National Audit Office

DEPARTMENTAL OVERVIEW

The performance of the Department of Health 2012-13

MARCH 2014

Our vision is to help the nation spend wisely.

Our public audit perspective helps Parliament hold government to account and improve public services.

The National Audit Office scrutinises public spending for Parliament and is independent of government. The Comptroller and Auditor General (C&AG), Amyas Morse, is an Officer of the House of Commons and leads the NAO, which employs some 860 staff. The C&AG certifies the accounts of all government departments and many other public sector bodies. He has statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively, and with economy. Our studies evaluate the value for money of public spending, nationally and locally. Our recommendations and reports on good practice help government improve public services, and our work led to audited savings of almost £1.2 billion in 2012.

Contents

Introduction

Aim and scope of this briefing

1 This report summarises the Department of Health's (the Department's) activity and performance since September 2012, based primarily on published sources including the Department's own accounts and the work of the National Audit Office (NAO).

2 Part One of the report focuses on the Department's role and activity over the past year. Part Two concentrates on recent NAO analyses of aspects of that activity. Part Three takes the form of a case study which looks in greater detail at funding for the clinical commissioning groups established under the Health and Social Care Act 2012.

Part One

About the Department

The Department's role

1.1 The Department of Health (the Department) has overall responsibility for providing the National Health Service, public health services and adult social care services (the health and care system) in England.

1.2 In April 2013, most of the government's reforms to the health system introduced by the Health and Social Care Act 2012 took effect. These reforms significantly change how the Department carries out its responsibilities, by removing day-to-day strategic management of the NHS from the Department's direct control. The Department remains responsible for stewardship of the system as a whole.

1.3 The Department's *Accounting Officer system statement*, published in September 2012, set out how accountabilities should work in the reformed health system.[1] 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.

1.4 The reforms did not make direct changes to the way healthcare is provided to patients. However, they did make significant changes to other aspects of the health system. More than 170 organisations were closed, and more than 240 new ones were created. In particular, responsibility for commissioning healthcare and public health services moved from 151 primary care trusts to NHS England, 211 clinical commissioning groups and 152 local authorities.

1 Department of Health, *Accounting Officer system statement*, September 2012, available at: www.gov.uk/government/publications/accounting-officer-system-statement--2, accessed 13 March 2014.

1.5 **Figure 1** shows that the health system is a complex network of commissioners and providers of care, organisations which hold them accountable locally, and various national bodies, such as the health regulators. In most cases, organisations are directly accountable to the bodies that fund them. But there are additional local and national accountabilities: for example, between clinical commissioning groups and local health and wellbeing boards; and between healthcare providers and national regulators.

Commissioning health and social care

1.6 A range of different organisations purchases (or 'commissions') healthcare, public health services and adult social care from providers.

1.7 The Department's largest arm's-length body, NHS England, has overall responsibility for the system for commissioning healthcare. The government sets objectives for the NHS through an annual mandate to NHS England, which is in turn accountable to the Department for the outcomes achieved by the NHS.

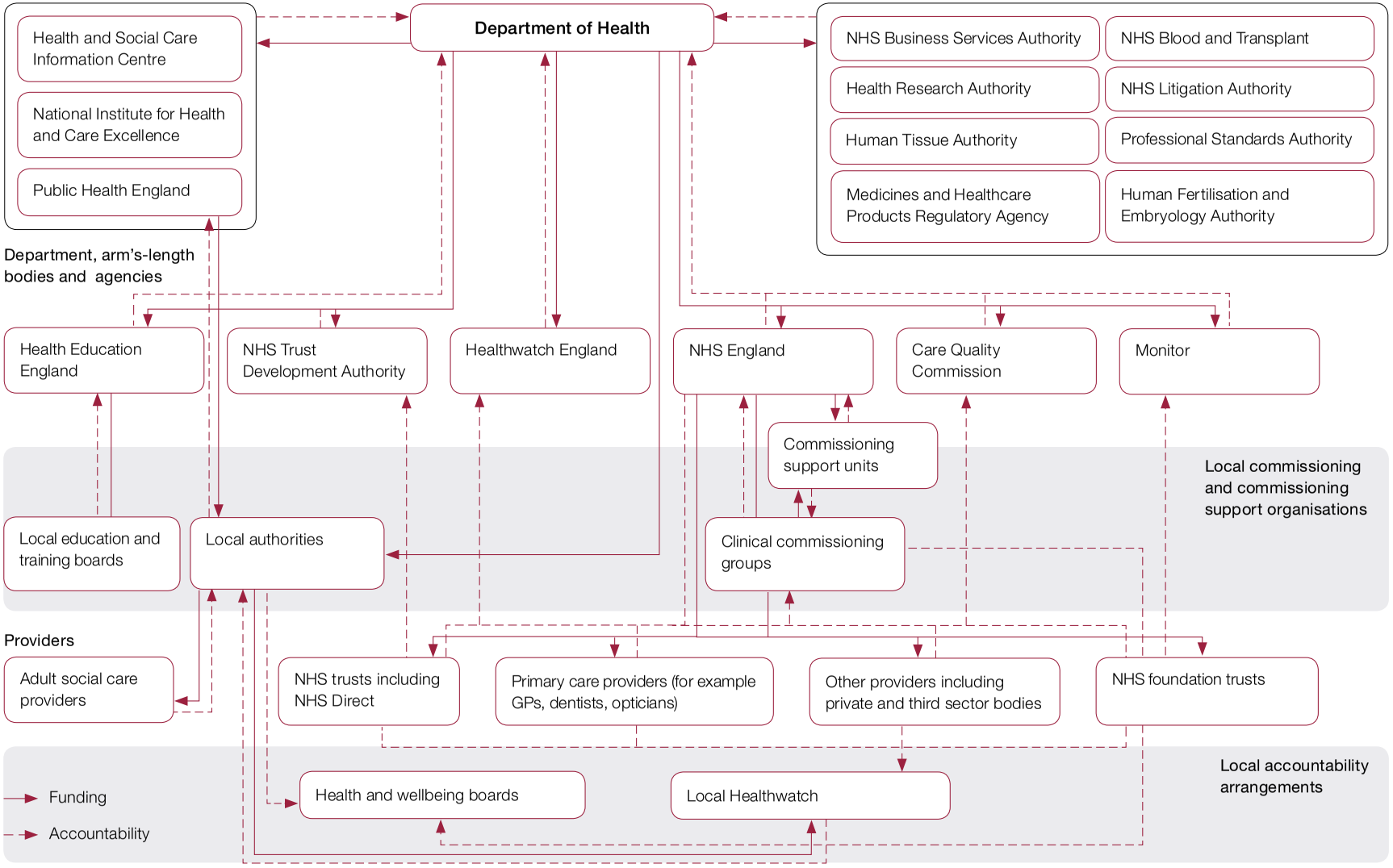
1.8 NHS England oversees 211 clinical commissioning groups, each of which commissions many of the healthcare services for people living in their area. NHS England decides how much money each group will receive, and in 2013-14 distributed a total of £64.7 billion between the groups (£63.4 billion for them to commission healthcare and £1.3 billion for their own running costs). NHS England is responsible for holding each group to account for its performance. It also commissions some services itself – primary care, specialised services (for example, treatments for rare cancers) and healthcare for those in prison or custody and in the armed forces.

1.9 Public health services, such as sexual health clinics, are about helping the public to stay healthy, rather than treating illnesses. They are largely commissioned by local authorities, which have a statutory duty to improve the health of their populations. The Department gives local authorities ring-fenced funding to carry out this role. Local authorities are supported by Public Health England, an executive agency of the Department, which is responsible for providing evidence and advice on how to improve public health. Public Health England also takes the lead on wider threats to the health of the population, such as emergencies and pandemics.

