HOUSE OF LORDS

Library Note

Health and Social Care Act 2012: Performance and Sustainability of the NHS

On 8 September 2016, the House of Lords will debate the motion "that this House takes note of the impact of the Health and Social Care Act 2012 on the current performance of the National Health Service and its future sustainability".

The Health and Social Care Act 2012 received royal assent on 27 March 2012, with many of its provisions coming into force on 1 April 2013. It introduced significant structural changes to the NHS, including the establishment of clinical commissioning groups, replacing the previous primary care trusts.

Since the passage of the Act, the NHS has continued to see increasing demand in a challenging economic environment. NHS Improvement—a body established on 1 April 2016 by bringing together existing organisations including Monitor and the NHS Trust Development Authority—has stated that:

> Sustained operational and financial challenges continued to affect adversely the performance of the NHS provider sector in 2015/16. Providers faced record high demand and increased cost pressures. Throughout the year, providers worked hard to improve services for patients, reduce costs and maximise resources. Despite these efforts, the sector as a whole continued to underperform against a number of national healthcare standards, and the year-end deficit was almost three times larger than position reported in 2014/15.

On 16 December 2015, the Government established the Sustainability and Transformation Fund (STF), providing £1.8 billion to "help challenged hospitals to achieve financial balance while focusing on changing the way they provide high quality care for patients".

This House of Lords Library briefing provides a short overview of the changes introduced by the Health and Social Care Act 2012, presents a selection of figures on the NHS's performance in a range of clinical areas, and concludes with recent developments on the subject of the NHS's financial sustainability (including the STF). In presenting the statistics, the Library makes no judgement as to the relationship between these statistics and the changes introduced by the Health and Social Care Act 2012.

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1. Introduction

The Health and Social Care Act 2012 introduced significant structural changes to the NHS in England, primarily through the creation of clinical commissioning groups (CCGs), health and wellbeing boards and NHS England. It also made changes to several existing regulatory bodies. The Coalition Government argued that "modernisation" was necessary in the light of three main challenges:

- Rising demand and treatment costs.
- A "need for improvement" in health outcomes, with the Coalition Government citing cancer survival rates as one example.
- The "state of public finances".[1]

This Library briefing provides an overview of the Health and Social Care Act 2012 and the changes that it introduced to the NHS in England. It then sets out a range of statistics measuring the NHS's performance and provides further information about the NHS's sustainability. In presenting the statistics, the Library makes no judgement as to the relationship between these statistics and the changes introduced by the Health and Social Care Act 2012.

Further information about the NHS's sustainability can be found in the House of Lords Library briefing, *Sustainability of the National Health Service as a Public Service Free at the Point of Need* (6 July 2015).

2. Health and Social Care Act 2012: A Summary

This section of the briefing provides an overview of some of the major changes to the structure and responsibilities of the NHS in England made by the Act.

The House of Commons Library has produced a briefing entitled *The Structure of the NHS in England* (10 March 2016), which provides extensive information on the structure of the NHS in England following the passage of the Health and Social Care Act 2012.

2.1 Organisational Changes

In a factsheet published shortly after the Health and Social Care Act 2012 received royal assent, the Coalition Government stated that the Act "puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health".[2] It added that "the reforms are intended to improve quality and efficiency by reforming the organisations that commission, regulate and support health and care services".[3]

Since the Health and Social Care Act 2012 came into force, the commissioning of NHS healthcare in England is now primarily organised through NHS England and regional CCGs. As noted in a recent briefing by the House of Commons Library, the Act gave:

> […] General Practitioners and other health professionals responsibility for commissioning the majority of health services, created an independent NHS

[1] Department of Health, *The Health and Social Care Act 2012*, 30 April 2012.
[2] ibid.
[3] Department of Health, *Overview of Health and Care Structures—The Health and Social Care Act 2012*, 30 April 2012.

> Commissioning Board (now known as NHS England), and gave local authorities responsibilities for public health and for coordinating local NHS services, social care and health improvement.[4]

Much of the statutory responsibility for these extended commissioning powers lies with CCGs.[5] There are currently over 200 CCGs in England. Among their responsibilities is the commissioning of services, which include:

- Urgent and emergency care (such as Accident and Emergency).
- Elective hospital care (including outpatient services).
- Community health services (such as health visiting and mental health services).[6]

CCGs were introduced on 1 April 2013, and replaced primary care trusts.[7] Responsibility for overseeing CCGs lies with NHS England. The relationship between these organisations can be described as follows:

> NHS England is […] the body responsible for ensuring that there is an effective and comprehensive system of CCGs. NHS England also provides national leadership on commissioning and allocates funding. It has a duty to publish commissioning guidance, to which CCGs must have regard, and will use the Commissioning Outcomes Framework to assess the performance of CCGs. CCGs are ultimately accountable to NHS England for their performance and under the Health and Social Care Act 2012, NHS England has powers to direct a CCG to discharge its functions in a particular way (but only when satisfied that a CCG has failed to discharge any of its functions).[8]

NHS England also has responsibility for commissioning primary care services (including GP services), and "provides national leadership for improving outcomes and driving up the quality of care".[9] The body is intended to be independent of the Government, and is tasked with delivering the mandate set by the Department of Health.

A number of regulatory bodies operate within the structure of the health service in England, providing regulation and support to the NHS in pursuit of its mandate. The Health and Social Care Act 2012 altered the areas over which some of these bodies were responsible. These include:

Care Quality Commission (CQC)

The CQC is the independent regulator for quality in health and social care in England and inspects and rates core health care services.[10] The CQC was established under the Health and Social Care Act 2008. The Health and Social Care Act 2012 established Healthwatch England as a statutory committee within the CQC.[11] Healthwatch England is the "national consumer champion" in health and care. It has "significant statutory powers to ensure the voice of the

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[4] House of Commons Library, *Structure of the NHS in England*, 10 March 2016.
[5] ibid, pp 7–8.
[6] The specific functions, duties and governance of CCGs are set out in part 1 of the Act.
[7] NHS Choices, 'NHS Structure', 13 April 2016.
[8] House of Commons Library, *Structure of the NHS in England*, 10 March 2016, pp 9–10.
[9] NHS Choices, 'NHS Structure', 13 April 2016.
[10] Further details can be found on the Care Quality Commission website.
[11] Health and Social Care Act 2012: Explanatory Notes, para 24.

consumer is strengthened and heard by those who commission, deliver and regulate health and care services".[12]

Monitor, the NHS Trusts Development Authority, and NHS Improvement

Monitor was established in 2004 to regulate NHS foundation trusts. The Health and Social Care Act 2012 widened Monitor's responsibilities. The House of Commons Library explains that:

> Monitor has the power to set and enforce a framework of rules for providers and commissioners; implemented in part through licences issued to NHS funded providers. Monitor works alongside the quality and safety regulator, the Care Quality Commission (CQC), to take remedial action when CQC reports that a hospital trust is failing to provide good quality care.[13]

Monitor explains that "taken together, the different parts of our role amount to a substantial responsibility for helping the NHS stay true to its founding principles while living within its means".[14]

The NHS Trust Development Authority oversaw the performance of NHS trusts, and supported their structure and transition towards Foundation Trusts.[15]

Since 1 April 2016, both Monitor and the NHS Trust Development Authority have been part of the new body NHS Improvement. NHS Improvement explains that it is responsible for:

> […] overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.[16]

NHS Improvement also brings together Patient Safety, including the National Reporting and Learning System, Advancing Change Team and Intensive Support Teams.

Figure 1 is taken from the National Audit Office's report *Managing the Transition to the Reformed Health System*.[17] It provides a schematic for the new structure of the NHS after the Health and Social Care Act 2012. It shows both the funding and accountability relationships between the various bodies that make up the NHS in England. Please note that it shows the NHS as at the time of original publication by the National Audit Office and therefore does not reflect the establishment of NHS Improvement.

