

# A Short Guide to the **Department of Health**

July 2015



National Audit Office



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The National Audit Office scrutinises public spending for Parliament and is independent of government. The Comptroller and Auditor General (C&AG), Sir Amyas Morse KCB, is an Officer of the House of Commons and leads the NAO, which employs some 810 people. The C&AG certifies the accounts of all government departments and many other public sector bodies. He has statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively, and with economy. Our studies evaluate the value for money of public spending, nationally and locally. Our recommendations and reports on good practice help government improve public services, and our work led to audited savings of £1.15 billion in 2014.


**This Short Guide summarises what the Department of Health and its arm's-length bodies do, their costs, recent and planned developments, and what to look out for across the main business areas.**

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More than  
**1%**  
**increase in real-terms funding**  
for health in the last 4 years



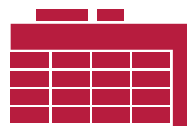
**26%**  
**drop in avoidable mortality**  
between 2003 and 2012



**40 NHS foundation**  
**and 26 NHS trusts**  
reported deficits in 2013-14



**90%**  
**of patients** – for the last 5 quarters  
NHS England has missed its target to  
start 90% of patients' treatments within  
18 weeks of referral



**13**  
**NHS foundation and**  
**NHS trusts** were in special  
measures in May 2015



More than  
**1 million**  
**bed days were lost in 2014-15**  
while patients waited to be transferred



**30 billion**  
**a year by 2020-21** – the  
NHS Five Year Forward View's  
estimate of the potential  
mismatch between resources  
and patient needs



More than  
**£5 billion**  
**a year is spent on treating**  
health conditions associated with obesity

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## Department of Health

Sets strategy, funds and oversees the health and care system in England.

Works with and through a variety of arm's-length bodies including NHS England and Public Health England, and regulators including the Care Quality Commission and Monitor.

### Goals 2014-15

Living and ageing well – helping people live healthier, longer lives.

Caring better – raising standards in health and care.

Preparing for the future – by making the right decisions.

