- In the light of the changes to the design of the new system, in September 2011 the Department amended the estimate to £1.0–£1.5 billion, with a best estimate of £1.2–£1.3 billion.
- The final cost estimate included in the business case for the reforms in December 2011 was £1.5 billion (including £0.1 billion of costs which did not need to be included in the impact assessments, for example departmental costs).

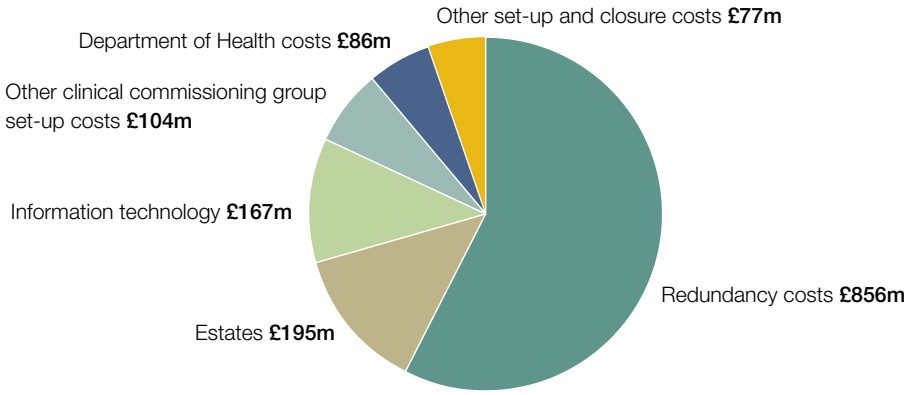
4.3 Over half of the final cost estimate (£856 million) related to redundancy payments to staff leaving the organisations that were to close (**Figure 8**). The reformed system was expected to be much smaller, employing some 34,200 staff compared with an estimated 53,900 staff in April 2010, a reduction of 37 per cent.

4.4 When the final cost estimate was made in December 2011, the Department used provisional administration budgets to estimate the number of staff which the new organisations would employ, and therefore the likely redundancy costs. Around 5,600 staff had already been made redundant at a cost of £195 million (an average of £34,821 per person). The Department's best estimate was that there would be 12,900 further redundancies, at a cost of £661 million (an average of £51,240 per person).

6 All costs and benefits are presented in cash terms.

Figure 8
The Department's estimate of the costs of the reforms, December 2011

The Department expected more than half of the cost estimate of £1.5 billion to relate to redundancies



Source: National Audit Office analysis of Department of Health business case

4.5 The estimates for other cost categories were subject to greater uncertainty. The Department had little reliable information on which to base its estimates and had to make broad assumptions. For example, it assumed that the cost of setting up new IT systems for clinical commissioning groups and transferring systems from old to new organisations would be equivalent to six months of primary care trusts' average IT spending.

Reported costs to 31 March 2013

4.6 The reforms are reported to have cost £1.1 billion to 31 March 2013, 15 per cent above the cost expected to this point (**Figure 9** overleaf). Forty-four per cent of these costs related to the closure of strategic health authorities and primary care trusts, and 36 per cent to setting up NHS England and clinical commissioning groups (**Figure 10** overleaf).

4.7 The main reasons for actual costs exceeding estimates were:

- Aside from redundancy, estates, IT and internal departmental costs, the costs of setting up clinical commissioning groups were nearly four times higher than estimated. This was due in part to the fact that the cost estimate did not include provision for paying locums to cover the time GPs spent working to set up the groups. To 31 March 2013, this cost £85.4 million.
- Aside from redundancy, estates, IT and internal departmental costs, the costs of setting up and closing other bodies were more than twice the estimate. Unspecified 'other' costs relating to the closure of strategic health authorities and primary care trusts cost £86.6 million to 31 March 2013, but were not included in the cost estimate. An exercise conducted by the Department found that these costs included staff training and advice from consultants.