1.10 Adult social care, such as residential care homes, is largely commissioned by local authorities. The Department sets the national policy and legal framework for adult social care and provides some funding. However, most funding for these services comes from other sources, such as the Department for Communities and Local Government and from people paying for their own care.

Figure 1

The health system from 1 April 2013



Source: National Audit Office

Providing health and social care

1.11 A range of different organisations provides healthcare, public health services and adult social care. This includes NHS trusts, NHS foundation trusts, GPs, dentists, and private and third sector providers.

1.12 NHS foundation trusts have more financial and operational freedom than NHS trusts. The Department's policy is that all NHS trusts should become NHS foundation trusts. The NHS Trust Development Authority oversees the performance of the remaining NHS trusts, and supports them to become foundation trusts.

Regulating health and social care

1.13 The Care Quality Commission regulates the quality and safety of services provided by all health and social care providers. The Commission registers and inspects providers, and can take enforcement action if providers are not meeting essential standards of quality and safety.

1.14 Monitor is the regulator of NHS foundation trusts. It determines whether NHS trusts are ready to become foundation trusts and regulates those trusts that achieve this status. Under the Health and Social Care Act 2012, Monitor's role expanded and it became the sector regulator for health services. Its role is 'to protect and promote the interests of patients by ensuring that the whole sector works for their benefit'. Its new responsibilities include setting prices for NHS-funded services, and helping commissioners make sure that essential local services for patients continue if providers get into serious difficulty. From 1 April 2014, Monitor will license other providers of NHS-commissioned services unless they are exempt.[2]

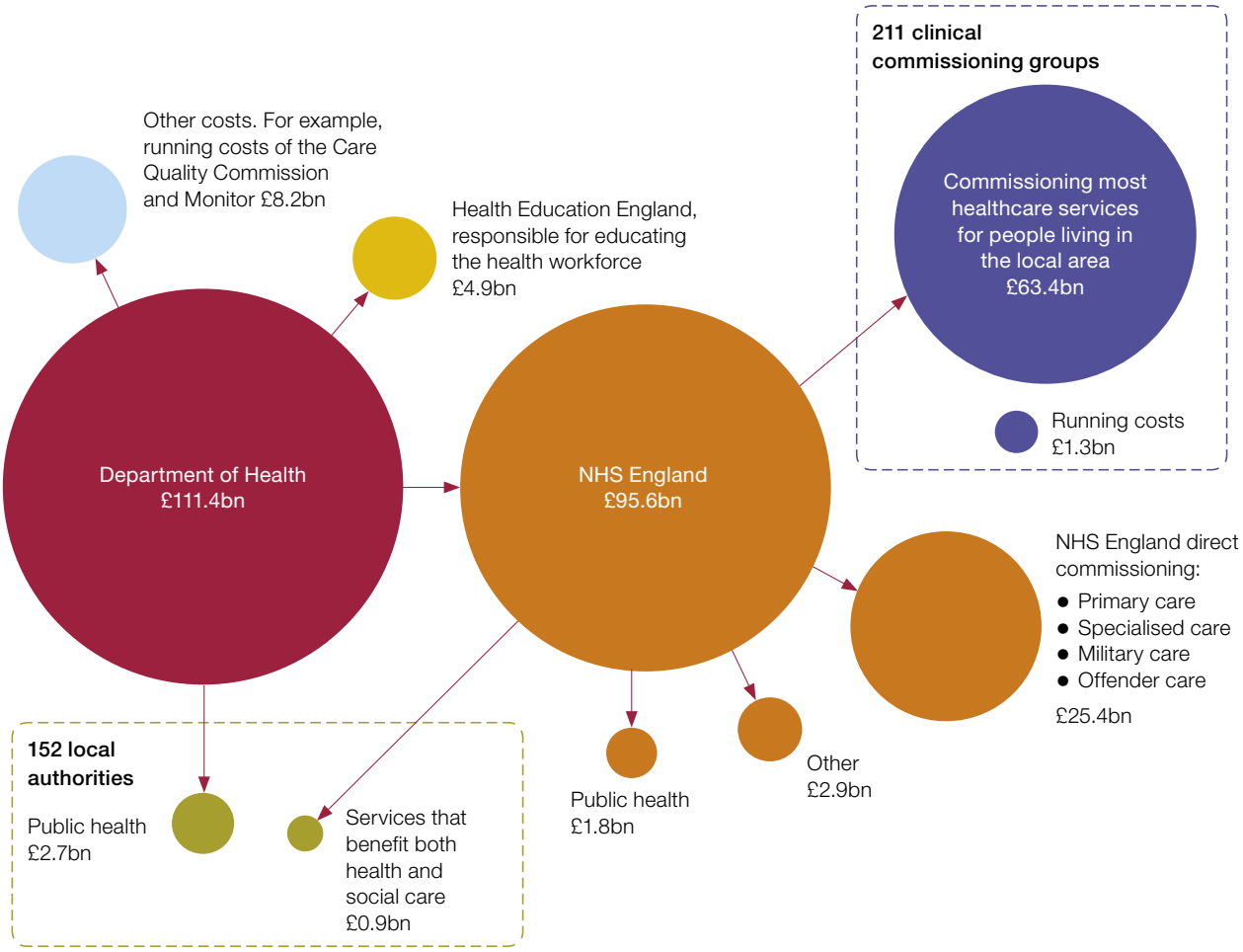
Where the Department spends its money

1.15 The Department of Health is the second biggest spending government department. Its spending review settlement for 2013-14 is £111.4 billion. **Figure 2** shows where the Department distributed this funding in 2013-14, and how it will be spent.

1.16 Although funding for the NHS has been maintained in real terms in the last two spending reviews, it needs to make significant efficiency savings to keep pace with demand and live within its means. The NHS faces continuing growth in the demand for healthcare, partly due to the ageing population and advances in drugs and technology. It is seeking to make efficiency savings of up to £20 billion in the four years to 2014-15. NHS England recently estimated that continuing with the current model of care will result in a total gap between spending requirements and resources available of around £30 billion between 2013-14 and 2020-21.

2 A number of providers are exempt from having to hold a licence from Monitor, including NHS trusts and providers of primary medical and dental services.

Figure 2
Where the Department spends its money



Note

1 In addition to the £1.8 billion shown for public health, £360 million of the £25.4 billion of NHS England direct commissioning is to fund public health activities through primary care. This means in total NHS England provides £2.2 billion of funding for public health.

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

The Department's digital strategy

1.17 Digital communications now play a key role in government business, and by December 2012 each government department was required to produce a digital strategy.

1.18 The Department of Health's 2012 strategy set out five key commitments:

- Improve the development and impact of open policy making – for example, by training policy makers to use digital techniques to inform policy development, engage different audiences and evaluate effectiveness.
- Increase the effectiveness of communications to, and engagement with, audiences and stakeholders – for example, by encouraging staff across the Department to use social media to communicate with stakeholders.
- Develop the digital skills it needs across the organisation – for example, by making sure that the Department's 2013 learning and development strategy considers staff's digital skills needs.
- Improve day-to-day efficiency – for example, by introducing a new fast-track approvals route for procuring digital products and services.
- Steward the health and care system towards a health information revolution – for example, by bringing together data from across the NHS, public health and social care into a single integrated information platform for citizens.

The Francis Report

1.19 In February 2013, Robert Francis QC published the report of his second inquiry into Mid Staffordshire NHS Foundation Trust. Robert Francis's first inquiry had found that there were "appalling standards of care" at Mid Staffordshire between 2005 and 2009. His second inquiry looked into why the NHS regulatory system had not identified these problems more quickly. **Figure 3** shows that the report identified seven main reasons.