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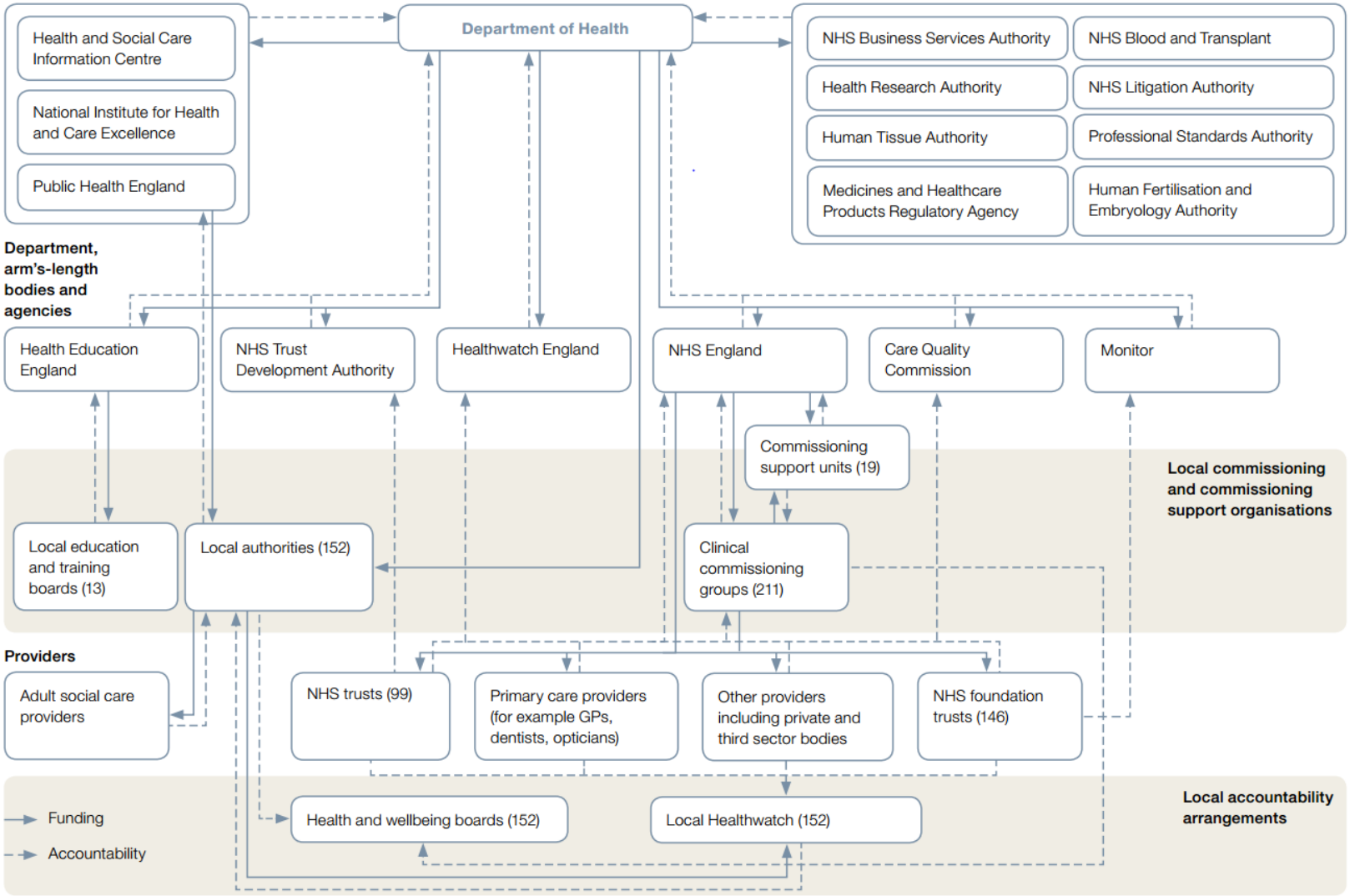
[12] Healthwatch England, 'About Us', accessed 19 July 2016.
[13] House of Commons Library, *Structure of the NHS in England*, 10 March 2016, p 14.
[14] Monitor, *About Us*, 2 July 2014, p 7.
[15] Further information on NHS Trusts and Foundation Trusts can be found on the NHS Choices website, 'NHS in England—NHS Trusts' (13 April 2016).
[16] NHS Improvement, 'Who We Are', accessed 19 July 2016.
[17] National Audit Office, *Managing the Transition to the Reformed Health System*, 10 July 2013, p 6.

Figure 1: The Structure of the NHS in England



Source: National Audit Office, *Managing the Transition to the Reformed Health System*, 10 July 2013, p 6.
Notes: As at the time of original publication by the National Audit Office; does not reflect the establishment of NHS Improvement, see page 3 of this briefing.

2.2 Other Changes

Alongside organisational changes to the NHS in England, the Health and Social Care Act 2012 made a number of significant operational changes as well. This section provides introductory information on competitive tendering and the government mandate to NHS England.

Competitive Tendering

The Health and Social Care Act 2012 introduced provisions to open up the NHS to greater levels of competition. The House of Commons Library explains that:

> Part 3 of the Health and Social Care Act 2012 creates a framework for choice and competition in the provision of NHS services. In particular, the 2012 Act allows the Department of Health to set regulations giving Monitor, as the new economic regulator for the NHS, the power to investigate and remedy anti-competitive behaviour by clinical commissioning groups or NHS England. Regulations on competition and procurement have been introduced under section 75 of the 2012 Act (and sometimes known as section 75 regulations).[18]

The Government has argued that "choice and competition" are "powerful means" to "deliver high quality services for patients, and value for money for taxpayers".[19] It has also stated that:

> The Act does not change EU or UK competition and procurement legislation. It also does not introduce or extend the previous Government's policy of patient choice of any qualified provider. What the Act does do is create a framework in which choice and competition (on quality, not price) can operate, including appropriate safeguards. Currently, there is not a robust framework tailored to healthcare able to protect patients. Our approach is to focus on protecting patients' rights to choice; ensuring good value for taxpayers' money; and addressing abuses that act against patients interests.[20]

NHS Improvement's *Memorandum of Understanding Between the Competition and Markets Authority and NHS Improvement* argues that "competition in the healthcare sector can be a powerful tool for improving quality of care" and that:

> In exercising our functions, we will have regard to the distinctive characteristics of the sector and seek to ensure that our two organisations make the best use of our powers, skills and experience to make the sector work for patients and service users. The CMA [Competition and Marketing Authority] and NHS Improvement can both enforce provisions of the Competition Act 1998 and the Treaty on the Functioning of the European Union in the healthcare services sector in England. We can exercise our competition law powers to take action in relation to anti-competitive agreements and conduct.[21]

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[18] House of Commons Library, *Structure of the NHS in England*, 10 March 2016, p 17.
[19] Department of Health, *Choice and Competition—The Health and Social Care Act 2012*, 30 April 2013.
[20] ibid.
[21] NHS Improvement and the Competition and Markets Authority, *Memorandum of Understanding Between the Competition and Markets Authority and NHS Improvement*, 1 April 2016.

The House of Commons Library explains that:

> Competition law is a complex area but, in brief, organisations are subject to EU and UK competition rules if they are "undertakings" for the purposes of those rules. Whether or not an NHS body is an undertaking will depend on the circumstances and in particular on whether they are engaged in economic activity, offering goods or services on a given market. EU law prohibits anti-competitive agreements, concerted practices or abuses of a dominant position by undertakings that affect trade between member states. Anti-competitive practices are also prohibited by the Competition Act 1998.
>
> There had been some contracting out of support services, such as cleaning and catering, during the 1980s but the first major reforms to introduce competition to the NHS came in 1991 with the first internal market reforms and the introduction of NHS trusts and the "purchaser-provider split" (the term commissioner is now preferred to purchaser). From 2002, a number of policies were introduced to strengthen the role of competition and patient choice within the NHS and NHS spending on non NHS providers in England grew steadily from around 3 percent in 2002/03 to 9 percent in 2014/15.[22]

On 19 July 2016, Paula Sherriff (Labour MP for Dewsbury) asked the Government what assessment it had:

> […] made of the effect on NHS services of private providers of those services entering into administration or suffering serious financial difficulty; and what contingency provisions he has put in place to mitigate such effects.[23]

In answer, the Government said that:

> It is the primary responsibility of commissioners to ensure continuity of commissioned services through contracting and contingency planning. Where a provider is considered hard to replace in the event of failure, its services can be designated as Commissioner Requested Services. This requires the provider to obtain a provider licence, if not otherwise required to hold a licence, and places the provider in NHS Improvement's financial oversight regime for private providers of essential NHS services.[24]

Government's Mandate to NHS England

The Department of Health explained that following the Health and Social Care Act 2012 ministers are still ultimately accountable for the NHS. However:

> Instead of directly managing providers or commissioners, ministers will transparently set objectives for the NHS through a mandate to the NHS Commissioning Board [now called NHS England]. It will hold to account all of the national bodies, with powers to intervene in the event of significant failure, or in an emergency.[25]

The Health and Social Care Act 2012 inserted provisions into the National Health Service Act 2006 to require the Secretary of State to publish a mandate for NHS England. The mandate sets

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[22] House of Commons Library, *Structure of the NHS in England*, 10 March 2016, p17.
[23] House of Commons, 'Written Question: Health Services: Private Sector', 21 July 2016, 43130.
[24] ibid.
[25] Department of Health, *Overview of Health and Care Structures—The Health and Social Care Act 2012*, 30 April 2012.

the Government's objectives for NHS England alongside any other requirements. It also sets its budget.[26] Jeremy Hunt, Secretary of State for Health, announced NHS England's mandate for 2016/17 on 17 December 2015. He stated that:

> This mandate confirms this Government's commitment to increase spending on the NHS in real terms every year in this Parliament. The NHS will receive £10 billion more per year in real terms by 2020/21 than in 2014/15. This investment backs in full the NHS's own *Five Year Forward View* and will mean patients receive seven day health services, with hospitals providing the services people need at the weekend and people able to access a GP at evenings and weekends.[27]

The 2016/17 mandate set NHS England the following objectives:

- To improve local and national health outcomes and reduce inequalities through better commissioning, supported by the new assessment framework for clinical commissioning groups.
- To help create the safest, highest quality health and care services seven days a week, including improved early diagnosis, services and outcomes for cancer patients.
- To balance the NHS budget and improve efficiency and productivity.
- To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives, including improvement in the quality of care and support for people with dementia and increased public awareness.
- To maintain and improve performance against core standards.
- To improve out-of-hospital care, including reducing the health gap between people with mental health problems, learning disabilities and autism and the population as a whole.
- To support research, innovation and growth.[28]

[26] Department of Health, *The Government's Mandate to NHS England 2016–17*, January 2016.
[27] House of Commons, 'Written Statement: The Government's Mandate to NHS England 2016–17', 17 December 2015, HCWS440.
[28] ibid.

3. Performance

NHS England collects and publishes a wide range of data on varying measures of performance, including on the time taken for patients to be referred for cancer treatment. These data are available from NHS England's 'Statistical Work Areas' website.

This section of the briefing presents statistics on selected performance measures based on NHS Improvement's report on *Performance of the NHS Provider Sector: Year Ended 31 March 2016*.[29] The charts provide an overview of performance within these areas. In presenting the statistics, the Library makes no judgement as to the relationship between these statistics and the changes introduced by the Health and Social Care Act 2012.

The House of Commons Library's *NHS Indicators: England, July 2016* (6 July 2016) provides further information on the performance of the NHS across a range of operational areas, including:

- Accident & Emergency attendance and performance
- Ambulance call volume and response times
- Waiting times for routine treatment
- Waiting times for cancer diagnosis and treatment
- Cancelled operations
- Delayed transfers of care
- Diagnostic waiting times and activity
- Waiting times for mental health treatment
- Workforce numbers for doctors, nurses and other staff
- Hospital activity, referrals and admissions
- Bed availability and occupancy

3.1 Referral to Treatment

Patients referred for non-emergency consultant-led treatment are said to be on referral to treatment (RTT) pathways. This pathway is the length of time a patient has waited between being referred for treatment and the start of that treatment. If treatment has not yet been started, then it is the length of time that patient has been waiting.

'Incomplete RTT pathways' are therefore often referred to as waiting list times. NHS England produces statistics on the number of people on RTT pathways. It explains that since 2012 an incomplete waiting time standard has been in operation. This states that the time waiting must be 18 weeks or less for at least 92 percent of patients on incomplete pathways.[30] The data presented in Charts 1 and 2 are figures as at the end of each month.

Chart 1 shows that in the years immediately following the introduction of the operational standard in 2012, performance remained consistently above the 92 percent target. However, in the latter part of 2015 and the beginning of 2016 this operational standard has been missed, following a general decreasing trend in performance.

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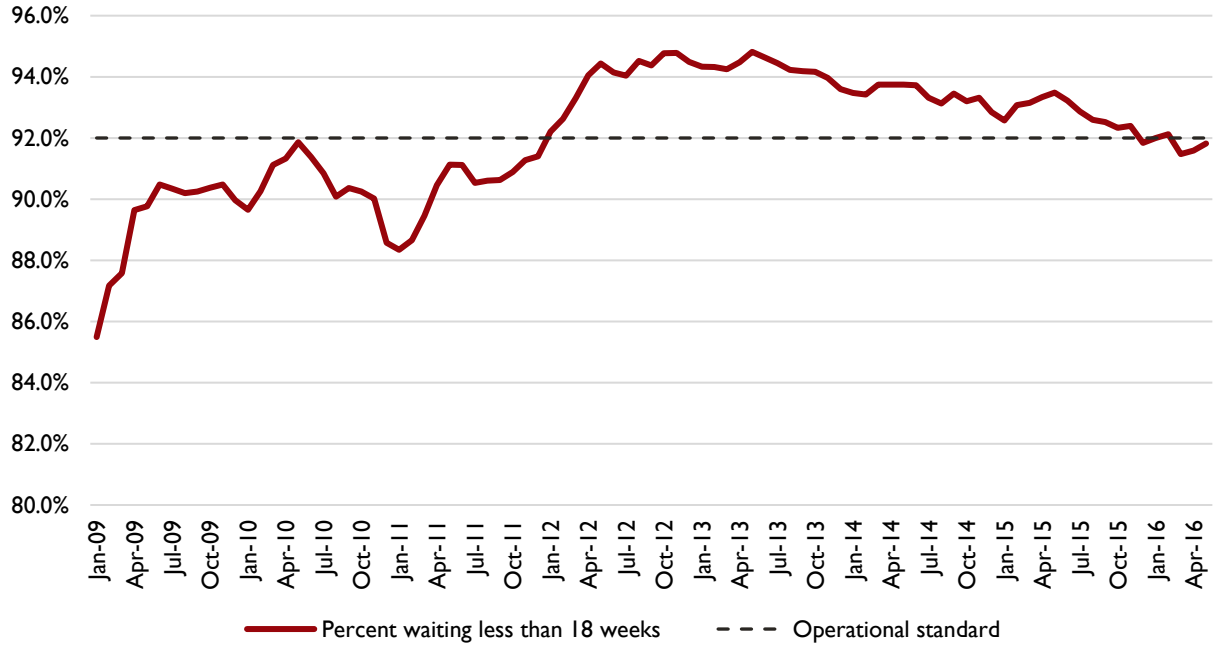
[29] NHS Improvement, 'NHS Providers Working Hard, But Still Under Pressure', 20 May 2016.
[30] NHS England, *Referral To Treatment (RTT) Waiting Times Statistics For Consultant-Led Elective Care: 2015/16 Annual Report*, 9 June 2016, p 5.

