



National Audit Office

**BRIEFING FOR THE
HOUSE OF COMMONS
HEALTH SELECT
COMMITTEE
DECEMBER 2010**

Department of Health

Health Resource Allocation

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This briefing has been prepared to help inform the House of Commons Health Select Committee examination of Health Resource Allocation.

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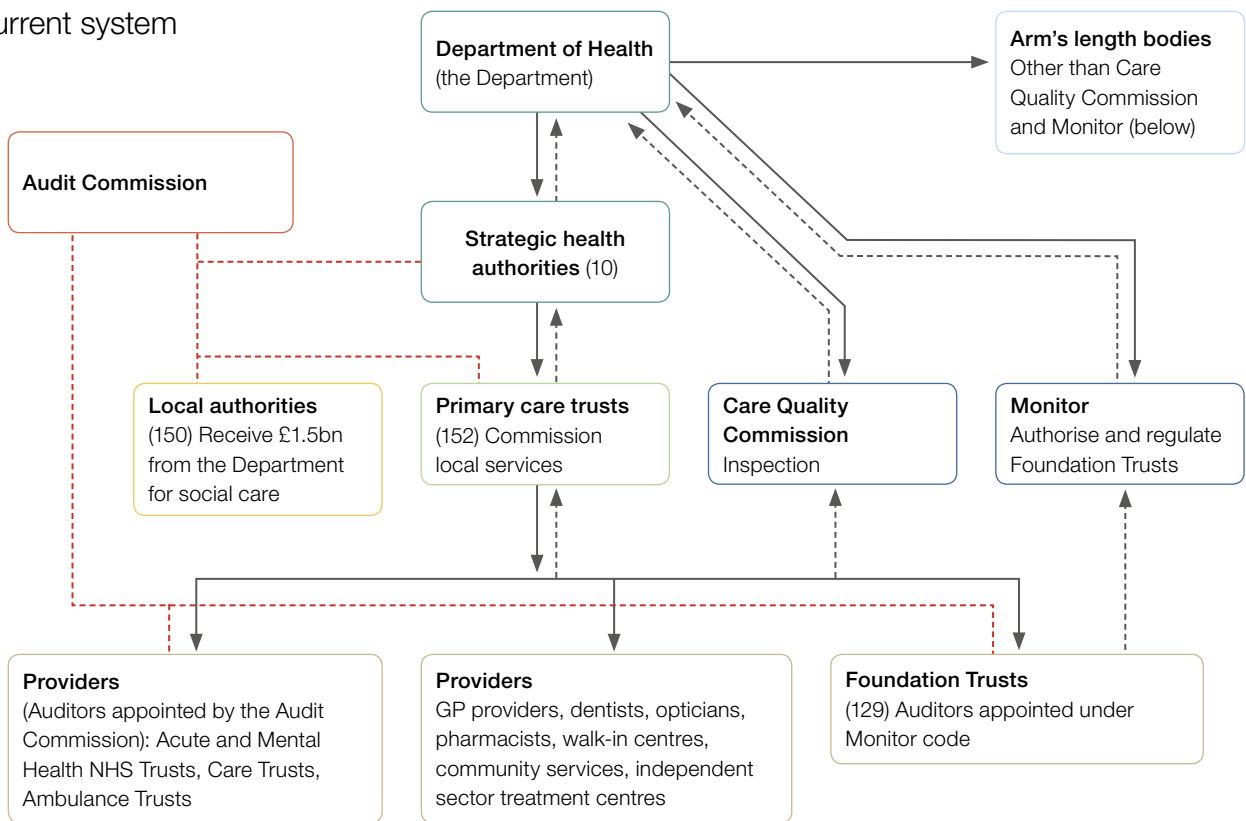
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Summary

1 This short briefing has been prepared for the Members of the Health Committee to support the Committee’s examination of health resource allocation. The NHS White Paper, *Equity and excellence: Liberating the NHS*, sets out the Coalition Government’s long-term vision for the future of the NHS. **Figure 1** shows the current NHS system and the proposed new NHS system. At the Committee’s request this briefing focuses on health resource allocation under the current system.

Figure 1
The current and new NHS system

Current system



→ Funding - - -> Regulation/Accountability - - - Audit

□ Department □ NHS Bodies □ Arms length bodies □ Auditors □ Regulators □ Local authority □ Providers

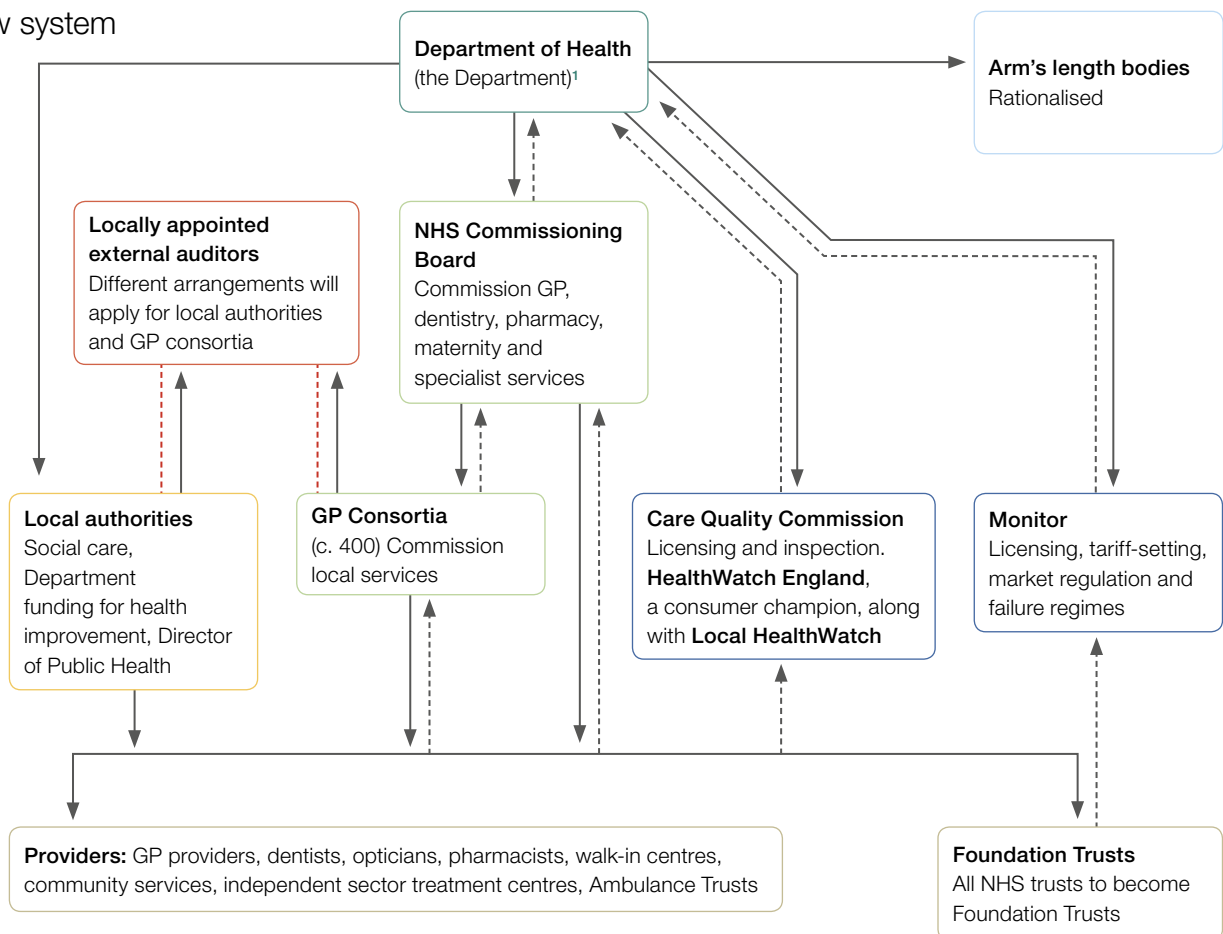
NOTE

1 The Public Health Service (within a much reduced Department) will work alongside local authorities in prioritising spend on public health issues.

2 It is based mainly on:

- Our analysis of data from the Department of Health, the NHS Summarised Accounts, primary care trust's accounts, and social care statistics published by the Chartered Institute of Public Finance and Accountancy and the NHS Information Centre;
- semi-structured interviews conducted with six primary care trusts and six local authorities; and
- previous National Audit Office value for money reports, financial audit reports and good practice guides.

New system



3 It is in six parts:

- Part One: The Department of Health's resources
- Part Two: The allocation of resources to primary care trusts
- Part Three: How primary care trusts spend their healthcare funding
- Part Four: How local authorities spend their social care funding
- Part Five: The interface between primary care trusts and local authorities
- Part Six: Maintaining services in a period of change