Figure 3

Why problems at Mid Staffordshire NHS Foundation Trust were not discovered sooner

1. As identified during the first inquiry, the Trust was an organisation that lacked insight and awareness of the reality of the care being provided to patients. It was generally defensive in its reaction to criticism and lacked openness with patients, the public and external agencies.
2. The responsibilities and accountabilities of external agencies were not well defined, often resulting in 'regulatory gaps' or failure to follow up warning signs. Organisations operated in silos, without consideration about the wider implications of their role, even guarding their territories on occasion.
3. This situation was exacerbated by a lack of effective communication across the healthcare system in sharing information and concerns. Organisations relied on others to keep them informed rather than actively seeking and sharing intelligence. At the heart of the failure was a lack of openness, transparency and candour in the information emanating from the Trust and over-reliance on that information by others.
4. This was not helped by the constant reorganisation of NHS structures, often leading to a loss of corporate memory and misunderstandings about an organisation's functions and responsibilities. Information flow was generally poor.
5. The combination of these 'regulatory gaps', lack of effective communication and constant reorganisation led to a systemic culture where organisations took inappropriate comfort from assurances given either by the Trust itself or from action taken by other regulatory organisations. As a result, organisations often failed to carry out sufficient scrutiny of information, instead treating these assurances as fulfilling their own, independent obligations.
6. This culture of assurances was operating in a structure where identifying systems and processes and meeting targets were the main measures of performance. Outcomes-based performance and risk-based, intelligence-informed regulation were still developing concepts.
7. The focus of the system resulted in a number of organisations failing to place quality of care and patients at the heart of their work. Finances and targets were often given priority without considering the impact on the quality of care. This was not helped by a general lack of effective engagement with patients and the public, and failure to place clinicians and other healthcare professionals at the heart of decision-making. Complaints were not given a high enough priority in identifying issues and learning lessons. Patients, clinicians and the public need to be at the heart of the health service and the decisions being made.

Source: *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*, HC 947, February 2013

1.20 The Department produced an initial response to the Francis Report in March 2013 which accepted, in principle or in their entirety, most of the 290 recommendations.[3] In some areas, the Department committed to taking immediate action. These include the following:

- The Department will introduce a new chief inspector of hospitals role at the Care Quality Commission. The chief inspector will assess every NHS hospital's performance, drawing on the views of commissioners, local patients and the public.
- Tough penalties will apply to hospitals that are found to be concealing the truth about their performance.
- The Department will introduce a 'failure regime' for care quality. This would mean that a hospital's board could be suspended, or the hospital shut down, if quality of care at the hospital did not meet fundamental standards.
- Starting with pilot schemes, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant, to promote frontline caring experience and values, as well as academic strength.

1.21 In its response, the Department also noted that "some recommendations are of necessity high level and will require considerable further detailed work to enable them to be implemented". As part of this detailed work, it commissioned six independent reviews:

- The Keogh Review investigated 14 hospital trusts with unexpectedly high mortality rates, to determine "whether there are any sustained failings in the quality of care and treatment being provided to patients at these trusts".[4] It found that, while all of the trusts did have pockets of excellent practice, they all needed to take urgent action to raise standards of care.
- The Cavendish Review investigated what can be done to ensure that healthcare assistants in health and social care treat patients with care and compassion.[5] It made 18 recommendations for improvement. For example, it found that there were no compulsory or consistent standards of training for healthcare assistants. In response, it recommended that Health Education England develop a new 'certificate of fundamental care', a nationally recognised caring qualification.

3 Department of Health, *Patients first and foremost*, Cm 8576, March 2013.
4 Professor Sir Bruce Keogh KBE, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, July 2013.
5 *The Cavendish Review: an Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, July 2013.

- The Berwick Review investigated how to improve patient safety in the NHS.[6] It found that in the vast majority of cases it is the systems, procedures, conditions, environment and constraints NHS staff face that lead to patient safety problems. It stated that the most important single change in the NHS in response to this report would be for it to become a system devoted to continual learning and improving patient care, and made various recommendations around this point.

- The Clwyd and Hart Review investigated ways to improve how the NHS handles complaints.[7] It made a range of recommendations for improvement. These include scrutiny of complaints by hospital boards, and hospitals offering independent investigations when serious incidents have occurred. A variety of NHS organisations have pledged to take action on the findings of this review.

- The NHS Confederation reviewed bureaucratic burden in the NHS.[8] It concluded that reducing unnecessary bureaucracy in the NHS is a task with three parts: tackling the volume of information requests made by national bodies to NHS providers; reducing the effort involved in responding to information requests; and maximising the value of collected information. It made a range of recommendations to help achieve these goals.

- The Children and Young People's Health Outcomes Forum was asked to find ways for the health system to improve the health outcomes experienced by children and young people.[9] It made a variety of recommendations for improvement, covering areas such as care integration and ensuring that all staff working with children and young people have the right skills.

1.22 In light of these reviews, in November 2013 the Department published its full response to the Francis Report.[10] The response noted a number of changes which the Department has made since the Francis Report was published. These include expert inspections of the hospitals with the highest mortality rates, and appointing chief inspectors of hospitals, adult social care, and primary care.

6 National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act*, August 2013.
7 Right Honourable Ann Clwyd MP and Professor Tricia Hart, *A Review of the NHS Hospital Complaints System: Putting Patients Back in the Picture*, October 2013.
8 NHS Confederation, *Challenging bureaucracy*, November 2013.
9 Professor Ian Lewis and Christine Lenehan, *Report of the Children and Young People's Health Outcomes Forum*, July 2012.
10 Department of Health, *Hard Truths: the journey to putting patients first*, Cm 8777, November 2013.

1.23 The response also explained further changes the Department plans to make. These include, for example:

- a new care certificate aimed at ensuring that healthcare assistants and social care support workers have the right fundamental training and skills in order to give personal care to patients and service users;
- transparent monthly reporting of ward-by-ward staffing levels and other safety measures; and
- a statutory duty of candour on providers and a professional duty of candour on individuals through changes to professional guidance and codes.