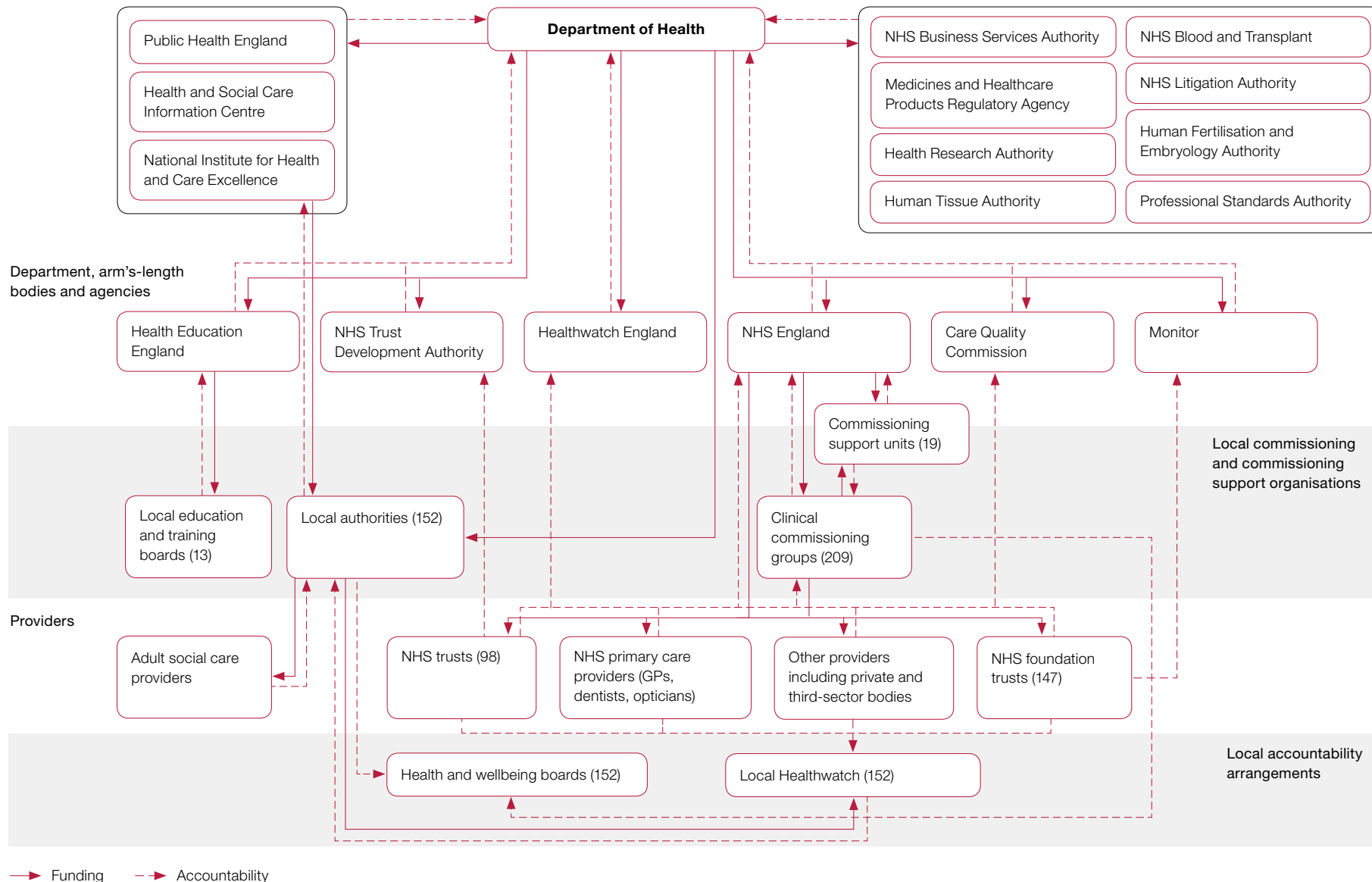
### Accountable to Parliament for

Ensuring that all expenditure by the Department, NHS England, Public Health England and other arm's-length bodies, and by the NHS, is contained within the overall budget.

Ensuring these organisations perform effectively and have governance and controls to ensure regularity, propriety and value for money.

Ensuring that ministers are advised on all matters of financial propriety and regularity, and value for money, across the health and care systems.

## The health system from April 2013



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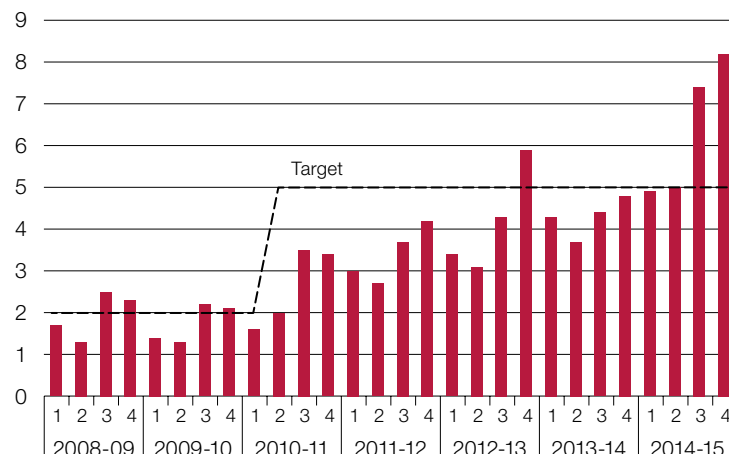
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### Patients in England waiting more than 4 hours in A&E, 2008-09 to 2014-15