Part One

The Department of Health's resources

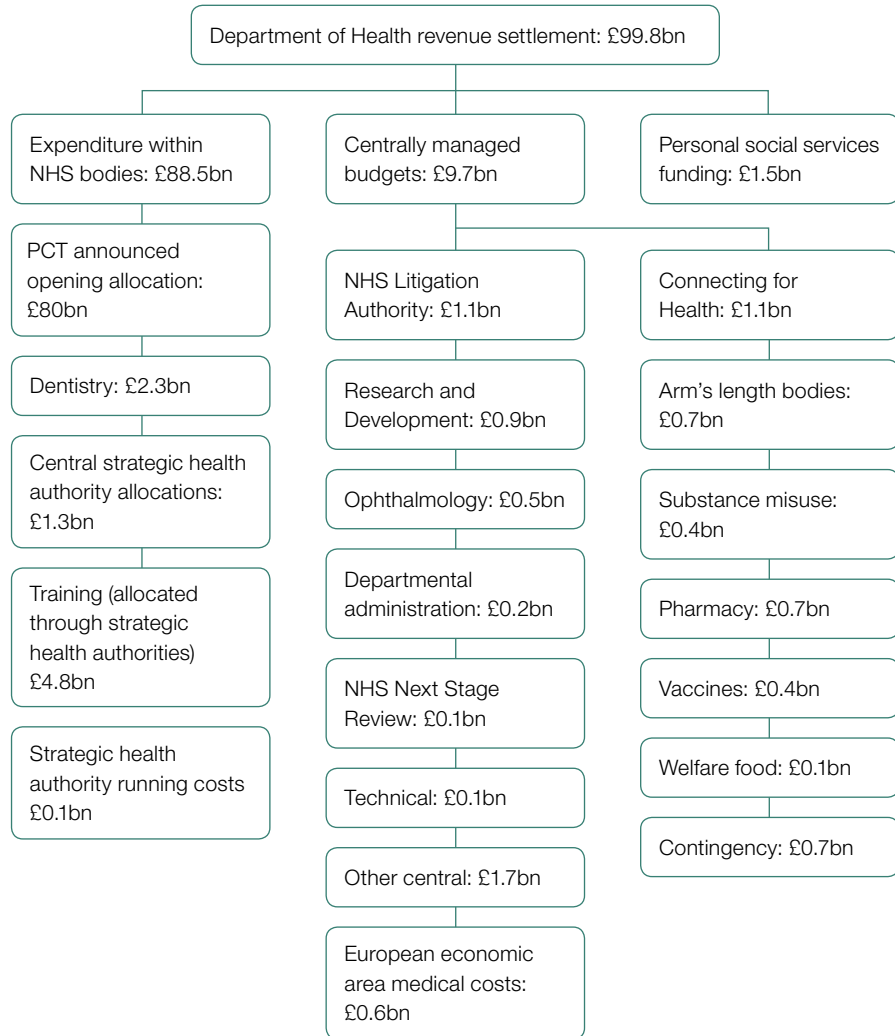
1.1 Over the last ten years there have been substantial increases in NHS funding. Between 2000-01 and 2010-11, annual expenditure on the NHS will have increased by 70 per cent from £60 billion to £102 billion, an average real term increase of 4.5 per cent a year.

1.2 In 2009-10, the Department of Health's (the Department's) revenue budget was £99.8 billion (**Figure 2** overleaf). The NHS accounts for 89 per cent of this figure, with 152 primary care trusts (PCTs) spending most of the money to commission healthcare services for their local population. Centrally managed budgets, such as those for arm's length bodies, account for almost 10 per cent of this budget and adult personal social services account for the remaining balance, of £1.5 billion (the main funding for adult social services comes from the Department for Communities and Local Government – see Part Four).

1.3 In 2009-10, the NHS' capital budget was £5.5 billion, including £0.1 billion from asset sales. The budget was allocated to NHS trusts and foundation trusts (£2.9 billion), PCTs (0.8 billion) and central budgets (the remaining £1.8 billion).

1.4 The Select Committee expressed an interest in the budget for medical training. Appendix One provides details of this budget, which strategic health authorities are responsible for.

Figure 2
The distribution of the Department of Health's resources for 2009-10



Source: Department of Health

Part Two

The allocation of funds to individual primary care trusts

2.1 Primary care trusts (PCTs) are responsible for commissioning healthcare services for their local population. They commission these services from a range of providers including acute trusts, foundation trusts, general practitioners (GPs), dentists, opticians, pharmacies, and private sector and voluntary sector organisations. They are responsible for over 80 per cent of the NHS revenue budget. The information provided in this section is based on allocations announced in December 2008 for 2009-10 and 2010-11.

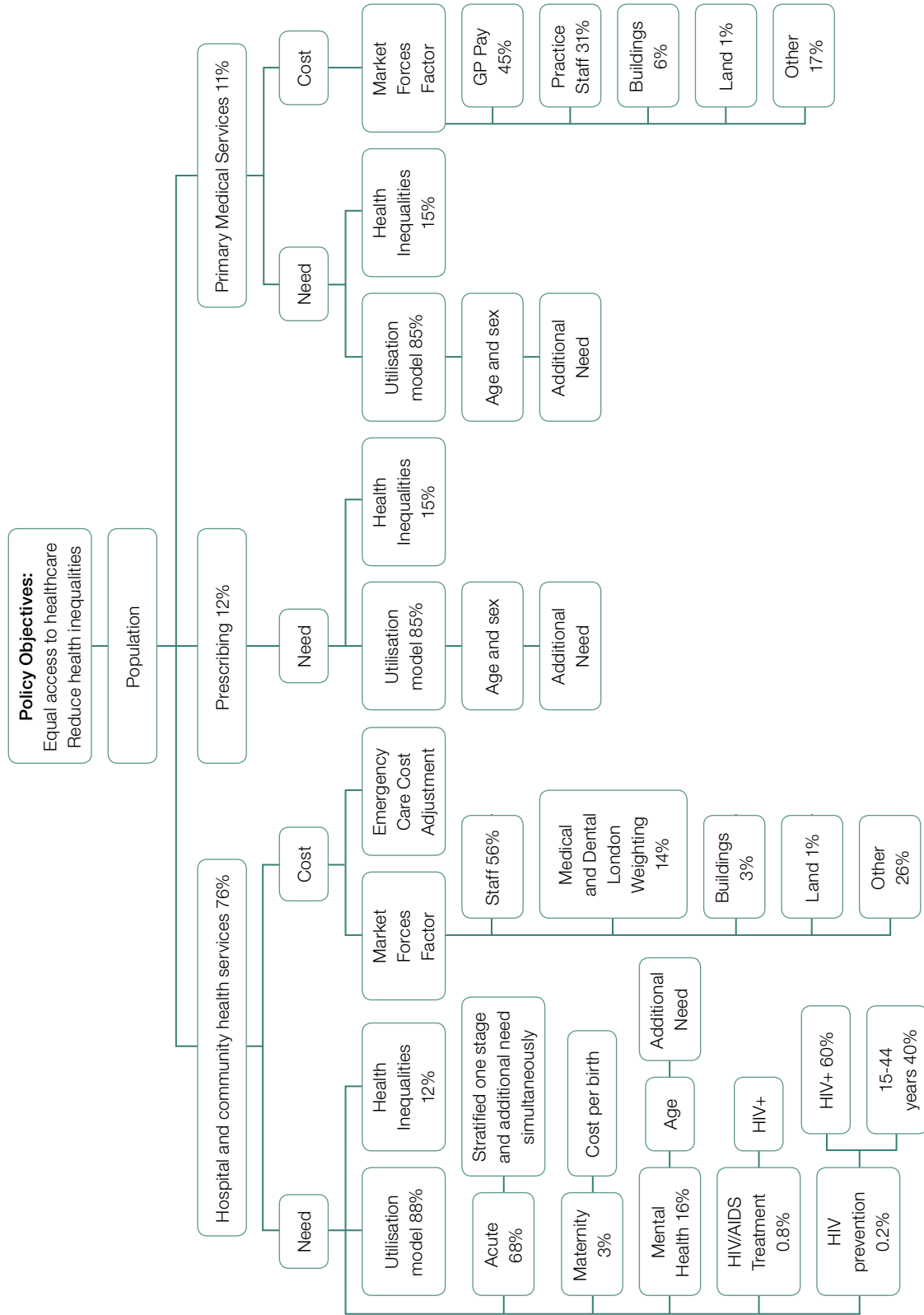
Weighted capitation formula

2.2 The Department has a long-standing commitment to allocate resources to PCTs, through a needs-based formula, known as the weighted capitation formula, which in 2008 aimed to ensure 'equal access to healthcare for people at equal risk' and 'to help reduce avoidable health inequalities'.

2.3 The national weighted capitation formula calculates PCTs' target shares of available resources based on PCT populations. In common with most other resource allocation methods used by other countries, the weighted capitation formula is designed to calculate the amount of money PCTs would need if, given their local characteristics, they were to deliver the national average package of health care to their citizens, with no adjustment for relative efficiency. The formula has three components (**Figure 3** overleaf):

- Hospital and community health services (accounting for over 76 per cent of the formula) which has separate need formulas for acute services, maternity, mental health and HIV/AIDS.
- Prescribing (12 per cent).
- Primary medical services (11 per cent).

Figure 3
Weighted capitation formula 2009-10 and 2010-11



2.4 The starting point of the formula is the population count. Each PCT's "crude" population is then adjusted, or weighted, according to its relative need (age, and additional need – an adjustment to reflect the effect of health status and socio-economic deprivation on a population's healthcare needs based on analyses of existing patterns of healthcare utilisation). There is also an adjustment for any unavoidable variations in the cost of providing healthcare in different locations (the market forces factor).

2.5 Each of the components of the weighted capitation formula has adjustments for age, additional need and unavoidable costs, with the exception of prescribing which has no adjustment for unavoidable costs. The weighted capitation formula has evolved over time and currently the Advisory Committee on Resource Allocation advises the Secretary of State for Health on the formula. The Committee is an independent body whose membership includes individuals with a wide range of expertise from within, and outside, the NHS.

2.6 The weighted capitation formula sets the amount of funding a PCT should receive – its target allocation. Historically, however, many PCTs have received less funding than their needs as calculated by the formula, while some have received more. If the target allocation is greater than their actual allocation a PCT is said to be under target and vice-versa for those PCTs which are over target; where the target allocation is smaller than the actual allocation. Under the pace of change policy, PCTs are moved towards their target allocations over a period of time to avoid financially destabilising PCTs which are over target and to support long-term planning.

2.7 The pace of change policy is part of wider deliberations annually by Ministers to determine the level of overall funding which PCTs will receive to deliver national and local priorities. It also determines the level of extra resources to PCTs which are under target to move them closer to their weighted capitation targets. For example, the pace of change policy for 2009-10 and 2010-11 is on the basis that:

- average PCT growth is 5.5 per cent each year;
- minimum growth is 5.2 per cent in 2009-10 and 5.1 per cent in 2010-11;
- no PCT will be more than 6.2 per cent under target by the end of 2010-11; and
- no PCT will move further under target as a result of above average population growth in 2010-11.