Staff attitudes

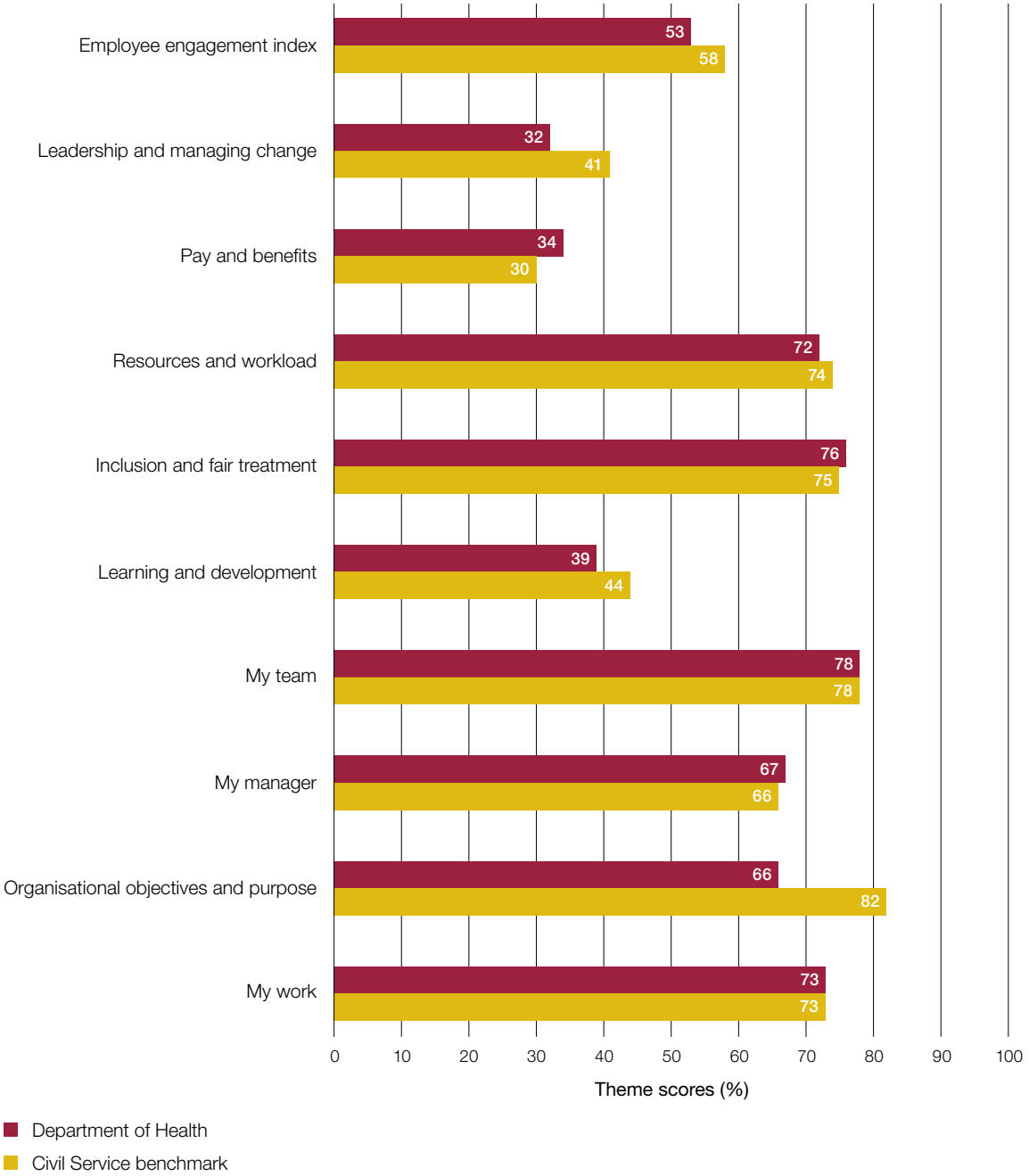
1.24 The government has conducted its Civil Service People Survey annually for the past five years. We have looked at the results from the October 2012 survey for comment in this report. **Figure 4** shows that for 2012, the Department matched or exceeded the civil service benchmark for five out of ten measures.[11]

1.25 The overarching measure from the survey is the 'employee engagement index'. This measures an employee's emotional response to working for their organisation. Employee engagement is shaped by staff experiences at work, which are measured by the nine themes of the survey. On the employee engagement index, the Department scored lower than the civil service benchmark, with 53 per cent of employees responding positively compared with 58 per cent across government as a whole. The Department's result on this measure was unchanged from 2011.

11 Cabinet Office, *Civil Service People Survey 2012*, February 2013.

Figure 4

Department of Health Civil Service People Survey results



Source: Civil Service People Survey 2012

Part Two

Recent NAO work on the Department

Our audit of the Department's accounts

2.1 The Comptroller and Auditor General (C&AG) certified the Department of Health's (the Department's) 2012-13 resource accounts on 12 July 2013. In his opinion, the accounts gave a true and fair view of the Department's financial affairs. The Department has recently invested significant effort in improving its accounts production process. This year it published its accounts several months earlier than in previous years. This is a significant achievement, and enabled the Department to lay its accounts before Parliament before the summer recess for the first time in three years.

2.2 In his report on the accounts, the C&AG drew attention to the level of uncertainty about the Clinical Negligence Scheme for trusts. The Scheme pays compensation for NHS clinical negligence which has happened since April 1995.[12] The Department estimates that it will have to make future payments of £20.4 billion in compensation for clinical negligence that happened before April 2013. This includes £7.7 billion for cases where a claim has been made but not yet settled. The remainder, £12.7 billion, is an estimate of the cost of negligence where no claim has yet been made. The C&AG reported in respect of the £12.7 billion that "given the long-term nature of the liabilities and the number and nature of the assumptions on which the estimate ... is based, a considerable degree of uncertainty remains over the value of the liability ... significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted".

Our audits of the Department's effectiveness and value for money

2.3 In the past year, our work on effectiveness and value for money has investigated financial sustainability and service delivery in the NHS, responded to a number of requests by Parliament, and also looked at the Department's reform of the health system. The conclusions of our reports are summarised below.

2.4 Most of our reports support a hearing of the House of Commons Committee of Public Accounts. In those cases, the Committee takes evidence from the senior accountable officials and publishes its own report. The government has to respond formally to the Committee's recommendations. These responses are known as Treasury Minutes, and are available on the government website.[13]

12 There is a separate scheme for clinical negligence which occurred before April 1995.
13 Available at: www.gov.uk/government/collections/treasury-minutes

Reports on financial sustainability

The franchising of Hinchingbrooke Healthcare NHS Trust (November 2012)

2.5 In February 2012, a private sector company, Circle, took control of Hinchingbrooke Healthcare NHS Trust under a franchise agreement. It was the first agreement of its kind in the NHS. Our report highlighted early lessons that can be learned from the procurement process and creating the franchise agreement with Circle.[14]

2.6 We concluded that, in considering value for money, we had to bear in mind that the Trust had been in financial difficulty for some time, and it was therefore reasonable to look to more radical options to turn things round. The North East of England Strategic Health Authority carried out a strategic evaluation of these options before opting for an operating franchise.

2.7 However, we had concerns about the winning bid for the franchise because most of the projected savings occur in the later years of the contract, and about how the risks associated with this were taken into account in the contract award decision.

2.8 If the contract goes well, it can deliver value for money, but it would need alert management by the Authority and the Trust board to monitor performance and intervene as necessary.

Progress in making NHS efficiency savings (December 2012)

2.9 In this report we examined progress in making NHS efficiency savings in 2011-12, and whether the NHS was well placed to make further savings.[15]

2.10 We concluded that the NHS has made a good start and clearly delivered substantial efficiency savings in 2011-12. These savings will need to be maintained and built on if up to £20 billion is to be generated by 2014-15. For the NHS to be financially sustainable and achieve value for money in the future, it will need to quicken the pace of service transformation and make significant changes to the way health services are provided.

2.11 Our overall positive comments reflected the fact that this report covered the early stages of the drive to secure efficiency savings and the Department was still developing its approach. We highlighted a variety of shortcomings in areas such as whether demand management is having positive or negative effects on access to healthcare; how service transformation can best be achieved; and the reliability of the reported savings data. Unless the Department takes action in these areas quickly, there is a risk that confidence will be undermined and the likelihood of success reduced.

14 Comptroller and Auditor General, *The franchising of Hinchingbrooke Healthcare NHS Trust*, Session 2012-13, HC 628, National Audit Office, November 2012.

15 Comptroller and Auditor General, *Progress in making NHS efficiency savings*, Session 2012-13, HC 686, National Audit Office, December 2012.

Update on indicators of financial sustainability in the NHS (July 2013)

2.12 In July 2012, we published our report *Securing the future financial sustainability of the NHS*.[16] That report found that the NHS as a whole delivered a surplus of £2.1 billion in 2011-12, but that within that total there was significant variation in financial performance, and some organisations had been given additional financial support. Our report in July 2013 updated that earlier work by looking at the financial sustainability of the NHS at the end of 2012-13.[17]

2.13 We found that strategic health authorities, primary care trusts, NHS trusts and foundation trusts had a combined surplus of £2.1 billion in 2012-13. In total, therefore, there was sufficient money in the health service to make ends meet. As in 2011-12, however, there was a substantial gap between the trusts with the largest surpluses and those with the largest deficits. There was a similar variation between local health economies. We found that some regions were in overall surplus, while others were not. The differences were most marked in London, where primary care trust clusters in parts of west London had some of the largest surpluses, whereas outer north-east London had one of the largest deficits.