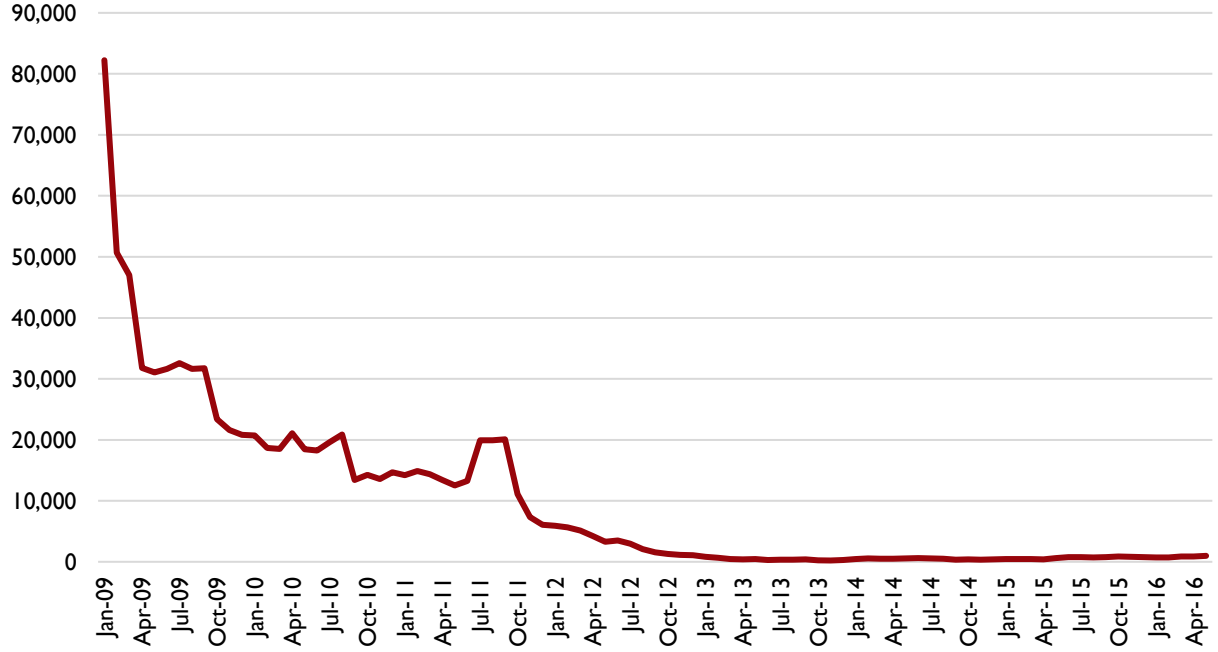
Chart 1: Incomplete Referral to Treatment Pathways, Performance Against Operational Standard, January 2009 to April 2016



Source: NHS England, '[Consultant-led Referral to Treatment Waiting Times Data 2016–17]', accessed 20 July 2016

Chart 2 shows that the number of patients waiting over 52 weeks fell between January 2009 and October 2012 and has remained at the lower level since then.

Chart 2: Number of Incomplete Pathways Over 52 Weeks



Source: NHS England, '[Consultant-led Referral to Treatment Waiting Times Data 2016–17]', accessed 20 July 2016

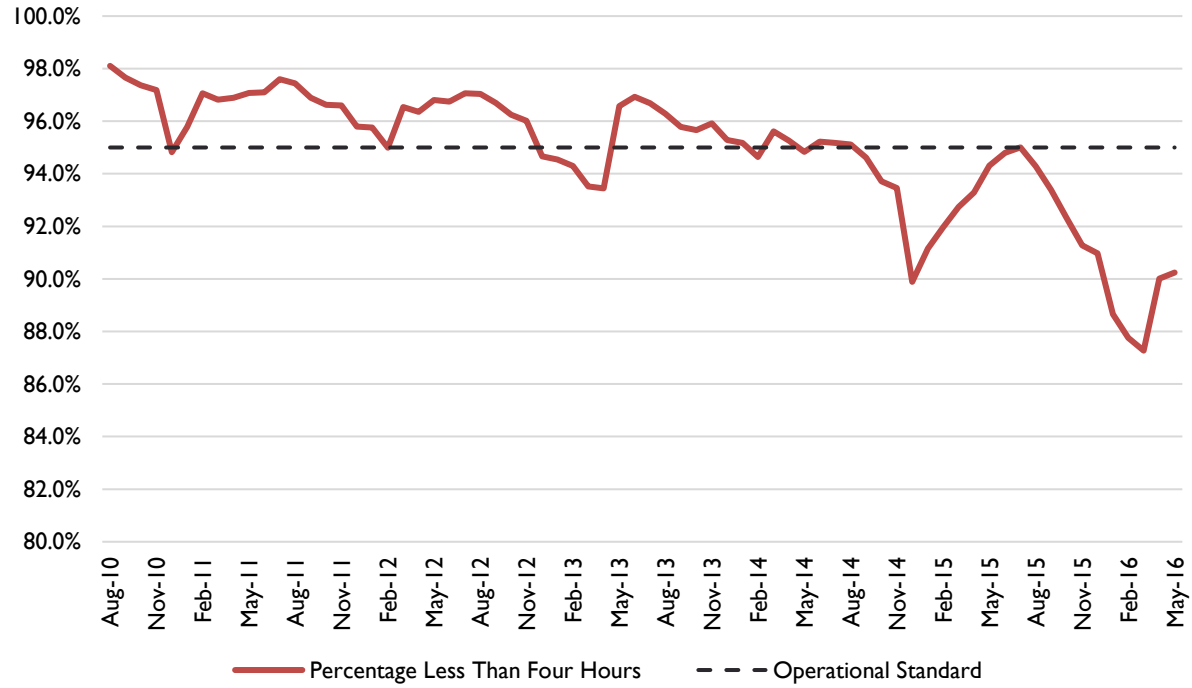
3.2 Accident and Emergency (A&E)

NHS England explains that:

> A&E waiting times form part of the NHS Constitution, which contains a list of expected rights and pledges for patients that NHS England take into account when assessing organisational delivery. The operational standard for A&E waiting times is that 95 percent of patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department.[31]

Chart 3 displays data on the percentage of people waiting less than four hours to admission, transfer or discharge against the operational standard of 95 percent.

Chart 3: Percentage of People Waiting Less Than Four Hours to Admission, Transfer or Discharge, August 2010 to May 2016



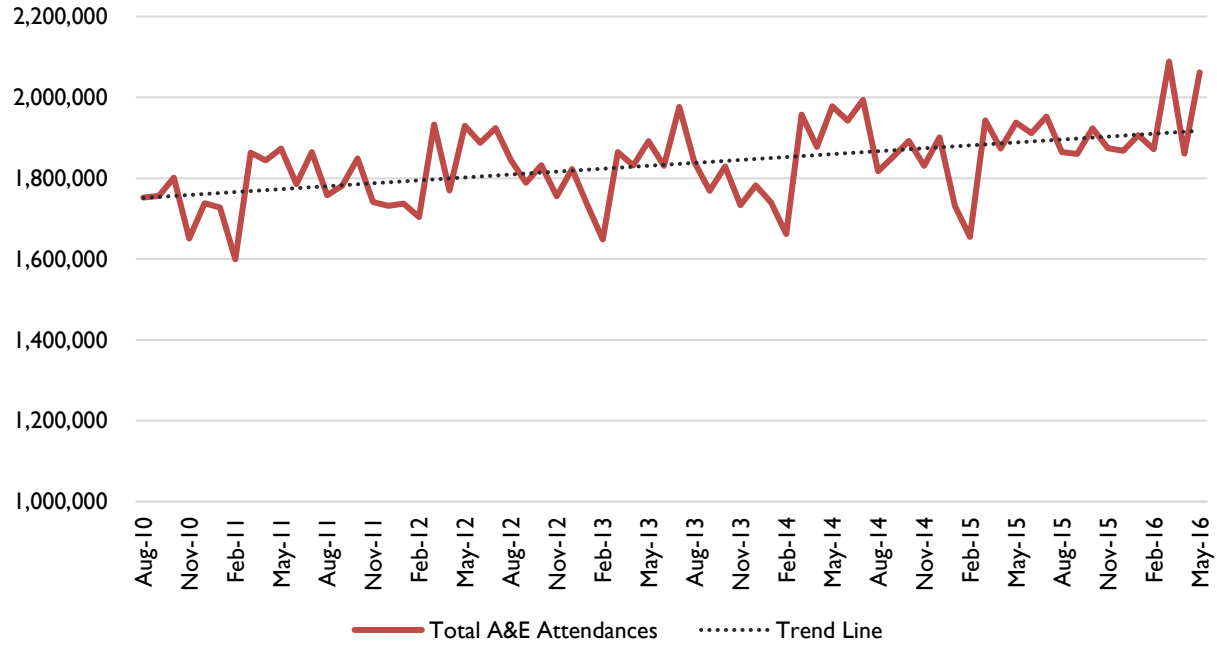
Source: NHS England, '[A&E Attendances and Emergency Admissions 2016–17]', accessed 20 July 2016

Chart 3 should be put in the context of a steadily increasing number of A&E attendances.

Chart 4 shows both the seasonal variation in attendances and—through the trend line—a general increase in numbers since August 2010. Please note that neither chart starts at zero.

[31] NHS England, *A&E Attendances and Emergency Admissions: May 2016 Monthly Report*, 14 July 2016, p 4.