2.8 The weighted capitation formula is a sophisticated method for allocating public funds. The King's Fund have noted that while it has a major impact on how much is spent in different areas of the country, there is little public understanding of the technicalities of the formula.¹

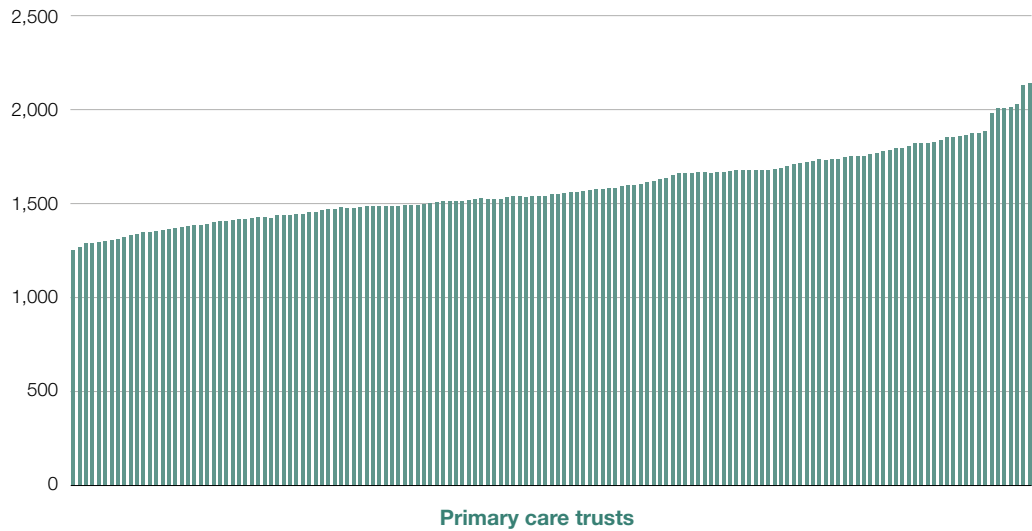
2.9 **Figure 4** overleaf shows that the allocation per head of population for 2009-10 across PCTs varied between £1,253 and £2,143, with an average of £1,540. The allocation per head varied regionally between the ten strategic health authorities, from £1,354 in South Central to £1,724 in the North East (**Figure 5** overleaf).

¹ John Appleby, *Winners and losers in PCT funding shake up*, King's Fund, December 2008.

Figure 4

Variations in allocation per head, 2009-10

Allocation per head of population (£)



Source: National Audit Office analysis of Departmental data

Figure 5

Regional variations in allocation per head, 2009-10

Strategic health authority	Allocation per head (£)	Distance from target (%)
North East	1,724	-2.2
London	1,714	8.0
North West	1,675	-1.1
West Midlands	1,545	-2.5
Yorkshire and the Humber	1,532	-3.2
South East Coast	1,496	4.1
South West	1,444	-1.0
East Midlands	1,430	-5.5
East of England	1,402	-1.9
South Central	1,354	1.7

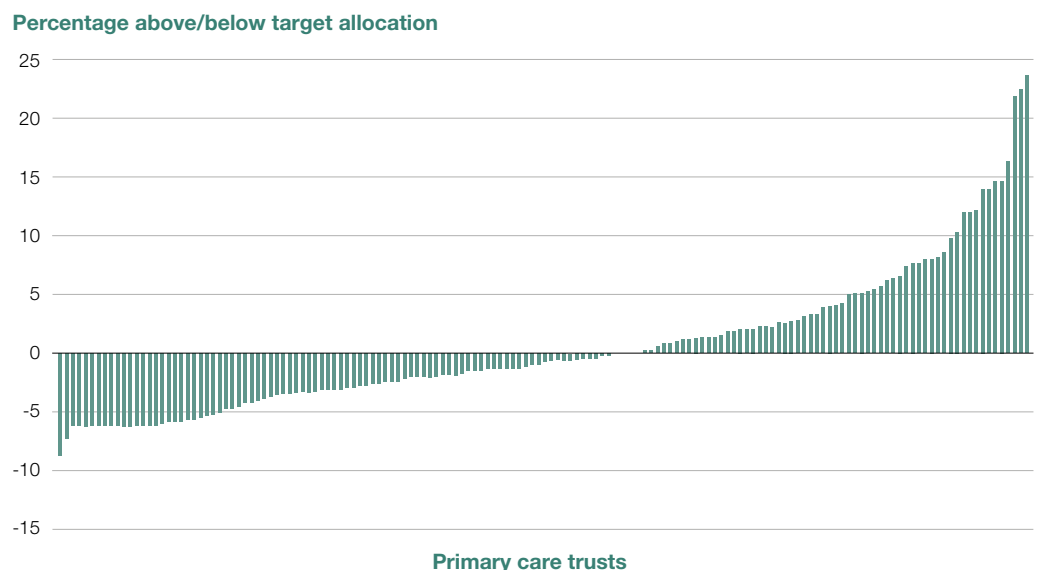
Source: National Audit Office analysis of Departmental data

2.10 In 2009-10, 59 per cent of PCTs were below their target allocation (**Figure 6**). There are considerable regional variations in distance from target (Figure 5); allocations to PCTs in the London region are, as a group, 8 per cent above target, whereas those in Yorkshire and the Humber are 3.2 per cent below target and those in the East Midlands are 5.5 per cent below target.

2.11 A group of 70 local authority areas with high levels of deprivation and poor health outcomes are known as spearhead areas. Our value for money report on health inequalities² found that 68 per cent of PCTs in these spearhead areas will still not receive their full needs-based allocations in 2010-11 (**Figure 7** overleaf). PCTs in these spearhead areas also display regional variations in distance from target highlighted in the previous paragraph; the spearhead PCTs that are funded above their target level are almost exclusively in London, while spearhead PCTs in East Midlands and Yorkshire and Humber are furthest below target.

2.12 There are both rural and urban PCTs which are under and over target, defined by population density. Rural PCTs are more likely to be below target allocation than urban trusts (**Figure 8** overleaf), though this pattern is not evident if London PCTs are excluded. Over three-quarters of PCTs ranked in the lowest fifth in terms of population density are below target.

Figure 6
Distance from target allocations, 2009-10



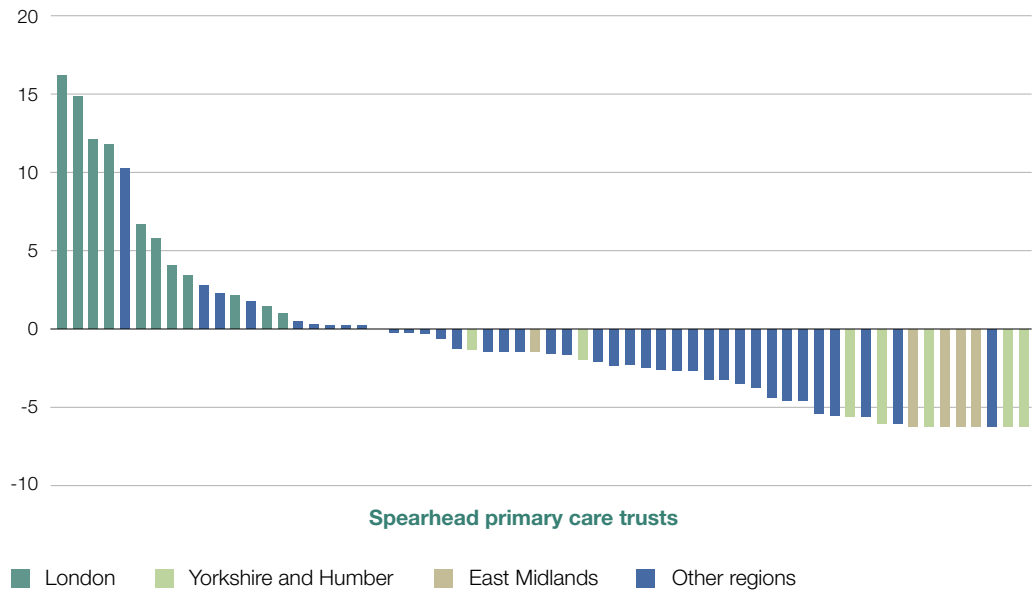
Source: National Audit Office analysis of Departmental data

² C&AG's report, *Tackling health inequalities in life expectancy in areas with the worst health and deprivation*, HC 186 Session 2010-11, July 2010.

Figure 7

Many spearhead PCTs will still be below target allocation for funding in 2010-11

Percentage above/below target allocation

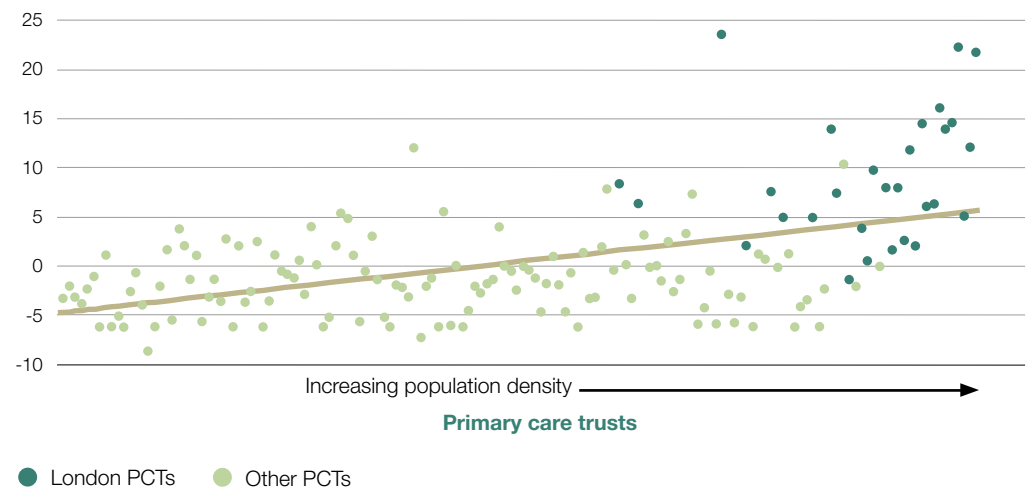


Source: C&AG's report, *Tackling health inequalities in life expectancy in areas with the worst health and deprivation*, HC 186 Session 2010-11, July 2010

Figure 8

Variation in distance from target with respect to population density

Percentage above/below target allocation



NOTE

1 PCTs are ranked according to population density.

Source: National Audit Office analysis of Departmental and Office for National Statistics data

Part Three

How primary care trusts spend their money

3.1 Under the model of devolved decision making PCTs have been largely free to decide how they spend the funds allocated to them by the Department. While the resource allocation model determines PCTs individual target allocations (see Part Two), there is little or no obligation on their part to spend their budgets in line with the factors and elements which determine their budgets in the first place. The ten strategic health authorities performance manage the PCTs in their region and are required to approve the plans of PCTs. The main aim of this oversight is to ensure that the objectives set for the NHS by the Government, through the NHS Operating Framework, are achieved.