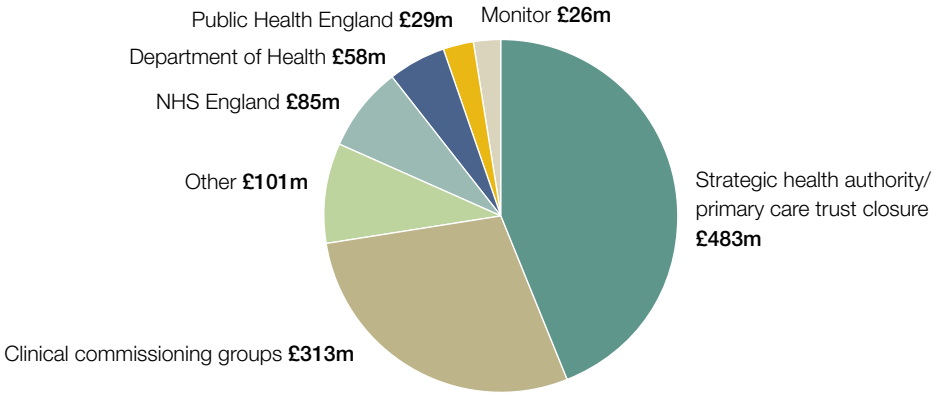
Figure 9
Reported costs of the reforms to 31 March 2013

Category	Business case estimate to 31 March 2013 (£m)	Reported outturn to 31 March 2013 (£m)	Variance (£m)	Variance (%)
Redundancy payments	555	435	-120	-22
IT	127	54	-73	-58
Internal departmental costs (excluding redundancy, estates and IT)	86	22	-64	-74
Other clinical commissioning group set-up costs (excluding redundancy, estates, IT and internal departmental costs)	83	299	216	260
Other set-up and closure costs of other bodies (excluding redundancy, estates, IT and internal departmental costs)	77	244	167	217
Estates	25	42	17	69
Total	**953**	**1,096**	**143**	**15**

Source: National Audit Office analysis of Department of Health data

Figure 10
Reported costs of the reforms by organisation to 31 March 2013

The majority of the reported costs of £1.1 billion related to closing and setting up local NHS organisations



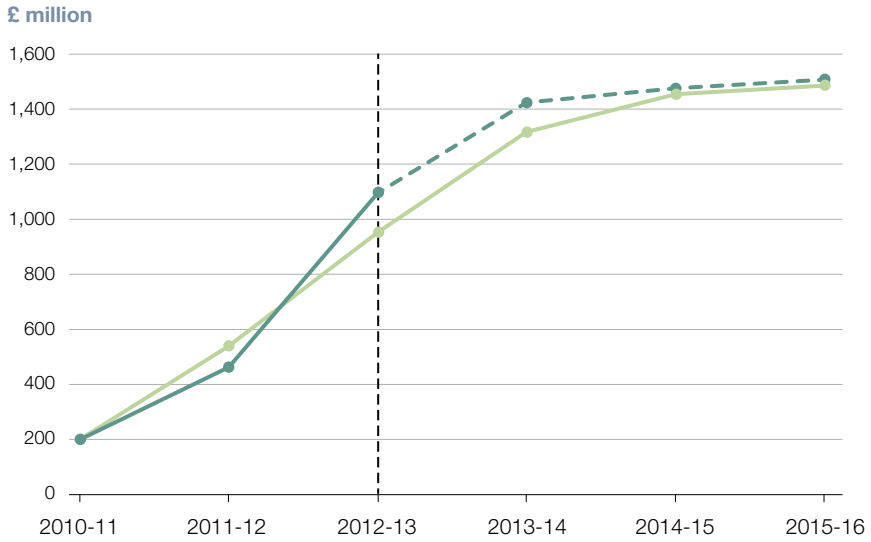
Source: National Audit Office analysis of Department of Health data

4.8 The Department is confident that the total costs of the reforms will not exceed £1.7 billion,[7] which is £215 million above the business case estimate. However, it does not have robust up-to-date data on the costs that are expected to be incurred in 2013-14 and beyond.