2.14 As in 2011-12, trusts in difficulty had once again relied on cash support from the Department or non-recurrent local revenue support from strategic health authorities and primary care trusts. We concluded in *Securing the future financial sustainability of the NHS* that it was hard to see that this approach would be a sustainable way of reconciling growing demand with the scale of efficiency gains required within the NHS, and that, without major change affecting some providers, the financial pressure on them would only get more severe.[18] This conclusion remains.

Reports on providing health services

Managing NHS hospital consultants (February 2013)

2.15 In 2003 the Department of Health introduced a new contract for NHS hospital consultants. In our report we looked at: how far the expected benefits of the contract have been realised; whether consultants are managed effectively and consistently across NHS trusts; and how far recommendations from a 2007 Committee of Public Accounts report, designed to improve the management of consultants, had been implemented.[19]

2.16 We concluded that NHS consultants play a key role in treating patients. Under the 2003 consultant contract, the NHS increased consultants' pay, investing up front for future benefits it hoped to achieve. We found that most of the expected benefits of the contract have been either fully or partly realised, which has improved the value for money of consultants to the NHS.

16 Comptroller and Auditor General, *Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012.
17 Comptroller and Auditor General, *2012-13 update on indicators of financial sustainability in the NHS*, Session 2013-14, HC 590, National Audit Office, July 2013.
18 See footnote 16.
19 Comptroller and Auditor General, *Managing NHS hospital consultants*, Session 2012-13, HC 885, National Audit Office, February 2013.

2.17 Despite some good practice, it is reasonable to expect that more progress would have been made in improving trusts' management of consultants and realising the full benefits of the contract. We could not, therefore, conclude that value for money has been fully achieved. There were still, for example, a number of trusts who had not fully implemented key elements of the contract and good practice management. Less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans or achieving objectives from appraisals. Trusts reported that 19 per cent of consultants have not had an appraisal in the last 12 months. In addition, most trusts continue to use locally agreed rates of pay well above defined contractual rates to secure extra work from consultants.

Emergency admissions to hospital: managing the demand (October 2013)

2.18 The number of emergency admissions to hospitals – admissions that are not planned and happen at short notice because of perceived clinical need – continues to rise, at a time when NHS budgets are under significant pressure. In 2012-13, there were 5.3 million emergency admissions to hospitals, representing around 67 per cent of hospital bed days in England, and costing approximately £12.5 billion.

2.19 We concluded that over the last 15 years the management of emergency admissions has become more efficient.[20] Waiting times in accident and emergency departments and lengths of stay in hospital have reduced, and outcomes for patients admitted to hospital have improved. However, at the heart of managing emergency admissions is the effective management of patient flow through the system. There were large variations in performance at every stage of the patient pathway, some of which were avoidable, suggesting scope for improved outcomes.

2.20 Many admissions are avoidable and many patients stay in hospital longer than is necessary. This places additional financial pressure on the NHS as the costs of hospitalisation are high. Improving the flow of patients will be critical to the NHS's ability to cope with future winter pressures on urgent and emergency care services. This will require both short-term interventions to manage the winter pressures over the next few years and long-term interventions to create a more accessible and integrated urgent and emergency care system. Until these systemic issues are addressed, value for money in managing emergency admissions will not be achieved.

20 Comptroller and Auditor General, *Emergency admissions to hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013.

Maternity services in England (November 2013)

2.21 Having a baby is the most common reason for admission to hospital in England. In 2012, there were 694,241 live births. Maternity is a unique area of the NHS as the services support predominantly healthy people through a natural, but very important, life event that does not always require doctor-led intervention.

2.22 We concluded that, for most women, NHS maternity services provide good outcomes and positive experiences.[21] Since 2007 there have been improvements in maternity care, with more midwifery-led units, greater consultant presence, and progress against the government's commitment to increase midwife numbers.

2.23 However, the Department's implementation of maternity services has not matched its ambition: the objectives of its maternity strategy are expressed in broad terms which leaves them open to interpretation and makes performance difficult to measure.[22] The Department has not monitored progress against the strategy and has limited assurance about value for money. When we investigated outcomes across the NHS, we found significant and unexplained local variation in performance against indicators of quality and safety, cost, and efficiency. Together these factors show there is substantial scope for improvement and, on this basis, we concluded that the Department has not achieved value for money for its spending on maternity services.

NHS waiting times for elective care in England (January 2014)

2.24 NHS patients have the right to receive elective pre-planned consultant-led care within 18 weeks of being referred for treatment (usually by their GP), unless they choose to wait longer or it is clinically appropriate to do so. In 2012-13, there were 19.1 million referrals to hospitals in England, with hospital-related costs we estimate at around £16 billion.

2.25 The current 18-week standards came into effect in 2008, and strengthening them over the last two years, has given NHS trusts a clear focus. The number of patients being referred to trusts continues to increase at a time when the NHS is under financial pressure and needs to make efficiency savings of up to £20 billion by March 2015. The challenge of sustaining the 18-week standards is increasing, and with it the importance of having reliable performance information and spreading good practice.

2.26 However, we found significant errors and inconsistencies in the way our sample of trusts assess waiting time.[23] We are not suggesting that the number of patients treated within 18 weeks has not increased, but the information recorded by trusts is not as reliable as it should be, and masks a great deal of variability in actual waiting times. This fails patients, GPs and other healthcare professionals, and hinders the identification and management of poor performance. The solution is not costly new processes, but making existing processes work properly and maintaining effective scrutiny of them.

21 Comptroller and Auditor General, *Maternity services in England*, Session 2013-14, HC 794, National Audit Office, November 2013.
22 Department of Health, *Maternity Matters: Choice, access and continuity of care in a safe service*, April 2007.
23 Comptroller and Auditor General, *NHS waiting times for elective care in England*, HC 964, National Audit Office, January 2014.

2.27 Some of the challenges facing trusts when managing waiting lists are the perennial systemic issues of balancing financial and clinical capacity with the demand for services. But there are areas of practical day-to-day management, such as the way financial incentives are applied and the routes by which patients are referred for treatment, where common administrative processes are approached very differently. They cannot all be equally effective, and opportunities to improve services and save money are being missed.

2.28 We concluded that value for money is being undermined by the problems with the completeness, consistency and accuracy of patient waiting time data; and by differences in the way that patient referrals to hospitals are managed.

Reports responding to MPs' concerns

Peterborough and Stamford Hospitals NHS Foundation Trust (November 2012)

2.29 In 2011-12, Peterborough and Stamford Hospitals NHS Foundation Trust had a deficit of £45.8 million, 22 per cent of its turnover. It featured as a case study in our 2012 report, *Securing the future financial sustainability of the NHS*.[24] Following this, the Committee of Public Accounts asked us to look further at the circumstances underlying the Trust's serious financial difficulties.

2.30 We concluded that the Trust board developed, and enthusiastically supported, an unrealistic business case for the new hospital that incorporated overly optimistic financial projections.[25] The Trust lacked the capacity and capability to deliver the financial performance improvements and cost control required to maintain financial sustainability. It therefore failed in its responsibility to secure value for money from its use of resources, even though the new hospital was delivered to time and budget.

2.31 In addition, the regulatory structure and approval processes put in place to evaluate major capital projects and regulate their implementation did not work as intended and did not ensure affordability. We reported that the Trust board's failure to respond fully to Monitor's early concerns about the affordability of the scheme was not addressed by the Department, and the Trust's deteriorating financial position was not responded to in a timely way by Monitor.

24 Comptroller and Auditor General, *Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012.

25 Comptroller and Auditor General, *Peterborough and Stamford Hospitals NHS Foundation Trust*, Session 2012-13, HC 658, National Audit Office, November 2012.