3.2 Individual PCT's Boards are responsible for approving all budgetary plans. Many PCTs also have Resource Oversight Committees, which are sub-committees of the Board and oversee allocation decisions. Professional Executive Committees (consisting primarily of clinicians) are also involved in oversight of resource allocation, allowing clinical involvement in budget setting. Budgets are usually set once per financial year, ahead of the beginning of the financial year. Commissioners report to the Board on a regular, often monthly basis, to provide in year progress updates on performance against plans and resources.

3.3 The majority of a PCT's allocation is spent on general and acute secondary care services and primary care services (**Figure 9** overleaf). Primary care refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. Around 90 per cent of peoples' contact with the NHS is with these services:

- GPs and practice nurses see over 800,000 people a day.
- Dentists see around 250,000 NHS patients a day.
- An estimated 1.6 million people visit a pharmacy each day, of whom 1.2 million do so for health-related reasons.
- There are 31,000 NHS sight tests carried out each day.

Secondary care is specialist care, typically provided in a hospital setting or following referral from a primary care or community health professional. Acute healthcare covers elective care or emergency care.

Figure 9

Breakdown of percentage of primary care trust expenditure by type of service

Area of care	2007-08 (%)	2008-09 (%)	2009-10 (%)	Change in percentage of total between 2007-08 and 2009-10 (%)
General and acute secondary care	42.6	43.2	44.8	+2.2
Primary care	27.1	25.2	23.8	-3.3
Mental illness	10.2	10.5	9.7	-0.5
Community health services	8.9	9.5	9.6	+0.7
Other contracts	3.0	3.1	3.4	+0.4
Learning difficulties	3.3	3.2	3.0	-0.3
Maternity	2.5	2.6	2.9	+0.4
Accident and emergency	2.5	2.5	2.5	0.0

Source: National Audit Office analysis of primary care trust accounts

3.4 Over the last three years, PCTs have been spending an increasing proportion of their allocation on general and acute secondary care and a decreasing proportion on primary care (Figure 9). The proportion of the allocation spent on community health services and maternity services has also increased over this period, but has decreased on services for those with mental illness and learning difficulties.

3.5 **Figures 10 and 11** show the variation in spend on primary care and general and acute secondary care services across PCTs. The range of spend across PCTs has changed little over the three year period – 2007-08 to 2009-10.

Figure 10

Primary care trust spend on primary care, 2009-10

Percentage of spend on primary care

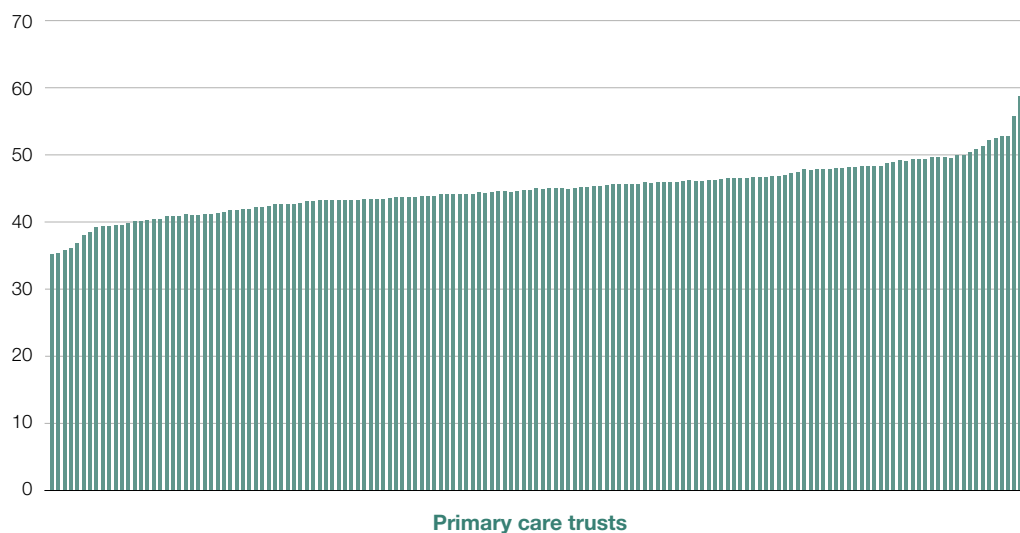


Source: National Audit Office analysis of primary care trust accounts

Figure 11

Primary care trust spend on general and acute secondary care, 2009-10

Percentage of spend on general and acute secondary care



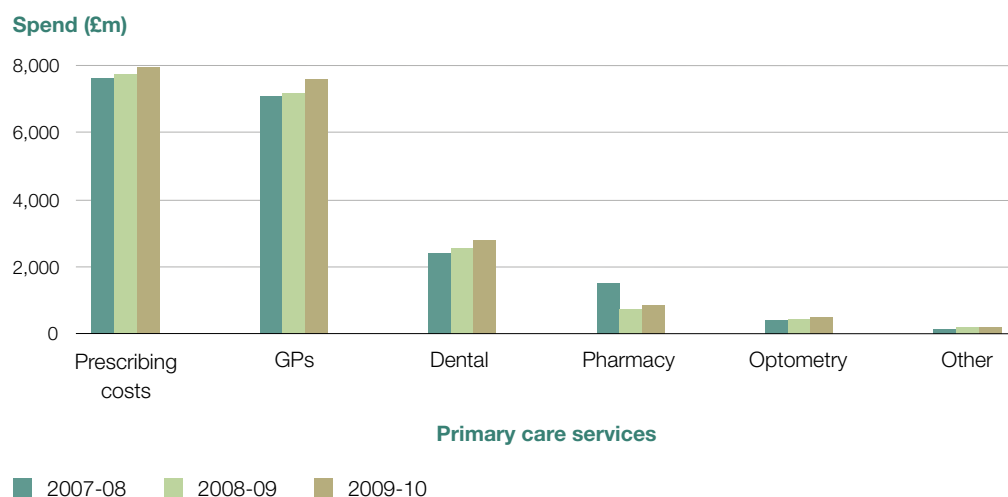
Source: National Audit Office analysis of primary care trust accounts

3.6 Figure 12 shows a breakdown of PCT spend on different primary care services. The vast majority of spend is accounted for by GPs (38 per cent) and prescribing costs (40 per cent). The only primary care service where spend has decreased over the last three years is pharmacy services, which halved between 2007-08 and 2008-09.

3.7 Services provided by hospitals are paid for through the nationally-set Payment by Results (PbR) regime, introduced in 2003-04, and locally-agreed block contracts or tariffs for the remainder of activity. Payments through PbR are based on a national price for a given unit of activity multiplied by the number of patients treated. The price for each treatment is determined using cost information, termed 'reference costs', provided by all hospitals in England. The price for a procedure is then largely set based on the relative average cost of that procedure compared to other procedures, adjusted to take into account inflation and other cost pressures (such as increases in pay) and efficiency expectations (currently 3.5 per cent).

3.8 PCTs told us that where possible they benchmark their expenditure against that of other comparable PCTs, in order to test the reasonableness of their spending. They may benchmark the expenditure of their providers to identify areas where efficiency and productivity can be improved and to judge the relative value for money of different providers.

Figure 12
Breakdown of total primary care trust spend on primary care



Source: National Audit Office analysis of primary care trust accounts

3.9 However, a common theme from our value for money work is that PCTs lack data against which they can benchmark themselves. For example, our report on young people's sexual health³ found that PCTs had limited benchmarks to guide their spending. Our report on end of life care⁴ found that commissioning end of life services is complex and there is a limited understanding of the national picture of demand and supply of end of life care services. We recommended that the Department should provide more information and, as appropriate, guidance to assist PCTs to meet end of life care needs and allocate resources more efficiently and effectively by building on the evidence from our work.

3.10 Since 2003-04, the Department has collected cost data from PCTs to map their expenditure to 23 programmes of care, including circulatory diseases, respiratory diseases, cancers and tumours and mental health. These 23 programmes of care are based on the World Health Organisation's International Classification of Diseases (ICD10). These data, known as programme budgeting data, are intended to inform commissioning decisions by making PCTs question their expenditure and consider the most efficient and effective way of delivering services.

3.11 **Figure 13** overleaf shows a breakdown of PCT expenditure by the 23 programme budgeting categories. Over the three year period, 2006-07 to 2008-09, PCTs have been spending an increasing proportion on social care needs and neurological conditions, whilst the proportion spent on circulatory diseases, gastrointestinal conditions genitourinary conditions and maternity and reproductive health has decreased.

3 C&AG's report, *Young people's sexual health: the national Chlamydia screening programme*, HC 963 Session 2008-09, November 2009.