4.9 The Department's current best estimate of the likely total costs is £1.51 billion (**Figure 11**), which comprises reported costs of £1.1 billion to 31 March 2013 plus estimated future costs of £411 million. This estimate of future costs dates from December 2011. Since then, aspects of the transition have been delayed and costs deferred to 2013-14. 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. Early indications were that future costs would be below the earlier estimate of £411 million, but the Department did not at that point have information from all arm's-length bodies and it had not assured the accuracy of the data it had received.

Figure 11
The costs of the reforms

The Department's best estimate is that transition costs will slightly exceed the final cost estimate in its business case



	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Department's business case estimate – December 2011	199.4	539.1	952.6	1,317.1	1,454.3	1,485.0
Outturn to 31 March 2013	199.4	463.0	1,095.8			
Department's projection at June 2013				1,424.5	1,476.1	1,506.7

Source: National Audit Office analysis of Department of Health data

7 Equivalent to £1.6 billion in 2010-11 prices.

Reliability of reported costs

4.10 In compiling reported costs, the Department relied heavily on monthly returns from strategic health authorities and primary care trusts; three-quarters of reported costs came from this source. The Department told us it had two main ways of gaining assurance about the accuracy of this data, but we found that these methods provided limited assurance:

- The Department relied on validation work by strategic health authorities. However, an internal audit review in August 2012 reported that strategic health authority staff did not verify the figures submitted to them by primary care trusts. The strategic health authority staff we spoke to confirmed that this was still the case.
- The Department reviewed the cost data centrally for anomalies. This work found, for example, that 15 of the 161 strategic health authorities and primary care trusts reported closure costs of zero in 2012-13, the year when they closed. However, we saw no evidence that the Department challenged these figures.

4.11 The reported costs do not reflect the time spent on transition by NHS staff unless they worked full-time on this activity. In practice, however, many worked part-time on transition during 2012-13, while also continuing to work in a closing organisation. The opportunity cost of this arrangement is likely to have been considerable, but the Department does not have information to quantify it.

Redundancy costs

4.12 Redundancy costs accounted for 40 per cent of the total costs incurred to 31 March 2013. In total 10,094 full-time equivalent staff were made redundant in the three years to 31 March 2013, at a cost of £435 million (an average of £43,095 per person). A further 3,841 staff left through natural wastage during 2012-13.

4.13 The Department sought to reduce the risk of staff receiving a redundancy payment from one NHS organisation and then being re-employed by another, but it has limited levers to prevent this happening. The Department's policy was that staff could take redundancy only if a suitable job could not be found for them in the new system. However, the terms of staff contracts mean that the NHS can reclaim a redundancy payment only if a member of staff rejoins within four weeks of leaving.

4.14 The Department estimates that 1,300 staff made redundant between May 2010 and September 2012 were subsequently re-employed in permanent posts in the NHS, and a further 900 were re-employed on fixed term contracts. It has no data on the value of the redundancy payments made to the staff concerned, or on how many staff were re-employed on an interim basis. At the time of our work, the Department was reviewing data to assess whether any staff made redundant from October 2012 onwards had been re-employed.

4.15 From August 2012, redundancy payments to board-level managers in strategic health authorities and chief executives of primary care trusts had to be approved by the NHS Chief Executive. For a payment to receive approval, there had to be evidence that no 'suitable alternative employment' in the NHS was available. Whether a post was regarded as suitable alternative employment depended on a number of factors including the location of the job, the pay and terms on offer, and the status of the post.

4.16 In total, 44 of these very senior managers were made redundant under this process between August 2012 and 31 March 2013. The redundancy payments made to these staff totalled £12.2 million, an average of £277,273 per person. Individual payments ranged from £33,771 to £578,470 (including any associated pension costs).

4.17 These managers were a subset of a wider group of approximately 330 'very senior managers' in strategic health authorities and primary care trusts. At the time of our work, the Department had not completed its analysis of redundancy payments made to this wider group where the approval of the NHS Chief Executive was not required.