Chart 4: Total Accident and Emergency Attendances, August 2010 to May 2016



Source: NHS England, '[A&E Attendances and Emergency Admissions 2016–17]', accessed 20 July 2016

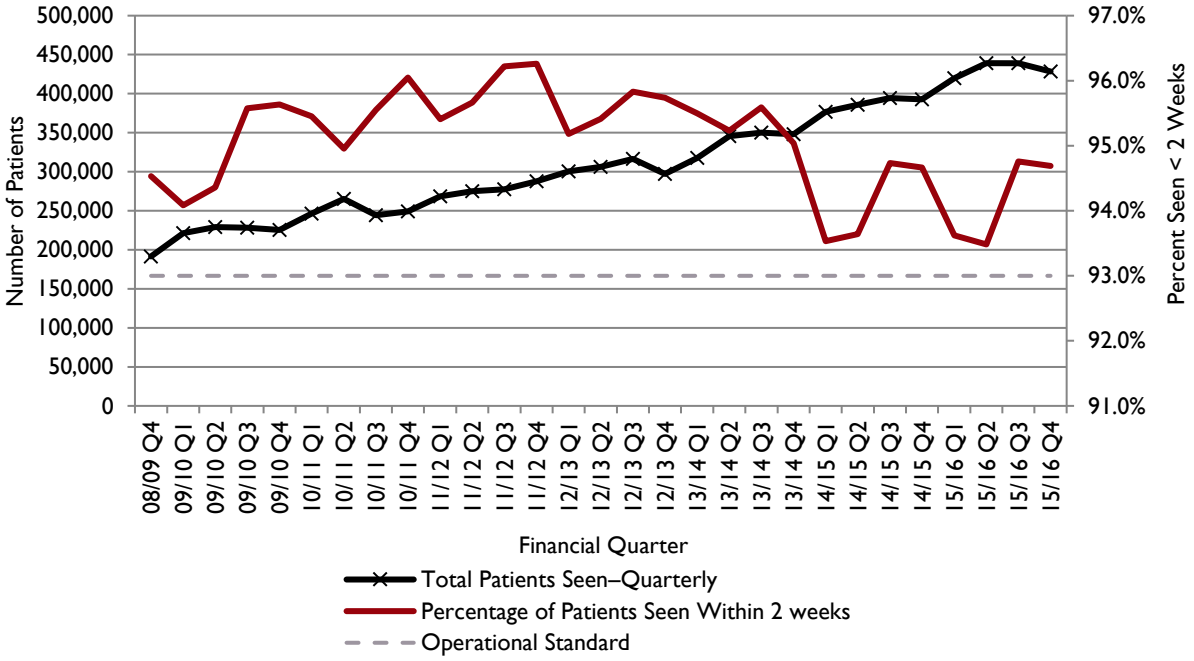
3.3 Cancer

NHS England explains that a patient should have to wait a maximum of two weeks to see a specialist having been referred urgently with suspected cancer by their GP. The operational standard specifies that 93 percent of such patients should be seen within this time period.[32]

Chart 5 displays data on the number of patients waiting being urgent referred by their GP and the percentage seen within two weeks. Whilst the operational standard of 93 percent has been consistently met, performance in recent quarters has been generally lower than between 2010 and 2014. However, this is within the context of an increase in patient numbers.

[32] NHS England, *Statistics on Waiting Times for Suspected and Diagnosed Cancer Patients Q4 2015/16 Key Points—Provider Based*, May 2016, p 3.

Chart 5: Two Week Wait from GP Urgent Referral to First Consultant Appointment



Source: NHS England, 'Cancer Waiting Times', accessed 20 July 2016

3.4 Diagnostic Tests

NHS England publishes a range of data on the length of time patients spend waiting for diagnostic tests.[33] The following charts display data on the percentage of patients waiting more than six weeks for a diagnostic test.

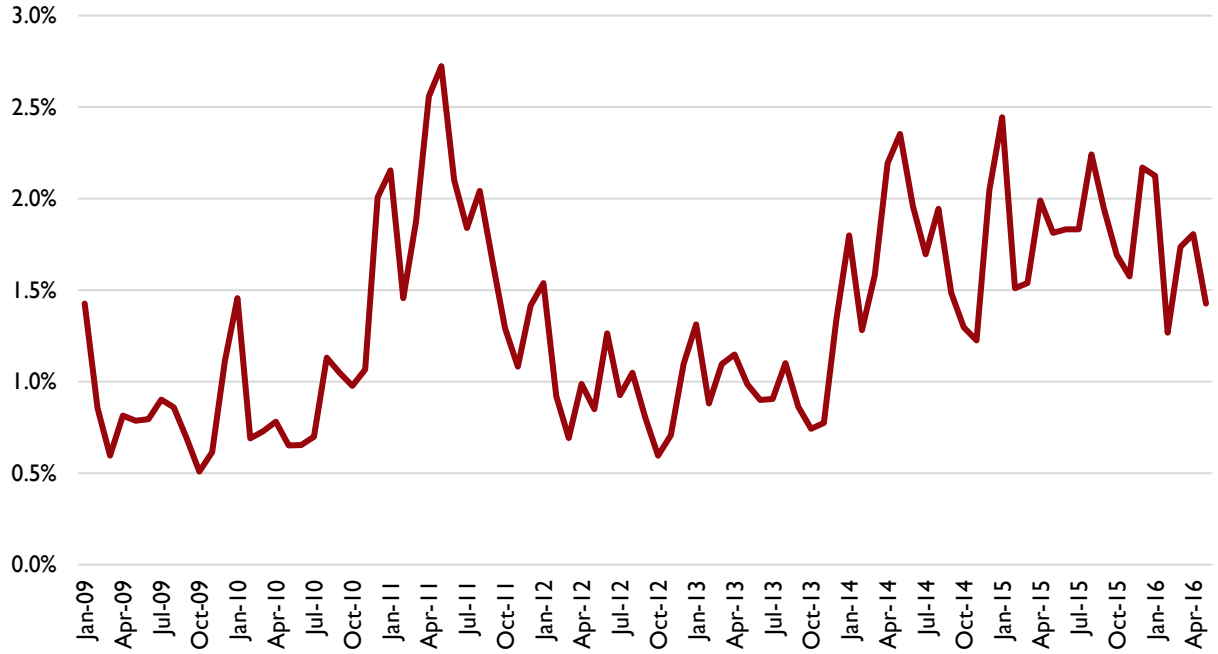
Chart 6 shows the pattern in the data over recent years. Chart 7 displays the full data available back to January 2006. This shows a fall in the percentage of patients waiting more than six weeks for diagnostic tests between 2006 and 2008.

NHS England explains that the six week diagnostic wait was initially introduced:

> […] as a 'milestone' from March 2008 towards achieving the standard Referral to Treatment wait of 18 weeks by December 2008, but diagnostic waiting times now form part of the NHS Constitution. This gives patients the legal right to treatment within 18 weeks of referral (18 week RTT) and as part of this, pledges that patients should not be required to wait 6 weeks or longer for a diagnostic test.[34]

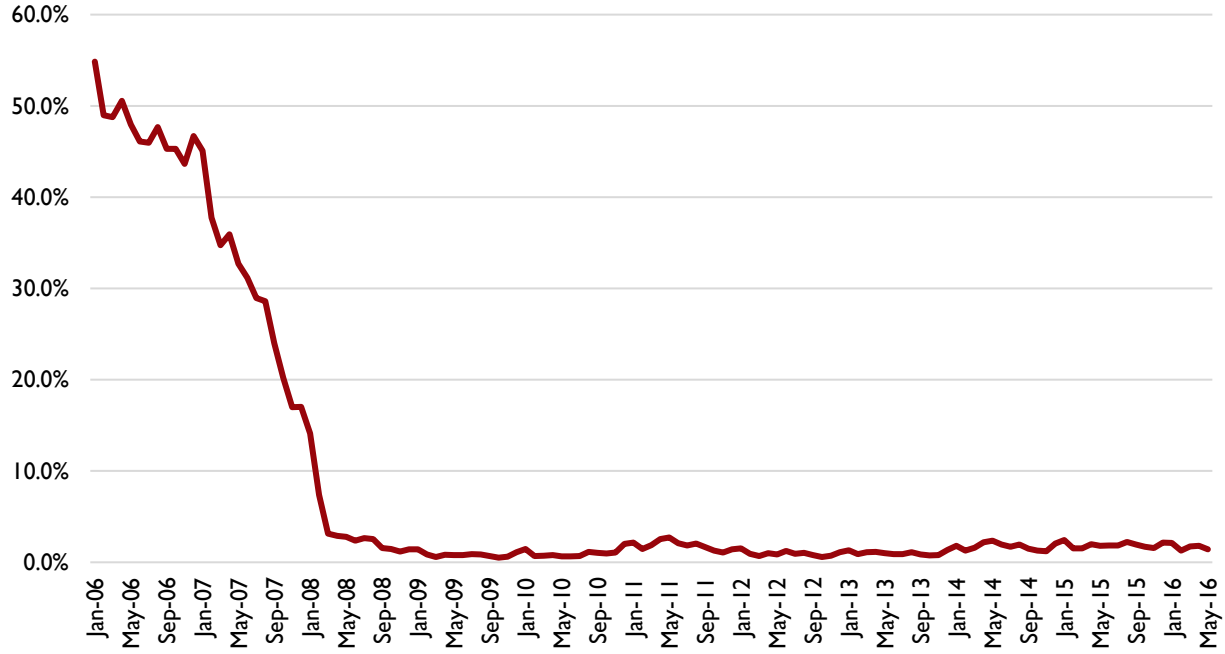
[33] NHS England, 'Diagnostics Waiting Times and Activity', accessed 20 July 2016.
[34] NHS England, *NHS Diagnostic Waiting Times and Activity Data*, 14 July 2016.