4 C&AG's report, *End of life care*, HC 1043 Session 2007-08, December 2008.

Figure 13

Breakdown of primary care trust expenditure by programme budgeting categories

Category	2006-07 (%)	2007-08 (%)	2008-09 (%)	Change in percentage between 2006-07 and 2008-09
Other areas of spend/other conditions	26.8	27.3	25.7	-1.1
Mental health	10.8	11.0	10.8	0.0
Circulation (cardiovascular diseases)	8.2	7.8	7.6	-0.5
Cancers and tumours	5.2	5.3	5.3	+0.1
Respiratory system	4.2	4.1	4.4	+0.2
Musculoskeletal system (excluding trauma)	4.2	4.4	4.4	+0.2
Gastrointestinal system	4.6	4.4	4.2	-0.3
Genitourinary system	4.5	3.9	4.1	-0.3
Neurological system	3.5	3.7	3.8	+0.3
Trauma and injuries (includes burns)	3.6	3.3	3.4	-0.1
Social care needs	2.0	2.2	3.3	+1.2
Dental	3.1	3.2	3.2	+0.1
Maternity and reproductive health	3.5	3.2	3.2	-0.3
Learning disability	3.0	3.1	3.0	+0.1
Endocrine, nutritional and metabolic	2.5	2.6	2.6	+0.1
Healthy individuals	1.8	1.9	2.0	+0.2
Skin problems	1.8	1.8	1.9	0.0
Eye/vision needs	1.6	1.7	1.7	+0.1
Infectious diseases	1.5	1.4	1.5	-0.1
Blood disorders	1.2	1.3	1.3	+0.1
Neonate conditions	1.0	1.0	1.1	+0.2
Poisoning	0.9	0.9	1.0	+0.1
Hearing problems	0.4	0.5	0.4	0.0

NOTE

1 Since first collected, refinements have been made to the programme budgeting methodology in order to improve data quality. The underlying data which support programme budgeting data are subject to yearly changes. Caution is, therefore, advised when using programme budgeting data to draw conclusions on changes in PCT spending patterns between years.

Source: National Audit Office analysis of programme budgeting data

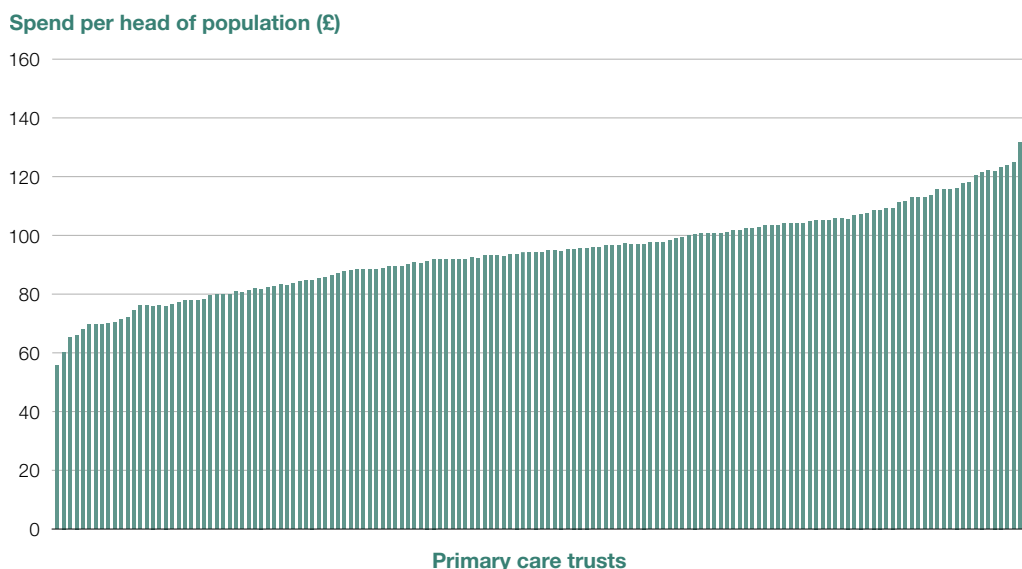
Case study: cancer services

3.12 Our 2010 report on cancer services⁵ found that reported PCT expenditure on cancer services varied from £55 to £154 per head of population in 2008-09 (**Figure 14**). Similar variations are found for all high-spend budget categories. For example, the difference in level of expenditure per head of population, in 2008-09 between the highest and lowest quintiles of PCTs was £24.20, £27.70 and £16.80 for cancer services, services for circulatory diseases and gastrointestinal services respectively.

3.13 We examined the variations in expenditure on cancer services and found that around 23 per cent of the variation could be explained by the number of cancer patients in the PCT area, the extent of inpatient activity, and local market price factors such as staff pay. A further 20 per cent could be accounted for by the needs-based formula the Department uses to allocate resources to PCTs, while 3 per cent could be explained by PCT size (as spend per head of population decreases as the size of the PCT increases). We could not identify an explanation for the remaining 54 per cent. For example, even though surgery, chemotherapy and radiotherapy are the main treatments for cancer, we did not find any correlation between recorded PCT activity in these areas and reported PCT spend. Some of the variation may also be due to PCTs simply choosing to spend more on cancer.

Figure 14

Primary care trust spend per head on cancer services



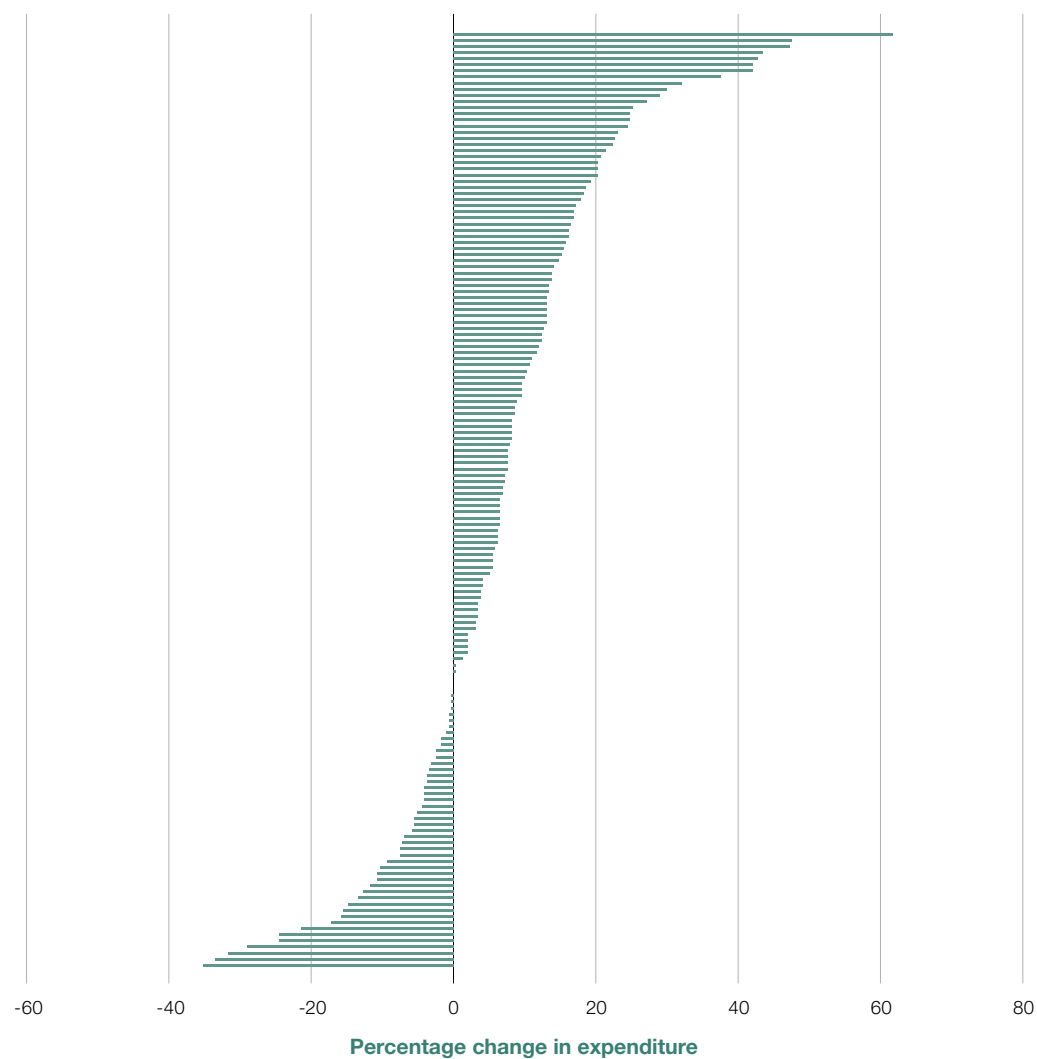
Source: National Audit Office analysis of programme budgeting data

5 C&AG's report, *Delivering the cancer reform strategy*, HC 568 Session 2010-11, November 2010.

3.14 The Kings Fund⁶ reported that there were large variations in PCTs' (programme budgeting) spending per head on cancer services between PCTs for every financial year between 2004-05 and 2008-09. The ratio between the maximum and minimum spending PCTs has been reduced from about 4 to 2.5. However, there have been minimal changes in other measures such as the ratio between the top and bottom deciles or top and bottom quartiles, or standard deviation. There have also been inexplicable large fluctuations in spending per head for the same PCT from year to year (**Figure 15**).

Figure 15

Percentage change in reported primary care trust spending per head of population on cancer services between 2007-08 and 2008-09



NOTE

1 Each bar represents a primary care trust.

Source: C&AG's report, *Delivering the cancer reform strategy*, HC 568 Session 2010-11, November 2010

6 John Appleby et al. *Explaining variations in Primary Care Trusts' spending on cancer services*, Kings Fund 2010.

3.15 There are concerns, however, about the quality of programme budgeting data. In 2008, we found⁷ that there was scope for improvement in the robustness of the data. There were large variations in the time spent preparing the data by hospital trusts and PCTs, ranging from two to over 200 hours, and in the seniority of staff involved in the review of the data. Our 2010 report on cancer services⁸ found that many PCTs lacked confidence in the cost data they had, with 41 per cent stating that it was not useful in informing decisions about delivering cancer services in different ways.

Specialised commissioning

3.16 Although most services in the NHS are currently commissioned by local PCTs, there are different arrangements for commissioning specialised services. A specialised service is defined as a service which covers a planning population (catchment area) of more than a million people. This means that generally a specialised service would be provided by less than 50 hospitals in England. NHS Specialised Services is a national organisation responsible for the commissioning of specialised services and each PCT contributes some of its budget to funding specialised services.