Memorandum on the provision of the out-of-hours GP service in Cornwall (March 2013)

2.32 During 2012, whistleblowers raised a number of concerns about the out-of-hours GP services in Cornwall provided by Serco, which were widely reported in the media. The Chair of the Committee of Public Accounts asked us to look into what had happened.[26]

2.33 The first concern was that Serco had been unable to fill shifts with appropriately qualified staff, with the result that the out-of-hours service was unsafe. We found that a clinical review of the out-of-hours service commissioned by the Primary Care Trust in June 2012 found no evidence that the service was, or had been, systematically clinically unsafe. During 2012, however, Serco regularly had insufficient staff to fill all clinical shifts. It also frequently redeployed some GPs, taking them out of the cars available for home visits and using them to cover clinic shifts instead.

2.34 The second concern was that Serco staff were altering performance data, with the result that the performance of the out-of-hours service reported to the Primary Care Trust was overstated. We found that a forensic audit by a specialist Serco team, covering data between January and June 2012, found that two members of Serco's staff made 252 unauthorised changes to performance data (0.2 per cent of all interactions) during the six-month period which were inappropriate or where there was no evidence to justify the change. The changes affected 20 of the 152 separate performance measures reported to the Primary Care Trust for those six months. The changes altered reported, not actual, performance.

2.35 The third concern was that protection for whistleblowers was insufficient, with the result that staff were reluctant to raise concerns. Whistleblowers played a significant role in bringing to the attention of the Primary Care Trust and the media concerns about Serco's provision of the out-of-hours service in Cornwall that had not been identified by routine management controls or by the Primary Care Trust itself. Serco had an established whistleblowing policy in place, but evidence suggests that whistleblowers were still fearful of raising concerns. This is an issue that is not confined to the out-of-hours service in Cornwall. The government has previously recognised that, although whistleblowers are legally protected, practice on the ground in the NHS has not always been effective.

26 Comptroller and Auditor General, *Memorandum on the provision of the out-of-hours GP service in Cornwall*, Session 2012-13, HC 1016, National Audit Office, March 2013.

Access to clinical trial information and the stockpiling of Tamiflu (May 2013)

2.36 We received correspondence from several MPs raising questions about access to all clinical trials information for UK regulators when licensing and appraising new medicines, and the decision to stockpile Tamiflu, an antiviral medicine used to manage pandemic influenza. A key concern was that, without full clinical trial information, public money could be spent on ineffective medicines.

2.37 We concluded that regulators are confident that they are provided with all required and requested information from manufacturers when licensing new medicines, insofar as it is possible to know.[27] We noted that the United States' regulator requests more information and may spend more time on performing its own analysis. National Institute for Health and Care Excellence's (NICE's) legal position is not as strong as that of regulators, as they have no automatic access rights to manufacturer information submitted to either the European Medicines Agency (EMA) or Medicines and Healthcare Products Regulatory Agency (MHRA). This means that they have to request data from the manufacturer which has already been provided as part of licensing.

2.38 Regulators' assessments of Tamiflu for the treatment of influenza have broadly agreed on its ability to reduce the duration of symptoms and to assist in preventing influenza illness. They, and other reviewers, have been generally reluctant to accept that clinical evidence is strong enough to support claims for avoidance of serious illness and death due to complications of influenza. Coming to a conclusion on the efficacy of treatment is, however, complicated by the fact that different reviewers may apply different criteria when evaluating evidence.

2.39 Stockpiling of antiviral medicines in anticipation of an influenza pandemic is in line with WHO guidance and is likely to be justified even with more cautious assessments of their efficacy. The Department's business case indicated that a stockpile providing 50 per cent population coverage would not provide significant additional benefits to a stockpile providing 25 per cent coverage, but this was based on the optimistic assumption that it would be possible to prioritise the use of the smaller stockpile on those most at risk. In reality this might not be possible. As the nature of a future pandemic virus is unknown, it is not possible to determine the ideal level of population coverage within the 25 to 50 per cent range but all stockpiles in this range are cost-effective. The Department also factored in the desire to maintain public confidence in the pandemic response by being able to make antivirals available to all those who might become ill in a pandemic and that the stockpile comprised both Tamiflu as the primary antiviral and Relenza as the contingency.

27 Comptroller and Auditor General, *Access to clinical trial information and the stockpiling of Tamiflu*, Session 2013-14, HC 125, National Audit Office, May 2013.

Review of the final benefits statement for programmes previously managed under the National Programme for IT in the NHS (June 2013)

2.40 Launched in 2002, the National Programme for IT in the NHS was designed to reform the way that the NHS in England uses information. In July 2012, the Department gave the Committee of Public Accounts a draft statement covering the costs and benefits to the end of March 2013 and also including forecasts to the end-of-life of its systems. The Committee asked us to review the benefits statement prior to its publication.[28]

2.41 We found that at March 2011 and March 2012, total costs were significantly greater than total benefits. The Department forecasts that benefits will slightly exceed costs over the whole life of the systems. There is, however, very considerable uncertainty around whether the forecast benefits will be realised, not least because the end-of-life dates for the various systems extend many years into the future, to 2024 in the case of the North, Midlands and East Programme for IT.

2.42 Overall, we found that the Department took a structured, logical approach to measuring and reporting costs and benefits. The cost figures are relatively certain in that around three-quarters of the total had been incurred by March 2012. In contrast, measuring the benefits of the programmes was not straightforward, as the benefits go beyond simple cost savings into wider benefits that are more difficult to identify, quantify and value.

Reports on implementing the NHS reforms

Managing the transition to the reformed health system (July 2013)

2.43 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. Most of the changes came into effect on 1 April 2013. This report examined how the Department and the NHS implemented the transition from the existing to the reformed health system.[29]

2.44 We concluded that 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.

28 National Audit Office, *Review of the final benefits statements for programmes previously managed under the National Programme for IT in the NHS*, June 2013.

29 Comptroller and Auditor General, *Managing the transition to the reformed health system*, Session 2013-14, HC 537, National Audit Office, July 2013.

2.45 Some parts of the system were less ready than others, and at the time of writing much remained to be done to complete the transition. Each individual organisation needed to reach a stable footing, and ensure in particular that they were 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.

Monitor: Regulating NHS foundation trusts (February 2014)

2.46 Monitor is responsible for assessing NHS trusts for foundation trust status, and ensuring that foundation trusts are well led in terms of their quality and finances. Under the recent NHS reforms, it also took on a new role as sector regulator of health services.

2.47 We concluded that Monitor has achieved value for money in regulating NHS foundation trusts.[30] Its processes for assessing and monitoring trusts are robust, its judgements have mostly been sound, and it has refined its approach in the light of experience. The balance of evidence suggests that Monitor has generally been effective in helping trusts in difficulty to improve. Its impact is particularly clear where the issues arise from weaknesses in trusts' internal management.

2.48 Monitor recognises that it needs to adapt how it regulates to address underlying weaknesses in local health economies that increase the risk of financial or clinical failure in individual trusts. It has started to take a more holistic and proactive approach in a number of cases. It will need to continue to develop its approach and work closely with other agencies within the NHS, as well as the Department, if it is to continue to be an effective regulator and provide value for money.

30 Comptroller and Auditor General, *Monitor: Regulating NHS foundation trusts*, Session 2013-14, HC 1071, National Audit Office, February 2014.

Part Three

Allocating funding between clinical commissioning groups

3.1 The single largest element of the Department of Health's (the Department's) budget in 2013-14, 57 per cent (£63.4 billion), was distributed by NHS England to the 211 clinical commissioning groups for them to commission healthcare for the people living in their area.[31] The way funding is divided between these groups is important because it affects the services available in different areas and potentially impacts on the financial sustainability of commissioners and providers. The way funding is allocated has recently undergone significant change.