Chart 6: Percentage of Diagnostics Tests Waiting for More than Six Weeks, January 2009 to April 2016



Source: NHS England, 'Monthly Diagnostics Data 2016–17', accessed 20 July 2016

Chart 7: Percentage of Diagnostics Tests Waiting for More than Six Weeks, January 2006 to April 2016



Source: NHS England, 'Monthly Diagnostics Data 2016–17', accessed 20 July 2016

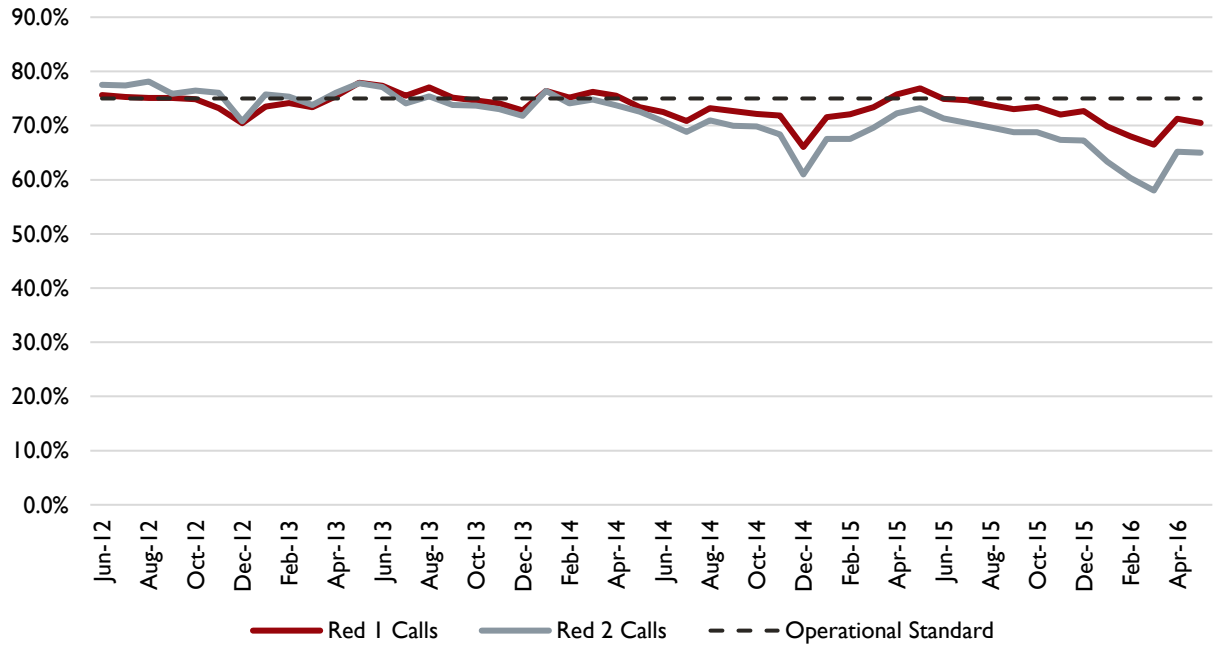
3.5 Ambulances

The *Handbook to the NHS Constitution* describes the operational standards which apply to ambulances. These are that:

> All ambulance trusts to respond to 75 percent of Category A calls within eight minutes and to respond to 95 percent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.[35]

Category A calls consist of Red 1 and Red 2 calls. Red 1 calls are "the most time critical, where patients are not breathing or do not have a pulse" and Red 2 calls are "still serious, but less immediately time critical, like strokes or fits".[36]

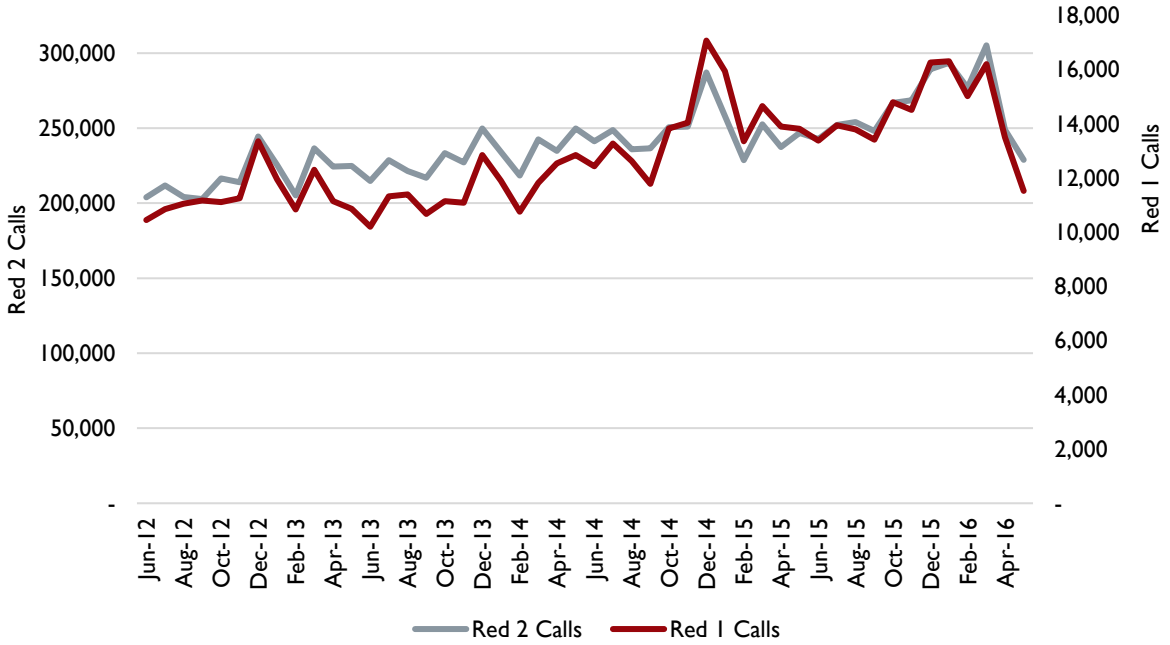
Chart 8: Percentage of Red 1 and Red 2 Ambulance Calls Responded to Within Eight Minutes, June 2012 to April 2016



Source: NHS England, '[Ambulance Quality Indicators](#)', accessed 20 July 2016

[35] Department of Health and Public Health England, *[Handbook to the NHS Constitution](#)*, 27 July 2016, p 34.
[36] NHS Choices, '[Urgent and Emergency Care Services in England](#)', 14 September 2015.

Chart 9: Numbers of Red 1 and Red 2 Calls Resulting in an Emergency Response, June 2012 to April 2016



Source: NHS England, '[Ambulance Quality Indicators]', accessed 20 July 2016

4 Sustainability

The sustainability of the NHS in England was covered extensively in the House of Lords Library's briefing *Sustainability of the National Health Service as a Public Service Free at the Point of Need*, published on 6 July 2015. This section of this briefing updates the previous note with developments since July 2015.