Benefits of the reforms

Reduced administration costs

4.18 The reforms were expected to reduce NHS administration costs by a third, allowing more money to be spent on front-line care. The reductions form part of the efficiency savings of up to £20 billion that the NHS is seeking to make in the four years to 2014-15.

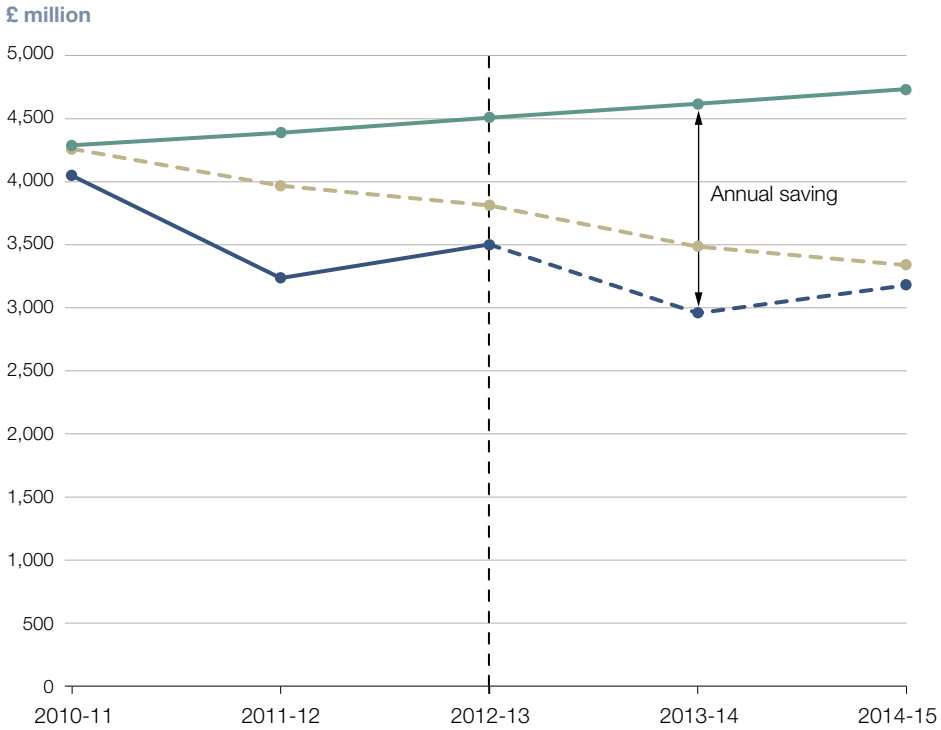
4.19 The Department estimates that to 31 March 2013 the reforms saved £2.4 billion in administration costs (**Figure 12** overleaf). This figure was calculated by comparing actual spending on administration in each year with what spending would have been without the reforms, assuming that costs rose in line with inflation. The Department expects administration costs to fall further in 2013-14.

4.20 The savings were assessed against a baseline of administration costs in 2010-11. At the time, the Department did not have to report the administration costs of NHS bodies in its accounts so the calculation of the baseline had to be based on management information. The baseline the Department calculated was higher than the actual costs incurred. This was because the Department attributed £240 million of savings made in 2010-11 to the reforms. It considered that the fact that NHS administration costs fell by £240 million more than the target was the result of the policy intention to abolish strategic health authorities and primary care trusts, set out in the government's White Paper in July 2010.

4.21 The evidence we reviewed indicated that the £240 million of savings related to reduced staff costs in primary care trusts; lower travel, training and other related costs; and reduced consultancy spending by strategic health authorities. We consider that, while it is reasonable to assume that these savings are attributable in part to the reforms, there is a lack of evidence to support the attribution of the whole amount to the reforms. In particular, the reduced consultancy spending is likely to be at least in part due to the introduction in June 2010 of new measures to control the use of consultants across government. Were the baseline of administration costs in 2010-11 not to include all of the £240 million, the total savings for each subsequent year would be lower than reported.