3.2 This part focuses on NHS England's funding of clinical commissioning groups and explains the changes that are happening. It covers:

- how NHS England allocated funding to clinical commissioning groups for 2013-14;
- how NHS England plans to allocate funds to clinical commissioning groups from 2014-15 onwards; and
- previous NAO work on the challenges of funding local health bodies.

How NHS England allocated funding to clinical commissioning groups for 2013-14

3.3 In our report on *Managing the transition to the reformed health system*, we looked at how funds were allocated to clinical commissioning groups.[32] Funding for commissioning healthcare was previously allocated to primary care trusts by the Department using a funding formula. As clinical commissioning groups would have different responsibilities and geographical boundaries from primary care trusts, the Department asked the independent Advisory Committee on Resource Allocation to propose a new formula.[33] The Department wanted the funding for clinical commissioning groups to reflect local need better than had been the case for primary care trusts.

31 NHS England allocated a further £1.3 billion to clinical commissioning groups for their own running costs.
32 See footnote 29.
33 The Advisory Committee on Resource Allocation is an independent expert body which makes recommendations to the Secretary of State for Health about how to distribute funding.

3.4 NHS England is now responsible for deciding how to allocate funds to clinical commissioning groups. In December 2012, it decided not to rely on the revised formula proposed by the Advisory Committee. NHS England considered that the proposed formula, used in isolation, risked increasing health inequalities because it would lead to more money going to areas with better health outcomes. There was insufficient time to resolve these concerns in time for 2013-14 allocations to be made. Instead, funding for clinical commissioning groups in 2013-14 was based on the amount that the Department and NHS England estimated that primary care trusts had spent in 2012-13 on the services the new groups would be responsible for, increased by a flat rate of 2.3 per cent. This means that the allocation of funding to clinical commissioning groups was strongly influenced by the way funding had previously been distributed between primary care trusts, which is shown in Appendix Five.

3.5 Primary care trusts faced a number of challenges in providing the spending data which underpinned the estimated figures for 2012-13 spending. For example, primary care trusts were asked to divide some categories of spending at GP practice level, but in many cases the required data did not exist and the trusts had to make assumptions. NHS England and the Department recognise that this will have affected the accuracy of the data and therefore how far the 2013-14 budget allocations for clinical commissioning groups reflect previous spending patterns.

How NHS England plans to allocate funding to clinical commissioning groups for 2014-15 onwards

3.6 During 2013, NHS England conducted a fundamental review of its allocations policy, including the funding formula for clinical commissioning groups.[34] This included:

- a detailed review of the Advisory Committee's proposed new formula;
- investigating whether the objectives of the formula require amendment, and if so how this can be achieved in an evidence-based way;
- a review of options for reflecting unmet or inappropriately met need in the formula;
- considering evidence about the additional costs of providing services in sparsely populated areas; and
- developing an evidence base for how quickly new growth in clinical commissioning group funding can be effectively used, and how much investment needs to be protected to support stability of existing services.

34 NHS England, *Fundamental Review of Allocations Policy – Annex D: Terms of Reference*, August 2013.

3.7 In December 2013, NHS England announced a new funding formula, informed by the findings of the review. The new formula is intended to reflect population changes more accurately, and also includes a specific measure for deprivation. Allocations to clinical commissioning groups will move towards the amount calculated by this formula over several years.

Previous NAO work on the challenges of funding local health bodies

3.8 In 2011, we published our report *Formula funding of local public services*, which covered the funding formula used at that time to apportion funds between primary care trusts.[35] We found that the funding objectives were transparent and clearly linked to the structure of the funding model. However, we identified several challenges associated with the formula, which we consider are still relevant. These include:

- The Department's approach to estimating need was contestable. Few indicators directly measure local needs. The Department therefore relied on proxy indicators of need, such as age or deprivation, based on their association with variations in past expenditure. This approach assumes that past expenditure is an appropriate basis for understanding underlying need, and has been criticised by academics and stakeholders. This is because expenditure on healthcare in an area can vary for reasons other than need, such as the efficiency of local hospitals and how well informed people are about local health services.

- As with any mathematical formula, the effectiveness of the funding formula depended on data quality. However, 10 per cent of the indicators used to calculate the formula were ten or more years old. Additionally, there was conflicting evidence about the size of local populations. The two main sources for population data are Office for National Statistics population projections and lists of patients registered with GPs; these can differ from each other by up to 25 per cent. Population data are central to the formula and therefore critical to its accuracy and responsiveness.

- The Department did not use objective analysis to judge the degree of financial stability required by individual trusts. The Department did not necessarily give primary care trusts the funding calculated using the formula because if it did, their budgets would vary more greatly from year to year, making it more difficult for them to plan financially and provide stable services. To avoid this, the Department set 'pace of change' criteria, which specified the minimum and maximum percentage by which any trust's funding can change from year to year. However, judgements about the levels of funding required to achieve stability were not based on an objective analysis of the changes in income that different primary care trusts could tolerate – for example, based on their different cost structures and financial positions.

35 Comptroller and Auditor General, *Formula funding of local public services*, Session 2010–2012, HC 1090, National Audit Office, July 2011.

Appendix One

The Department's sponsored bodies at 1 April 2013

Non-ministerial department

Food Standards Agency

Executive agencies

Medicines and Healthcare Products Regulatory Agency

Public Health England

Executive non-departmental public bodies

Care Quality Commission

Human Fertilisation and Embryology Authority

Human Tissue Authority

Monitor

National Institute for Health and Care Excellence

NHS England

Health and Social Care Information Centre

Advisory non-departmental public bodies

Advisory Committee on Clinical Excellence Awards

Administration of Radioactive Substances Advisory Committee

British Pharmacopoeia Commission

Commission on Human Medicines

Committee on Mutagenicity of Chemicals in Food, Consumer Products and the Environment

Independent Reconfiguration Panel

Review Body on Doctors' and Dentists' Remuneration

NHS Pay Review Body

Other

Health Research Authority

NHS Trust Development Authority

NHS Blood and Transplant

NHS Litigation Authority

NHS Business Services Authority

Health Education England

Appendix Two

Results of the Civil Service People Survey 2012

Question scores (% strongly agree or agree)	Civil service overall	Department for Business, Innovation & Skills (excluding agencies)
Leadership and managing change		
I feel that the Department as a whole is managed well	**43**	39
Senior civil servants in the Department are sufficiently visible	**48**	51
I believe the actions of senior civil servants are consistent with the Department's values	**42**	40
I believe that the departmental board has a clear vision for the future of the Department	**40**	41
Overall, I have confidence in the decisions made by the Department's senior civil servants	**39**	37
I feel that change is managed well in the Department	**29**	26
When changes are made in the Department they are usually for the better	**25**	19
The Department keeps me informed about matters that affect me	**56**	59
I have the opportunity to contribute my views before decisions are made that affect me	**36**	31
I think it is safe to challenge the way things are done in the Department	**40**	37
Organisational objectives and purpose		
I have a clear understanding of the Department's purpose	**84**	81
I have a clear understanding of the Department's objectives	**79**	74
I understand how my work contributes to the Department's objectives	**82**	79

Note

1 The score for a question is the percentage of respondents who strongly agree or agree to that question.

Source: Civil Service People Survey 2012, available at: www.civilservice.gov.uk/about/improving/employee-engagement-in-the-civil-service/people-survey-2012, accessed 28 August 2013