4.1 Sustainability and Transformation Fund

The Sustainability and Transformation Fund (STF) was announced on 16 December 2015, providing hospitals with £1.8 billion to "help challenged hospitals to achieve financial balance while focusing on changing the way they provide high quality care for patients".[37] The Government stated that:

> The transformation fund, which will be allocated dependent on hospitals meeting a series of strict conditions, will give the NHS the time and space it needs to put transformation plans in place. This will make seven day services a reality for patients and will meet the ambitions of the NHS *Five Year Forward View*.[38]

The STF introduced "control totals" for trusts' 2016/17 budgets. Control totals represent:

> […] the minimum level of financial performance, against which their boards, governing bodies and chief executives must deliver in 2016/17, and for which they will be held directly accountable.[39]

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[37] Department of Health, 'Hospitals Get £1.8 Billion for Sustainability and Transformation', 16 December 2015.
[38] ibid.
[39] NHS England and NHS Improvement, *Strengthening Financial Performance and Accountability in 2016/17*, 21 July 2016, p 3.

NHS Improvement explains that:

> NHS Improvement […] wrote to NHS trusts and NHS foundation trusts about their financial outturn for 2015/16 and plans for 2016/17 on 15 January 2016. These letters set out provisional allocations of the recently announced Sustainability and Transformation Fund (STF) and an indicative financial control total for each provider.[40]

In answer to a written question in the House of Lords, the Government explained that:

> NHS Improvement continues to work with those providers who have not been able to agree control totals by the end of July. At present, 213 of 238 providers (89.5 percent) have an agreed a control total. Those providers who have been unable to agree a control total will not be able to access the Sustainability and Transformation Fund.
>
> NHS Improvement is currently consulting on a new oversight regime, which details proposals on how providers will be monitored in future and this will set out how variance from financial plan or control total will be managed.
>
> NHS Improvement does not intend to replace the boards of those providers who do not achieve financial balance by the end of 2016/17. The organisation's new oversight regime also sets out in detail how it proposes to monitor and support providers.
>
> The Government's mandate to the NHS 2016/17 […] confirms that the National Health Service must ensure that it balances its budget, including commissioners and providers living within their budgets. To support this, £1.8 billion of NHS England's budget for 2016/17 will be allocated through the Sustainability and Transformation Fund to support providers, in particular emergency services, payable through commissioning or as other support.[41]

4.2 Carter Review

In June 2014, the Coalition Government asked Lord Carter of Coles (Labour) to examine how hospitals in England could improve their efficiency. Lord Carter's final report was published on 5 February 2016.[42] The report's executive summary explained that:

> This review looked at productivity and efficiency in English non-specialist acute hospitals, which account for half of the total health budget, using a series of metrics and benchmarks to enable comparison. We conclude that there is significant unwarranted variation across all of the main resource areas, and although we found many examples of good practice, no one hospital is good at everything. We estimate this unwarranted variation is worth £5bn in terms of efficiency opportunity—a potential contribution of at least 9 percent on the £55.6 billion spent by our acute hospitals. The report makes 15 recommendations designed to tackle this variation and help trusts improve their performance to match the best.[43]

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[40] NHS Improvement, *The Sustainability and Transformation Fund and Financial Control Totals for 2016/17: Methodology*, March 2016, p 3.
[41] House of Lords, 'Written Question: NHS Finance', 13 July 2016, HL1045.
[42] Carter Review, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations*, February 2016.
[43] ibid, p 6.

The report's recommendations included, but were not limited to, the following:

- NHS Improvement should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all trusts.

- Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.

- Trusts should operate at or above the benchmarks agreed by NHS Improvement for the operational management of their estates and facilities functions by April 2017; with all trusts (where appropriate) having a plan to operate with a maximum of 35 percent of nonclinical floor space and 2.5 percent of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.

- NHS England and NHS Improvement should work with trust boards to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community.[44]

Jeremy Hunt, Secretary of State for Health, responded to Lord Carter's report in a written statement on 5 February 2016. Mr Hunt wrote that:

> Lord Carter proposes and has already developed the first iterations of a model hospital with metrics and benchmarks for measuring productivity and efficiency across a whole range of costs. He also proposes a single integrated performance framework for hospitals—one version of the truth—that will help trusts set baselines for improvement and provide them with the tools to manage their resources daily, weekly, monthly, yearly. He recommends NHS Improvement should become the organisation to host performance management and to provide the skills and expertise to help trusts improve. I welcome Lord Carter's non-executive director role at NHS Improvement and look forward to his going input into the implementation of his review.
>
> In light of Lord Carter's report, I can now announce that we will act upon all his recommendations and have asked Lord Carter to report back on progress with implementation by spring 2017.[45]

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[44] Lord Carter of Coles, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations*, February 2016, p 10.
[45] House of Commons, 'Written Statement: Government Response to Lord Carter of Coles' Report: Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations', 5 February 2016, HCWS515.

As part of its response to the Carter review, NHS Improvement announced the establishment of a Financial Improvement Programme to help find £50 million worth of savings.[46] From 80 volunteers 16 trusts were selected. NHS Improvement explains that:

> The selected providers will bring in teams of experts—jointly selected by the trust and us—who will offer skills and experience to build on existing financial improvement measures. The appointed experts will be paid partly according to the savings they make.
>
> The programme is likely to cost around £25 million and will save the NHS around £50 million in the first year alone.[47]

A second wave, involving more NHS providers, will be brought into the programme later in 2016.

4.3 Data from NHS Improvement

NHS Improvement's report on *Performance of the NHS provider Sector: Year Ended 31 March 2016*—referenced in this briefing's section on performance—also looks at the financial performance of NHS providers.[48] It should be noted that NHS Improvement explains that "the financial information contained within the report is subject to a consolidation and full audit process and may change".[49]

The report found that:

> The NHS provider sector's financial performance declined sharply in 2015/16. The year-end deficit of £2.45 billion was almost three times greater than that reported in 2014/15, and £461 million worse than the revised plan (£340 million worse than initial plan).

And that:

> The run rate forecast earlier in the year suggested the full year deficit could be as high as £2.8 billion. The sector's run rate improved during the second half of the financial year as measures introduced by NHS Improvement (including agency and consultancy controls) started to have a positive, albeit limited, impact. Providers were also committed to continually improving their financial sustainability and reducing the sector deficit. Between December 2015 and March 2016, providers realised £724 million of financial improvement opportunities. These included local capital-to-revenue transfers and one-off technical measures.[50]

NHS Improvement identified the following factors affecting NHS providers' financial performance:

- High usage of contract and agency staff. The cost of unplanned agency staff contributed £1.4 billion to the full year adverse variance despite agency controls.

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[46] NHS Improvement, 'Financial Improvement Programme to Save the NHS Tens of Millions of Pounds', 20 May 2016.
[47] ibid.
[48] NHS Improvement, 'NHS Providers Working Hard, But Still Under Pressure', 20 May 2016.
[49] ibid, p 1.
[50] ibid, p 3.

The overspending was partly offset by savings from underspending on substantive staff.

- Delayed transfers of care. Providers have estimated that such delays have cost £145 million this year. However, full costs could be much higher.
- Financial sanctions. Financial pressures were further exacerbated by £498 million of fines and readmission penalties.
- Costs of waiting list initiative (WLI) work. Providers have spent £143 million on such work this financial year to avoid breaches of waiting time targets.
- A shortfall of £316 million cost savings against the planned cost improvement programmes.
- A reduction in non-recurrent income compared to 2014/15 including the loss of one-off deficit support.

On 21 July 2016, NHS Improvement and NHS England published "a suite of new measures for providers and commissioners to restore financial discipline and help ensure ongoing financial sustainability for the NHS".[51] These measures are set out in the accompanying document, *Strengthening Financial Performance and Accountability in 2016/17,* and include but are not limited to:

- [replacing] national fines with trust-specific incentives linked to agreed organisation-specific published performance improvement trajectories, so as to kickstart a multi-year recovery and redesign of A&E and elective care.