Figure 12
Administration costs compared with baseline, 2010-11 to 2014-15

The Department estimates that the reforms have generated administration cost savings of £2.4 billion to 31 March 2013



	2010-11	2011-12	2012-13	2013-14	2014-15
Department's original baseline	4,288	4,389	4,507	4,619	4,735
Department's original target	4,260	3,969	3,811	3,486	3,337
Actual outturn	4,048	3,237	3,502		
Department's projection of outturn				2,957	3,180

Source: National Audit Office analysis of Department of Health data

4.22 Total administration costs are now reported in the Department's resource accounts and subject to audit, although at the time of our work the audit of the 2012-13 accounts, including administration costs of £3.5 billion, had not been completed.

4.23 On the basis of the figures in Figure 12, the savings in administration costs outweigh the costs of the reforms. Furthermore, some cost elements are included both in the costs of the reforms and in total administration costs. Removing these elements from administration costs would produce a more accurate estimate of the benefits of the reforms. As we were finalising this report, the Department estimated that making this adjustment would increase the savings in administration costs by around £660 million compared to its previous approach. However, we were not able to review the underlying evidence to confirm this figure in the time available.

Wider benefits

4.24 In reforming the NHS, the government's aim was to create a more responsive, patient-centred NHS and public health system, which achieves outcomes that are among the best in the world. The Department has set out a series of wider benefits that it expects the reforms to achieve over many years (**Figure 13**).

4.25 The benefits set out by the Department are high-level and expressed in aspirational terms. At the time of our work, the Department was developing plans for tracking the impact of the reforms. Responsibility for achieving the benefits in the main rests with arm's-length bodies. Indicators are in place to assess some of the benefits, including improvements in health outcomes (paragraphs 3.40 and 3.41). However, it is not currently clear how progress will be measured in other areas, including what the indicators of success and the starting baselines will be.

4.26 A common view among the NHS staff we interviewed was that understandably less attention had been paid to the benefits of the reforms during the transition process. They identified a variety of potential benefits. For example, some thought that making NHS England responsible for specialised commissioning should reduce variations in care quality for rare conditions; and others thought that greater GP involvement in commissioning would make services more responsive to patient needs.

Figure 13
The expected benefits of the reforms

The Department expects a wide range of benefits from the reforms

- Improve NHS outcomes.
- Improve public health outcomes.
- Greater patient/public involvement.
- Improve patient/public experience.
- Focus more on prevention.
- Increase the local democratic legitimacy of local commissioning.
- Improve NHS commissioning.
- Liberate the provider sector.
- Drive quality and productivity improvements.
- Develop a more flexible and responsive workforce.
- Reduce health inequalities.