3.17 In England, there are ten specialised commissioning groups that commission specialised services for their regional populations, which range in size from 2.8 million people to 7.5 million people. Services include those for severe burns, children's and young people's cancers and haemophilia. In 2009-10, £4.9 billion was spent on commissioning these services. A national specialised commissioning group facilitates working across these ten groups at a regional and supra-regional level.

3.18 About 60 highly specialised services are commissioned nationally by NHS Specialised Services, such as heart, liver and lung transplants. These are services that generally affect fewer than 500 people across England or involve services where fewer than 500 highly specialised procedures are undertaken each year. In 2009-10, £0.5 billion was spent on commissioning these services. The Advisory Group for National Specialised Services is a committee that advises health ministers on which services should be nationally commissioned and the centres that should provide them.

⁷ National Audit Office, *Good Governance Report: review of Programme Budgeting*, 2008.

⁸ C&AG's report, *Delivering the cancer reform strategy*, HC 568 Session 2010-11, November 2010.

Part Four

How local authorities spend their social care funding

4.1 Local authorities (councils with adult social services responsibilities) receive central government funding for social care from the Department for Communities and Local Government. They also receive funding from other sources, for example through grants from the Department of Health, service user and client contributions and council tax. In 2008-09, local authorities' net spend on social care was £13.6 billion (excluding supporting people funding which aims to offer vulnerable people the opportunity to improve their life through greater independence). This represents 12 per cent of their total net current expenditure of £113.1 billion. The net cost of £13.6 billion is reached after offsetting £3.9 billion of income (including joint arrangements with other local authorities) from other sources including £1.2 billion from the NHS and £2.2 billion from sales, fees and charges.⁹

4.2 Local authorities, allocate this funding based on locally agreed and nationally determined eligibility criteria which includes an assessment of care needs and means (testing). Other adjustments allow for demographic changes, investment in prevention and early intervention services and other local priorities for example uptake of direct payments and personal budgets. Direct cash payments enable individuals to arrange their own services, rather than the local authority social services department providing or arranging the community care services it has assessed the individual as needing. A personal budget is a sum of money allocated to an individual who is assessed as needing personal assistance and support services, in a non-urgent situation.

4.3 Local authorities commission the majority (around two-thirds) of their social care services expenditure externally from the independent sector.

4.4 Adult social care is provided to five client categories:

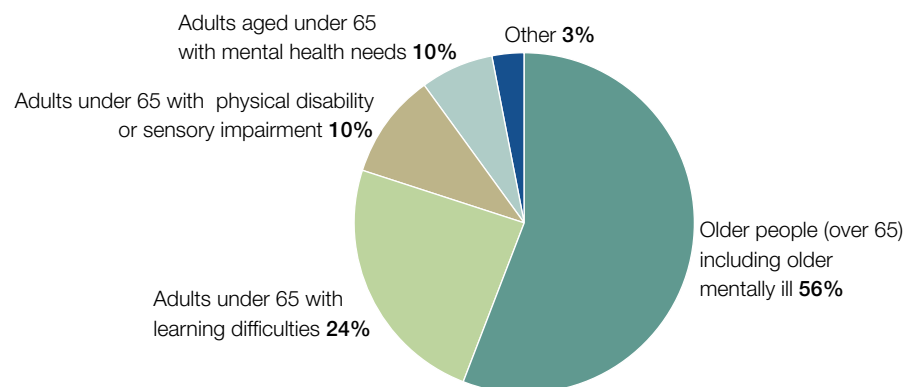
- Older people (aged 65 or over) including older mentally ill.
- Adults aged 18-64 with a physical disability or sensory impairment.
- Adults aged 18-64 with learning disabilities.
- Adults aged 18-64 with mental health needs.
- Other adult services and asylum seekers.

⁹ Social Care Statistics 2008-09, published by CIPFA.

4.5 Figure 16 shows a breakdown of the gross expenditure on social care by client group. Over half is spent on older people and almost a quarter is spent on adults under 65 years of age with learning difficulties. Services for adults under 65 years of age with learning difficulties are accounting for an increasing percentage of total expenditure (20.9 per cent in 2003-04 to 23.7 per cent in 2008-09). Services for older people, on the other hand, are accounting for a decreasing percentage of total expenditure (59.1 per cent in 2003-04 to 56.5 per cent in 2008-09).

4.6 The elected members, or councillors, of local authorities have the ultimate responsibility for local authority budgetary approval. A departmental management team puts together its business case for the local authority's health and social care budget, which is then reviewed by the Overview and Scrutiny Committee and the Local Authority Cabinet. Budgets are set once per financial year, with some flexibility to revise the budget if necessary. Generally, however, overspends or underspends are reported to members and the lessons learned are fed into next year's budget setting process. Budget holders report to senior management every month. A finance report is submitted to the Cabinet, also on a monthly basis; this finance report includes details of any variances from the budget. Local authority scrutiny groups such as a Community Services Scrutiny and Performance Panel also review expenditure to ensure it is in line with local authority strategy and objectives.

Figure 16
Breakdown of social care expenditure by client group, 2008-09



NOTE

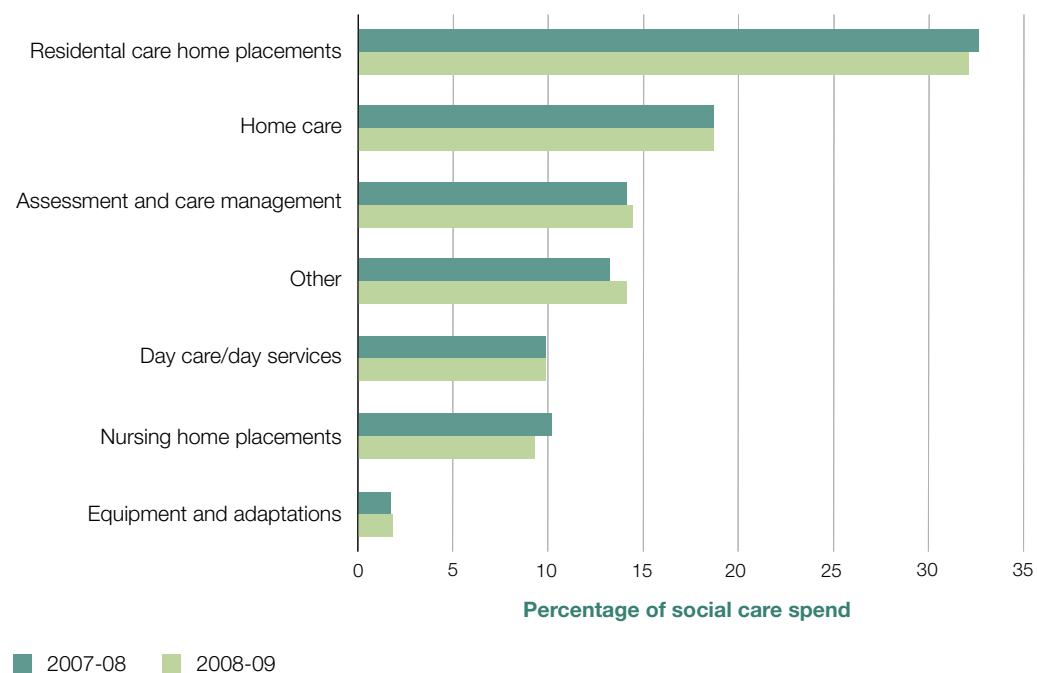
1 Other includes services for asylum seekers and services strategy.

Source: National Audit Office analysis of social care statistics published by the NHS Information Centre

4.7 Figure 17 show a breakdown of social care spend by type of provision for 2007-08 and 2008-09. Residential care home placements and home care account for about half of all expenditure.

Figure 17

Breakdown of spend on social care by type of provision



NOTE

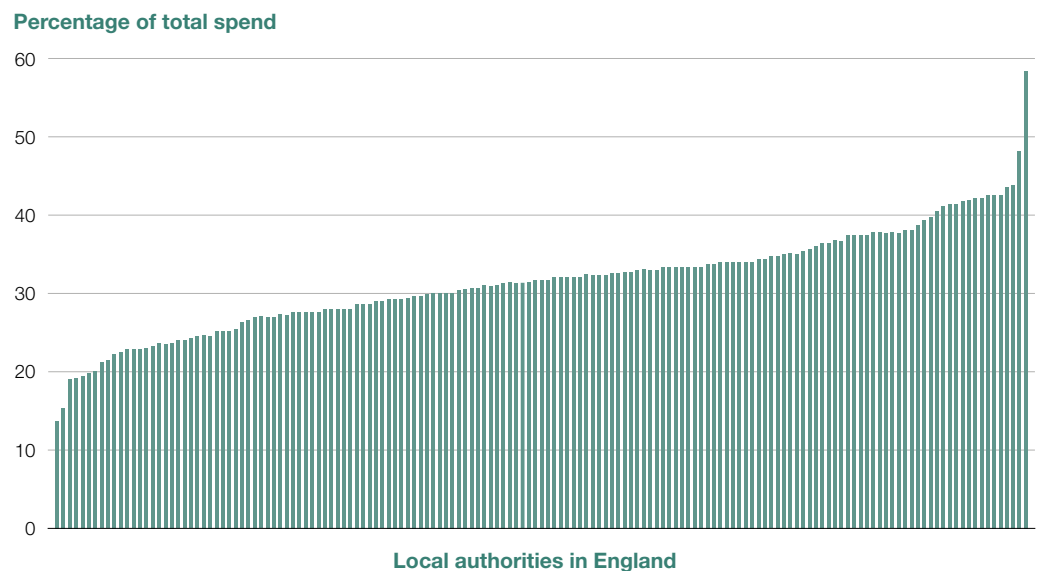
1 The 'other' category includes: adult services strategy, supported and other accommodation, direct payments, meals, HIV/AIDS, asylum seekers (lone parents and substance abuse).