Cabinet Office (excluding agencies)	Department for Communities and Local Government (excluding agencies)	Department for Culture, Media & Sport (excluding agencies)	Ministry of Defence (excluding agencies)	Department for Education	Department of Energy & Climate Change	Department for Environment, Food & Rural Affairs (excluding agencies)	Foreign & Commonwealth Office (excluding agencies)	Department of Health (excluding agencies)	HM Revenue & Customs (excluding agencies)	HM Treasury	Home Office (excluding agencies)	Department for International Development	Ministry of Justice (excluding agencies)	Department for Transport (excluding agencies)	Department for Work & Pensions (excluding agencies)
38	31	23	19	39	39	29	56	31	21	62	39	63	48	43	29
47	45	37	26	46	64	42	59	47	33	71	48	71	56	59	30
40	33	23	24	39	47	34	55	39	27	59	40	62	47	47	29
29	31	29	22	31	27	22	54	24	24	47	28	64	37	35	30
40	30	18	16	35	42	29	50	33	19	57	35	58	43	39	23
28	22	19	11	27	27	19	42	18	17	49	23	44	34	27	24
22	14	12	9	17	25	14	36	14	14	35	18	32	29	19	20
57	54	56	41	55	67	56	62	49	40	72	60	69	61	63	46
34	32	32	20	37	39	31	42	30	20	48	33	50	37	35	23
41	29	32	30	36	43	37	45	31	29	54	38	44	41	43	33
73	67	64	80	83	87	74	83	68	75	86	84	94	79	80	79
63	63	62	72	77	84	70	80	62	72	80	80	92	73	74	77
73	72	70	76	80	86	75	84	69	75	82	81	91	77	79	78

Appendix Three

Publications by the NAO on the Department since April 2012

Publication date	Report title	HC number	Parliamentary session
26 February 2014	Monitor: Regulating NHS foundation trusts	HC 1071	2013-14
23 January 2014	NHS waiting times for elective care in England	HC 964	2013-14
8 November 2013	Maternity services in England	HC 794	2013-14
31 October 2013	Emergency admissions to hospital: managing the demand	HC 739	2013-14
18 July 2013	2012-13 update on indicators of financial sustainability in the NHS	HC 590	2013-14
10 July 2013	Managing the transition to the reformed health system	HC 537	2013-14
6 June 2013	Memorandum for the Committee of Public Accounts: Review of the final benefits statement for programmes previously managed under the National Programme for IT in the NHS	www.nao.org.uk/report/review-of-the-final-benefits-statement-for-programmes-previously-managed-under-the-national-programme-for-it-in-the-nhs/	
21 May 2013	Access to clinical trial information and the stockpiling of Tamiflu	HC 125	2013-14
7 March 2013	Memorandum on the provision of the out-of-hours GP service in Cornwall	HC 1016	2012-13
6 February 2013	Managing NHS hospital consultants	HC 885	2012-13

Publication date	Report title	HC number	Parliamentary session
13 December 2012	Progress in making NHS efficiency savings	HC 686	2012-13
29 November 2012	Peterborough and Stamford Hospitals NHS Foundation Trust	HC 658	2012-13
8 November 2012	The franchising of Hinchingbrooke Health Care NHS Trust	HC 628	2012-13
19 July 2012	Memorandum: An update on the government's approach to tackling obesity	www.nao.org.uk/wp-content/uploads/2012/07/tackling_obesity_update.pdf	
17 July 2012	Memorandum: Progress in implementing the 2010 Adult Autism Strategy	www.nao.org.uk/wp-content/uploads/2012/07/adult_autism_strategy_progress.pdf	
5 July 2012	Securing the future financial sustainability of the NHS	HC 191	2012-13
29 June 2012	Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland	HC 192	2012-13
22 May 2012	The management of adult diabetes services in the NHS	HC 21	2012-13

Appendix Four

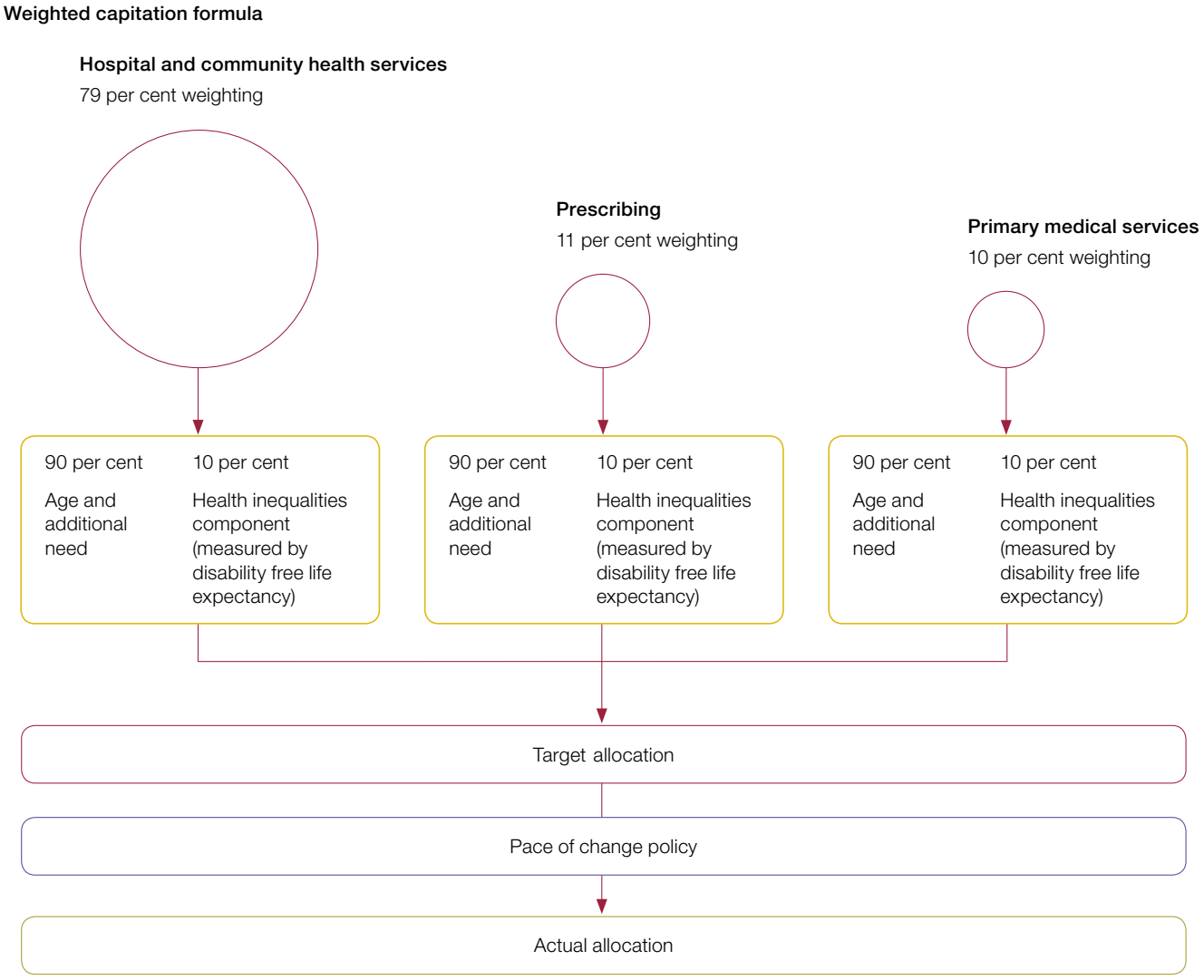
Cross-government reports of relevance to the Department

Publication date	Report title	HC number	Parliamentary Session
13 June 2013	Financial management in government	HC 131	2013-14
31 January 2013	Early action: landscape review	HC 683	2012-13

Appendix Five

The primary care trust funding formula

Figure 5
The structure of the primary care trust allocations model



Note
1 The weightings applied are for 2011-12 allocations.

Source: National Audit Office

Where to find out more

The National Audit Office website is
www.nao.org.uk

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