Source: Department of Health

Appendix One

Our audit approach

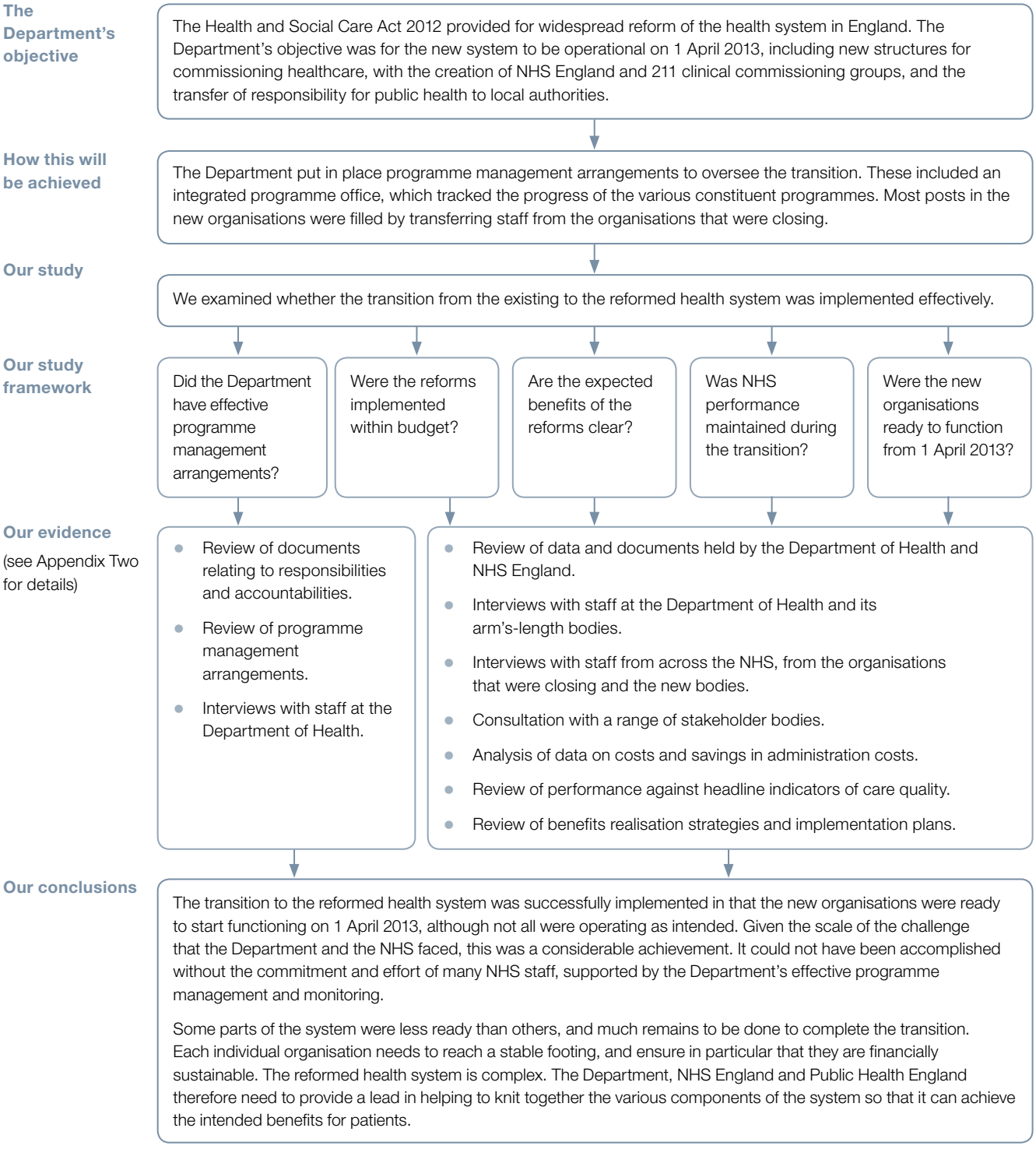
1 The Health and Social Care Act 2012 provided for widespread reform of the health system in England. This report examines whether the transition to the reformed health system was carried out effectively. We reviewed whether:

- the new organisations were ready to function from 1 April 2013;
- the reforms were implemented within budget;
- the expected benefits of the reforms are clear;
- NHS performance was maintained during the transition; and
- the Department had effective programme management arrangements.

2 In reviewing these issues, we applied an analytical framework with evaluative criteria, which considered what arrangements would be optimal for carrying out the transition. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied restrictions or constraints. In this case, the constraints included the timetable imposed by the legislation and the need to maintain 'business as usual' during the transition process.

3 Our audit approach is summarised in **Figure 14**. Our evidence base is described in Appendix Two.

Figure 14
Our audit approach



Appendix Two

Our evidence base

1 Our independent conclusions on managing the transition to the reformed health system were reached following our analysis of evidence collected between December 2012 and May 2013. Our audit approach is outlined in Appendix One.