Source: National Audit Office analysis of social care statistics published by the Chartered Institute for Public Finance and Accountancy

4.8 Figure 18 shows the variations in local authority spend as a percentage of total spend for residential care home placements in 2008-09. For each type of provision there is considerable variation (**Figure 19** overleaf). These variations were explored in the Department's publication, *Use of resources in adult social care*,¹⁰ which aimed to help and encourage local authorities to understand their patterns of spend in adult social care and ensure that this spend matches their local priorities. It provided good practice examples from local authorities that had already demonstrated good use of resources across the provision of adult social care services. Spend on each type of provision, as a percentage of total spend has changed little between 2007-08 and 2008-09.

Figure 18

Variation in local authorities' spend on residential care home placements, 2008-09

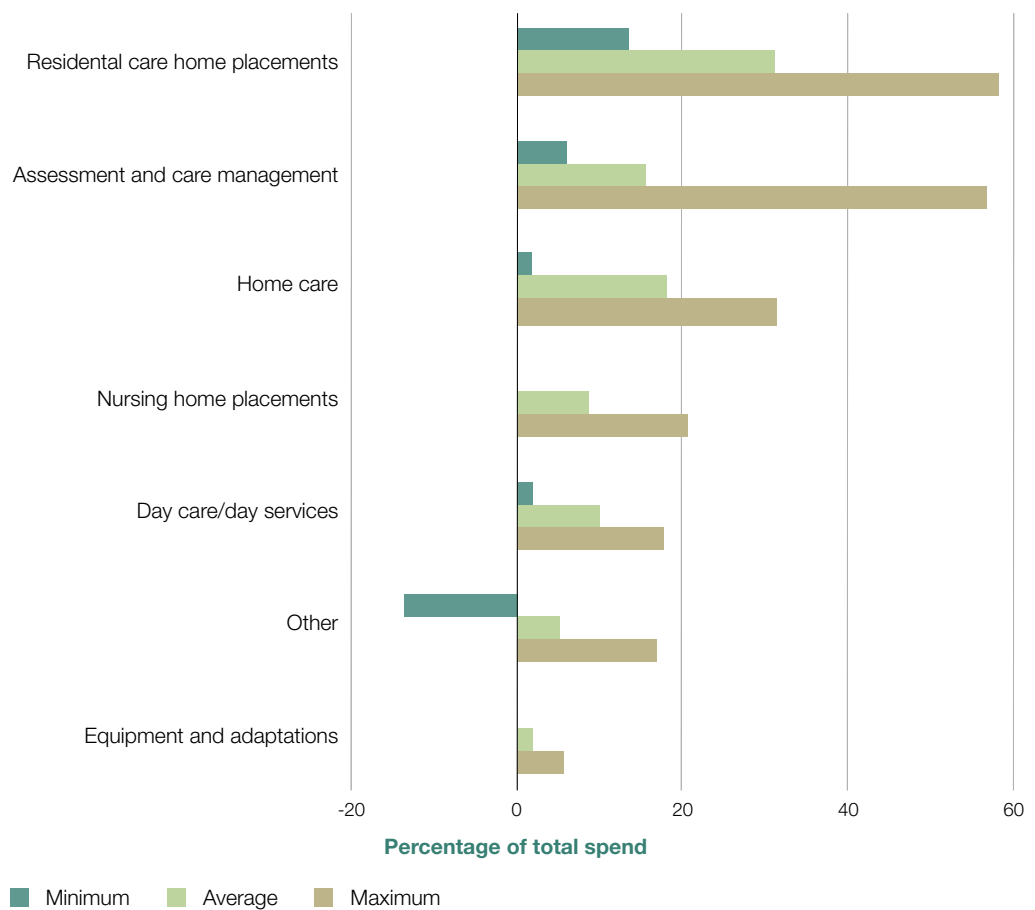


Source: National Audit Office analysis of social care statistics published by the Chartered Institute for Public Finance and Accountancy

10 Department of Health, *Use of resources in adult social care; a guide for local authorities*, October 2009.

Figure 19

Variation in local authorities' spend by types of provision for social care, 2008-09



NOTE

1 Nil returns have been excluded from this analysis but negative costs (income) are included.

Source: National Audit Office analysis of social care statistics published by the Chartered Institute for Public Finance and Accountancy

Part Five

The interface between primary care trusts and local authorities

5.1 PCTs and local authorities share a common responsibility to their local population, despite the constitutional and organisational differences between them. They are both charged with securing better outcomes for health and wellbeing. In order to work towards these goals, there are joint working arrangements in place. Examples of services jointly commissioned by PCTs and local authorities include children's services, services for those with learning disabilities, mental health services and services for elderly people.

5.2 Since 2007, PCTs and local authorities have been required (a statutory requirement) to produce a Joint Strategic Needs Assessment of the health and wellbeing of their local community. The assessment is intended to identify current and future health and wellbeing needs in light of existing services, and inform future service planning, taking into account evidence of effectiveness. It encourages joined-up strategic planning by local authorities and their partner organisations. The assessment fed into a Local Area Agreement, which set out the priorities for a local area and how these would be tackled in partnership. Local Area Agreements were scrapped by the Coalition Government in 2010.

5.3 In our discussions with a number of PCTs and local authorities, they reported that integrated working and joint commissioning had increased in the last few years and provided a number of examples of how effective joint working was being facilitated:

- They have reciprocal places on each other's committees.
- Representatives from the PCT may meet as a board with the council's cabinet in order to facilitate better joint working.
- Many Directors of Public Health are joint posts.
- Their finance departments meet regularly, usually around once per quarter.
- They shared targets e.g. NHS vital signs indicators.
- Their Chief Executives meet regularly.

5.4 PCTs and local authorities told us that plans at the interface are made jointly with extensive consultation between both organisations' staff. Staff from these organisations reported that determining who is responsible for what expenditure can be somewhat of a grey area. In most cases, responsibility for expenditure is covered by each organisation's strategy and budget. However, where the boundaries are more blurred, there are several ways of resolving the issue. Some services, for example children's services, are commissioned on a joint basis. Sometimes the PCT and the local authority both invest in a project, for example the co-funding of capital developments which will have benefits for both health and social care. If the PCT is funding social care services, the local authority will grant the PCT a health and wellbeing grant.

5.5 PCTs and local authorities told us that one of the most difficult issues to resolve occurs when the cost is incurred in one organisation and benefit realised in the other. For example, people can leave hospital earlier than they otherwise would if they have additional home support provided by the local authority. In this case, the cost is incurred by the local authority but the benefit is received by the hospital which has a reduced length of stay for these patients. In these cases, joint working and discussion is necessary to determine how the costs are allocated between the PCT and local authority. Criteria are often put in place to determine who bears which costs as individual situations arise throughout the financial year. Many PCTs and local authorities also utilise Total Place budgets, which pool resources in a local area to allow more flexibility in meeting people's needs.

5.6 A number of recent National Audit Office value for money reports have highlighted issues relating to the interaction between PCTs and local authorities on health and social care, and these are set out below.

5.7 For our recent report on health inequalities,¹¹ we undertook a survey of spearhead PCTs and local authorities, which asked a number of questions relating to partnership working. The two biggest factors for both spearhead PCTs and local authorities in making partnership working more effective in tackling health inequalities over the last five years were the identification of health inequality priorities in Local Area Agreements and the creation of joint posts, such as Directors of Public Health. Other important factors were shared objectives, national targets to reduce health inequalities and the quality of personal relationships.

5.8 The post of Director of Public Health was a joint appointment between the PCTs and the local authority (or authorities) in 86 per cent of the spearhead PCTs who responded to the survey. More than 50 per cent of spearhead PCTs also had joint appointments with their local authority (or authorities) for other public health positions and for commissioning posts. Joint appointments are a recent trend; almost two-thirds of joint Directors of Public Health in spearhead areas have been appointed since the beginning of 2006.

¹¹ C&AG's report, *Tackling health inequalities in life expectancy in areas with the worst health and deprivation*, HC 186 Session 2010-11, July 2010.

5.9 Both PCTs and local authorities in spearhead areas reported that over the last five years the factor having the biggest impact in holding back partnership working to address health inequalities was that the pay offs from tackling health inequalities were realised over long timescales (e.g. 15-20 years). PCTs reported that organisations having different objectives and not knowing what works in tackling health inequalities were also important factors holding back work to tackle health inequalities. Local authorities reported that financial constraints and a lack of public health infrastructure in their organisations were important factors.

5.10 Our 2007 report on dementia services¹² found that a lack of joined-up health and social care planning and delivery was a barrier to improvements in dementia. Our 2010 follow up report¹³ found that although joined-up working between health and social care, commissioners and providers, was also a core principle of the Department's management model, it remained very patchy. As a result, people with dementia were still being unnecessarily admitted to hospital, having longer lengths of stay and entering residential care prematurely. While we found examples of good practice, these were not being adopted widely.

5.11 Our 2009 report on autism¹⁴ found that autism was not being prioritised in Joint Strategic Needs Assessments. Over 90 per cent of local authorities responding to the report's survey said they had a Joint Strategic Needs Assessments in place, but only 21 per cent of these said that it included specific information on the needs of people with autism. As a consequence, autism needs in the community were being overlooked by local authorities and a clear picture of need, such as robust data on numbers of people with autism in the area, was not available in many cases. The Autism Strategy, *Fulfilling and rewarding lives*, published by the Department in March 2010, provides guidance to local authorities to help them commission services for adults with autism more effectively and the Department plans to issue further guidance in December 2010.

5.12 Similarly, our 2008 report on reducing alcohol harm¹⁵ found that a significant minority – 22 per cent – of PCTs had not carried out a local needs assessment for alcohol services since January 2004. This is despite the fact that, along with local authorities, they are required to undertake a Joint Strategic Needs Assessment of the future health and wellbeing needs of the local population.

¹² C&AG's report, *Improving service and support for people with dementia*, HC 604 Session 2006-07, July 2007.

¹³ C&AG's report, *Improving dementia services in England – interim report*, HC 82 Session 2009-10, January 2010.

¹⁴ C&AG's report, *Supporting people with autism through adulthood*, HC 556 Session 2008-09, June 2009.

¹⁵ C&AG's report, *Reducing alcohol harm: health services in England for alcohol misuse*, HC 1049 Session 2007-08, October 2008.