And:

- [introducing] new intervention regimes of special measures which will be applied to both trusts and CCGs who are not meeting their financial commitments.[52]

4.4 Kings Fund, *Deficits in the NHS 2016*

On 11 July 2016, the King's Fund published a report entitled *Deficits in the NHS 2016*. The King's Fund describes itself as "independent charity working to improve health and care in England".[53] The report was based on unaudited data drawn from NHS commissioners (CCGs and NHS England). The King's Fund wrote that these bodies:

> […] ended 2015/16 with an aggregate deficit of £1.85 billion (unaudited), a threefold increase on the previous year. This is the largest aggregate deficit in NHS history.[54]

The King's Fund went on to argue that, in its view, the "scale of aggregate deficit makes it clear that overspending is largely not attributable to mismanagement in individual organisations" but

[51] NHS Improvement, 'Strengthening Trusts' Financial and Operational Performance for 2016/17', 21 July 2016.
[52] NHS England and NHS Improvement, *Strengthening Financial Performance and Accountability in 2016/17*, 21 July 2016, p 3.
[53] King's Fund, 'About Us', accessed 1 August 2016.
[54] King's Fund, *Deficits in the NHS 2016*, 11 July 2016, p 1.

that it was as a result of "huge" financial and operational pressures.[55] The report's final key message was that, in light of the King's Fund's findings, the Government should review its priorities for the NHS and:

> […] ensure these can be delivered within the resources available. This includes revisiting the feasibility of the commitment to seven-day services and may mean reviewing key waiting times targets. There must be realism about what the NHS can achieve with the funding allocated to it and there should be an honest debate with the public about this.[56]

Luciana Berger (Labour MP for Liverpool, Wavertree) asked the Government—in reference to the King's Fund's report—what steps it was taking to reduce the NHS's aggregate deficit. In response, Alistair Burt, the then Minister of State at the Department of Health, stated that:

> It is clear that the National Health Service faces a significant challenge, and this is why we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year.
>
> We have introduced tough new financial controls to cut down on waste in the NHS—including introducing caps for agency staff and management consultants, and introducing central procurement rules. In 2016/17, we have introduced a £1.8 billion Sustainability and Transformation Fund to support providers to move to a financially sustainable footing. We will be providing intensive support to the most challenged NHS organisations through the new special measures programme.[57]

The £10 billion referred to in the above written answer was announced as part of the 2015 Spending Review. HM Treasury and the Department of Health explained that this was a:

> £10 billion real terms increase in NHS funding in England between 2014/15 and 2020/21, of which £6 billion will be delivered by the end of 2016/17, and £4.8 billion capital funding every year for the next five years.[58]

In its report, *Impact of the Spending Review on Health and Social Care*, the House of Commons Health Committee argued that the £10 billion figure does not accurately reflect the effect of the Spending Review on health expenditure. It argued that there were two reasons for this:

> The first is that the £10 billion figure is expressed in 2020–21 prices, rather than the current (2015–16, the time of the Spending Review) prices which would normally be expected to have been used in the calculation of such figures. At 2015–16 prices, NHS England's budget will rise by £9.5 billion between 2014–15 and 2020–21. The second reason is that the £10 billion figure refers to the additional sum allocated to NHS England, not to total health spending. Part of the increase in funding to NHS England is being funded by reductions in areas of health spending which fall outside NHS England's budget, such as the public health grant to local authorities, and education and training funded through Health Education England. Those reductions amount to £3.5 billion in real terms, at 2015/16 prices, between 2014/15 and 2020/21. The overall impact is that total health spending—the Department of Health's budget—will increase in real terms,

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[55] King's Fund, *Deficits in the NHS 2016*, 11 July 2016, p 1.
[56] ibid, p 2.
[57] House of Commons, 'Written Question: NHS: Finance', 14 July 2016, 42447.
[58] HM Treasury and Department of Health, 'Department of Health's Settlement at the Spending Review 2015', 25 November 2015.

> at 2015/16 prices, by £6 billion between 2014/15 and 2020/21. If the spending review period is considered—2015/16 to 2020/21—that increase is £4.5 billion.[59]

4.5 House of Commons Public Accounts Committee

On 15 March 2016, the House of Commons Public Accounts Committee published its report *Sustainability and Financial Performance of Acute Hospital Trusts*.[60] The Committee found that the finances of NHS trusts and foundation trusts had "significantly worsened" in the past three financial years and that "trusts had a net deficit of £843 million in 2014/15, which is a severe decline from trusts' £91 million deficit in 2013/14, and £592 million surplus in 2012/13".[61]

The Committee also wrote that:

> There has been significant change in the NHS since the introduction of the Health and Social Care Act 2012. These changes have come at a time of increased financial pressures in government arising from austerity. Health is an area of public spending that the Government has protected in recent years compared with most other areas of government spending. However, finances have become increasingly tight with health funding rising at a historically low rate of 1.8 percent in real terms between 2010/11 and 2014/15.[62]

The Public Accounts Committee recommended that:

- The Department, NHS England and NHS Improvement should make sure all trusts in deficit have realistic recovery plans by the start of the 2016/17 financial year that will lead to timely and sustainable improvements.
- The Department, NHS England and NHS Improvement should set informed and realistic targets for providers to make efficiencies.
- NHS Improvement should set out how it will work with trusts in the 2016/17 financial year to improve the quality of the data on which its savings targets are based.
- NHS England and NHS Improvement should set out proposals for changing the payment and contracting system for providers to one that supports financial and service sustainability, incentivises integration and service collaboration and reduces the need for reactive financial support to providers in difficulty.
- NHS England and NHS Improvement should be clear that spending on agency staff is only one contributing factor to the deficit. They should set out how they will support providers to secure the collective action that is needed to get value for money from the use of agency staff as a matter of urgency.

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[59] House of Commons Health Committee, *Impact of the Spending Review on Health and Social Care*, 19 July 2016, HC 139 of session 2016–17, p 8.
[60] House of Commons Public Accounts Committee, *Sustainability and Financial Performance of Acute Hospital Trusts*, 15 March 2016, HC 709 of session 2015–16.
[61] ibid, p 3.
[62] ibid, p 8.

- The Department of Health, NHS England and NHS Improvement should report to us jointly in September 2016 on their progress with implementing the NAO's recommendations and the further recommendations we make in this report.

In its response the Government stated that it accepted all the Committee's recommendations; that it had implemented recommendations 2 and 5; recommendation 1 would be implemented by June 2016; recommendation 3 would be implemented by January 2017; recommendation 4 would be implemented by March 2017; and recommendation 6 would be implemented by September 2016.[63]

The Public Accounts Committee's report followed a report by the National Audit Office (NAO) on this subject.[64] The NAO wrote that:

> The Department is ultimately responsible for securing value for money for this funding. In 2014/15, it came close to exceeding its £111 billion revenue expenditure budget authorised by Parliament, underspending by just £1.2 million or 0.001 percent.[65]

The NAO made five recommendations:

- The Department, NHS England, Monitor and the NHS Trust Development Authority (NHS TDA) should work together to improve the trust planning process and their oversight of financial risk.
- When designing measures to control costs, the Department should consider how these measures will be implemented successfully.
- The Department, NHS England, Monitor and the NHS TDA should put in place a clear plan for improving financial sustainability.
- The Department must move ambitiously and more thoroughly to set out savings goals to secure financial sustainability.
- Price and tariff setters (NHS England and Monitor) should move faster to ensure that payment systems support change and promote financial sustainability.[66]

4.6 House of Lords Long Term Sustainability of the NHS Committee

The issue of the NHS's future sustainability is the subject of a current inquiry by the House of Lords Long Term Sustainability of the NHS Committee.[67] The Committee was appointed on 25 May 2016.

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[63] HM Treasury, *Treasury Minutes Government Responses on the Twenty Seventh to the Thirty Third Reports from the Committee of Public Accounts: Session 2015–16*, May 2016, Cm 9270, pp 10–13.
[64] National Audit Office, *Sustainability and Financial Performance of Acute Hospital Trusts*, 16 December 2015, HC 611 of session 2015–16.
[65] ibid, p 5.
[66] ibid, pp 13–14.
[67] House of Lords Long Term Sustainability of the NHS Committee, 'Role', accessed 20 July 2016.

The Committee held its first evidence session on 12 July 2016. In regard to the reforms made by the Health and Social Care Act 2012, Andrew Baigent, Director of Finance at the Department of Health, said that:

> […] the Department's role changed in 2013. We devolved a lot of the operational delivery of the health service to our arm's-length bodies—NHS England, Public Health England and others. To some extent, that has freed us up to look at some of the longer-term issues within the department.[68]

The Committee is scheduled to report by 31 March 2017.

[68] House of Lords Long Term Sustainability of the NHS Committee, 'Unrevised Transcript of Evidence Session 1', 12 July 2016, p 2.