2 We examined data and documents held by the Department of Health and NHS England on the progress of the transition and the position at 1 April 2013. These included:

- Monthly status reports to the programme boards overseeing aspects of the transition, from July 2012 to May 2013.
- Minutes of the monthly meetings of the Human Resources Strategy Group, the Transition Executive Forum, and the Department of Health, Public Health and Local Government Board, from July 2012 to May 2013.
- Monthly data on the movement of staff between the bodies that were closing and the new organisations, from July 2012 to March 2013.
- Gateway reviews for the Department's main arm's-length bodies.
- State-of-readiness reviews for the Department's main arm's-length bodies.
- Reviews by the Major Projects Review Group and the Major Projects Authority.
- Data on the position of clinical commissioning groups for February and March 2013.
- Daily and weekly situation reports received by the Department during April 2013.
- Papers relating to the allocation of budgets to clinical commissioning groups and local authorities.

3 We reviewed the results of NHS England's process for authorising clinical commissioning groups, including details of conditions and directions. We also reviewed the results of the authorisation process for commissioning support units and local education and training boards.

4 We reviewed documents on responsibilities and accountabilities, including the Department's accounting officer system statement, NHS England's mandate, and the NHS outcomes framework.

5 We carried out interviews with senior staff at the Department of Health and its arm's-length bodies to gain a more in-depth understanding of the issues faced in managing the transition to the reformed health system. The staff included:

- At the Department: the senior responsible owner for the transition programme, and the director of the integrated programme office.
- At NHS England: the chief financial officer, the corporate chief information officer, the director of commissioning development, the national director for human resources and the national director for policy.
- At other arm's-length bodies: the chief executives of the NHS Trust Development Authority, Health Education England, the Health and Social Care Information Centre and NHS Property Services Limited, and the director of policy at Public Health England.

6 We also interviewed one of the Department's non-executive directors and the external senior representative with specific responsibility for the transition.

7 We carried out interviews with 34 senior representatives from across the NHS, including:

- staff from strategic health authorities and primary care trusts that were closing; and
- accountable officers and other senior staff from new organisations – clinical commissioning groups, commissioning support units, and NHS England regional teams and local area teams.

The issues covered included: progress in closing and setting up bodies, the challenges of the transition, the readiness of the reformed system, the impact of the transition on care quality, and the benefits of the reforms.

8 We interviewed and/or consulted a range of stakeholders to obtain their views on the readiness of the reformed system, and the costs and benefits of the reforms. We received contributions from: the Association of Directors of Public Health, the Foundation Trust Network, the Local Government Association, the NHS Confederation, the Specialised Healthcare Alliance, UNISON and Unite.

9 In addition, the Foundation Trust Network consulted their members (NHS foundation trusts and NHS trusts) on our behalf about how the reforms were affecting NHS providers, in particular in relation to commissioning and contracting issues. We also conducted a discussion group with members of the commissioning faculty of the Healthcare Financial Management Association.

10 We reviewed the cost estimates included in the two impact assessments, which accompanied the Health and Social Care Bill, and the business case for the reforms, including the underlying assumptions. We analysed data on reported transition costs and reviewed the process for generating cost data. This work included reviewing departmental internal audit reports on transition costs; and interviewing staff from the Department with responsibility for measuring and validating transition costs at national level, and staff from strategic health authorities and primary care trusts with responsibility for measuring local transition costs.

11 We analysed data on savings in administration costs, including reviewing the Department's calculation of the baseline of administration costs in 2010-11. We also drew on work done by the National Audit Office as part of the audit of the Department's resource accounts for 2011-12 and 2012-13. We interviewed staff from the Department with responsibility for measuring and validating administration costs.

12 We reviewed departmental documents setting out the expected wider benefits of the reforms, and how the expected benefits might be measured. We interviewed staff from the Department with responsibility for developing plans for tracking and measuring the benefits of the reforms.

13 We assessed whether NHS performance was maintained during the transition by reviewing headline indicators of the quality of healthcare, in particular those from the NHS Operating Framework. We used data published by the Department, including on waiting times and healthcare associated infection rates. We also reviewed the minutes of the NHS Operations Committee, and consulted the Care Quality Commission.

14 We applied the National Audit Office's *Initiating Successful Projects* framework to assess the Department's programme management arrangements. Our assessment drew on a range of documents, including monthly status reports, stakeholder engagement strategies, and documents outlining the governance arrangements for the programme.

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