5.13 Our 2008 report on end of life care¹⁶ concluded that coordination between health and social care services in relation to the planning, delivery and monitoring of end of life care was generally poor and was hampered by different funding streams. It noted that a lack of integrated services and an absence of a single point of contact to coordinate care could lead to particular frustration for patients. The report also found that there was considerable variation between PCTs in how specialist palliative care services are commissioned and in the availability of such services to the local population. We recommended that when working with local authorities in carrying out Joint Strategic Needs Assessments and developing priorities for Local Area Agreements, Directors of Public Health should monitor whether the current provision of end of life care services and the needs of the local population are fully assessed and gaps addressed.

5.14 The Department noted that the quality of Joint Strategic Needs Assessments has developed considerably over the last two and a half years with many places now using a third generation Joint Strategic Needs Assessment. In addition, it is important to recognise that these assessments allow local partnerships to come to their own view of what local priorities are – this inevitably means that some issues are not seen as a priority. What is important is that local partnerships, through their Joint Strategic Needs Assessments, are clear about how priorities are reached. While there are good examples of this happening, the Department recognises that further development work is required in this area.

5.15 The Local Government Improvement and Development Agency, which works with local authorities in developing good practice and encouraging innovation, has recently completed work¹⁷ that explores the relationships between councils and PCTs. The agency found that although strong relationships exist in many parts of the country, over the past two years, progress has been interrupted in some places, and stretched to breaking point in others. The Improvement and Development Agency reported that this was due to an imperative to control health service deficits and the disruption associated with PCT mergers.

¹⁶ C&AG's report, *End of life care*, HC 1043 Session 2007-08, December 2008.

¹⁷ <http://www.idea.gov.uk/idk/core/page.do?pagelId=7314811>

Part Six

Maintaining services in a period of change

6.1 The way in which costs are reduced during implementation of change has a fundamental impact on the ability to maintain service levels. There will be a significant challenge in bringing about major structural change whilst achieving reductions in administration costs of 30 per cent and wider savings of £14 billion to £20 billion from NHS services.

6.2 The National Audit Office recently produced a report on machinery of Government changes which examines the costs and risks of such changes. It has also published two guides in this area focussing on:

- structured cost reduction; and
- managing staff costs in a period of spending reduction.

6.3 Our 2010 report, *Reorganising Central Government*,¹⁸ examined over 90 reorganisations of central government departments and their arm's length bodies that occurred between May 2005 and June 2009 and found that:

- **Reorganisation costs tend to be significant.** The report estimated the gross cost of the 51 reorganisations covered by the report's survey to be £780 million, equivalent to £15 million for each reorganisation and just under £200 million a year. It found that around 85 per cent of the total cost is for establishing and reorganising arm's length bodies. The main cost areas relate to staff, information technology and property.
- **The ability of central government bodies to identify reorganisation costs was very poor.** There was no requirement for central government bodies: to prepare and approve business cases for reorganisations; to set reorganisation budgets; and to disclose the costs of reorganisations after they happen.
- **Central government bodies were weak at identifying and systematically securing the benefits they hoped to gain from reorganisation.** No departments set metrics to track the benefits that should justify reorganisation. Arm's length bodies were better at setting metrics.

¹⁸ C&AG's report, *Reorganising Central Government*, HC 452 Session 2009-10, March 2010.

6.4 The report made a number of recommendations:

- For announcements of significant reorganisations, a statement should be presented to Parliament, quantifying expected costs, demonstrating how benefits justify these costs and showing how both will be measured and controlled.
- Intended benefits should be stated in specific measurable terms that enable their later achievement (or otherwise) to be demonstrated.
- The planned and actual costs of reorganisations should be separately identified within financial accounting systems so costs can be managed and subsequently reported.
- There should be a single team in government with oversight and advance warning of all government reorganisations; one with the skills and experience to exercise quality control over reorganisations.

6.5 In 2010 we published a short guide to structured cost reduction,¹⁹ which highlighted the fact that to meet current challenges, departments must look beyond immediate short-term 'efficiencies' and think more radically about how to take cost out of the business long-term. Cutting spending effectively requires departments to take a strategic overview to avoid an erosion of service quality in priority delivery areas. Departments should clearly prioritise what matters most, based on an accurate, realistic assessment of the costs, benefits and risks of the options.

6.6 An understanding of costs (inputs) should be linked to an understanding of value (outputs and outcomes). The concept of value should drive the organisation's strategic objectives and inform its cost reduction strategy. This will avoid inadvertent cuts to high-value, low-cost services.

6.7 The report also explains the trade off which exists between the implementation time/expense of cost reduction initiatives and the sustainability of those initiatives. For example, tactical "quick wins" such as process improvements can be quick and cheap to implement. However, the benefit is likely to be a one off or short-term gain, whereas, strategic cost reduction programmes may take longer to implement, but embed cost management and continuous improvement into the fabric of the organisation. These cost reductions are therefore sustainable in the long term and means that organisation can maintain the provision of services that are most cost-beneficial. **Figure 20** sets out the principles we expect departments to demonstrate to achieve the goal of structured cost reduction.

¹⁹ <http://web.nao.org.uk/search/search.aspx?Schema=&terms=structured+cost+reduction>

Figure 20

Principles of structured cost reduction

A data-driven approach to understanding, comparing and interrogating costs	Often departments do not have a good grip on the costs of their activities, and it is rare to see good information on the unit costs of outputs.
A change in organisational culture	Departments must question how they have always done things, and to be bold in developing alternative ways of doing business.
An analytical framework for assessing opportunities to reduce costs and understand cost levers	It is essential to understand the drivers of cost. Departments should use an analytical framework, with both quantitative and qualitative factors, to assess how to influence cost drivers for an optimal result.
An analysis of the cost to value ratio	An understanding of costs (inputs) should be linked to an understanding of value (outputs and outcomes). The concept of value should drive the organisation's strategic objectives and inform its cost reduction strategy. This will avoid inadvertent cuts to high-value, low-cost services.
A comprehensive risk assessment	Different approaches to reducing costs carry varying levels of risk. A major change programme may require significant capital investment and reconfiguration but with high risks attached; the improvement of existing business processes will have a lower risk profile.
A focus on realisation	All cost reduction programmes must focus on realising the savings through identifying, quantifying, delivering and measuring the real cost reductions.
Accountability	Boards should hold senior management accountable for strategic choices, implementing the cost reduction strategy and, ultimately, for achieving results.
A business as usual approach to cost reduction	Ideas for cost reduction and continuous improvement encouraged, tested, implemented and evaluated on an ongoing basis.

Source: National Audit Office, A short guide to structured cost reduction, 2010

6.8 In August 2010, we published a guide to *Managing staff costs in a period of spending reduction*.²⁰ The public sector as a whole employs around six million staff. NHS staff make up around 27 per cent of this total and “other health” staff around 6 per cent. The guide builds on the principles set out in our short guide to structured cost reduction and applies them to reducing staff costs. It highlights the importance of good management information in order to accurately cost activities, and understand the relationship between the drivers of costs and service outputs. It recommends a strategic information-driven approach be adopted; that high priority services with good cost to value ratios should be focused on, and demand for services managed. In this way services can be maintained as best as possible through periods of staff cost reductions.

6.9 The report sets out a four stage framework for managing staff costs in periods of spending reduction that is underpinned by the proper use of high quality management information:

- **Identifying and appraising options for staff cost reduction.** Using high quality information to establish a clear understanding of direct and indirect staff costs, identify staff cost reduction opportunities and appraise options for staff cost reduction.
- **Planning staff cost reduction.** This is underpinned by mapping future needs and current capability, building capability to address gaps, understanding the full costs and wider impacts of reducing capability and assessing the overall value for money of the cost reduction programme.
- **Delivering staff cost reduction.** This is underpinned by setting strong direction for the change programme, implementing the change programme and learning from the change programme.
- **Embedding a business as usual approach to staff cost management.** This is underpinned by using information to provide ongoing challenge to staff costs and expanding the ownership of staff cost management.

20 <http://web.nao.org.uk/search/search.aspx?Schema=&terms=managing+staff+costs>

Appendix One

Medical training

1 The allocated training budget, which strategic health authorities are responsible for, was £4.8 billion in 2009-10. Medical education falls into two categories:

- Undergraduate medical education, provided by Higher Education Institutions who run the medical schools. The institutions costs are met by the Department for Business, Innovation and Skills who pass the funding to the Higher Education Funding Council for England to administer. The costs to NHS trusts incurred as a result of having medical students on practice placement during their courses, is referred to as the Service Increment for Teaching, and is paid for by the NHS via the Multi Professional Education and Training budget.
- Postgraduate medical education and training, which is undertaken by doctors in training whilst working in the NHS after graduation, while also undertaking training as hospital specialists or GPs. This is also paid for via the Multi Professional Education and Training budget.

2 The Multi Professional Education and Training budget was created in 2001 and consists of four elements:

- Non-Medical Education and Training, which supports the pre-registration education and training of non-medical professionals and some part of their post-registration education and training.
- Medical and Dental Education Levy, which supports the cost of postgraduate medical and dental education.
- Medical Service Increment for Teaching.
- Dental Service Increment for Teaching.

3 **Figure 21** shows a breakdown of the Multi Professional Education and Training budget for the last three years. In 2009-10, the Medical and Dental Education Levy supported over 43,000 trainees and the Medical Service Increment for Teaching supported over 19,000 medical and dental undergraduates. The funding methodology for the Multi Professional Education and Training budget has been reviewed periodically since 2001.

Figure 21

The Multi Professional Education and Training budget for 2007-08 to 2009-10

	2007-08 (£m)	2008-09 (£m)	2009-10 (£m)
Non-Medical Education and Training (NMET)	1,797	1,895	2,000
Medical and Dental Education Levy (MADEL)	1,629	1,801	1,841
Dental and Medical Service Increment for Teaching (SIFT)	905	937	979
Adjustment		-85	-174
Total	4,331	4,633	4,820

NOTE

1 The adjustment is made to ensure the Multi Professional Education and Training Budget is in line with the Department's overall budget.

Source: Department of Health

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