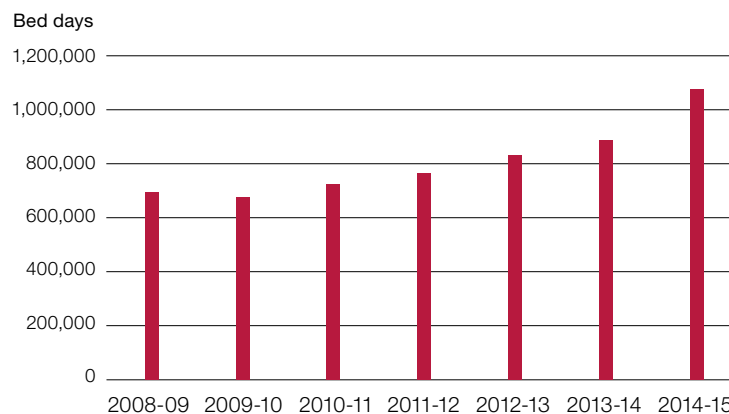
In the past 2 quarters, NHS England missed its target for at least 95% of patients to be treated, discharged or admitted within 4 hours of arrival

Percentage of patients not treated, discharged or admitted within 4 hours of arrival



### Bed days lost in England from delayed transfers of care from acute settings, 2008-09 to 2014-15

There has been a steady increase in bed days lost while people are waiting to be transferred from hospital to other care settings

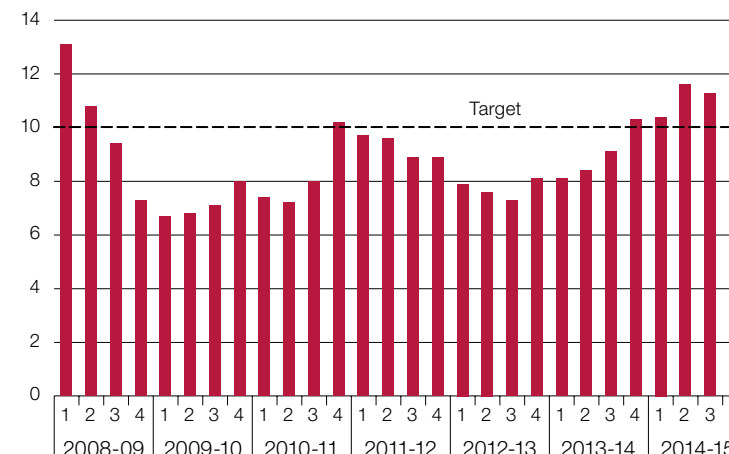


Source: Data from NHS England and Office for National Statistics

### Patients in England waiting more than 18 weeks for elective treatment, 2008-09 to 2014-15

For the past 5 quarters NHS England has missed its target for 90% of patients to start treatment within 18 weeks of referral

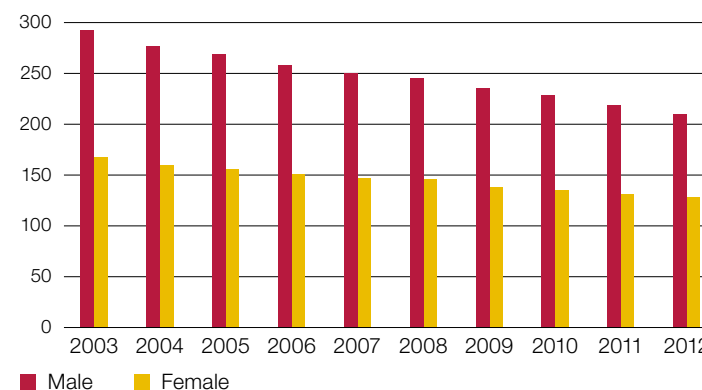
Percentage of patients who did not start treatment within 18 weeks of referral



### Avoidable mortality in England, 2003 to 2012

The number of deaths per 100,000 from causes considered avoidable has fallen since 2003, indicating improvements in healthcare quality

Avoidable deaths per 100,000 people



Note

1 2012 is the latest available data due to the time lag in producing mortality data.

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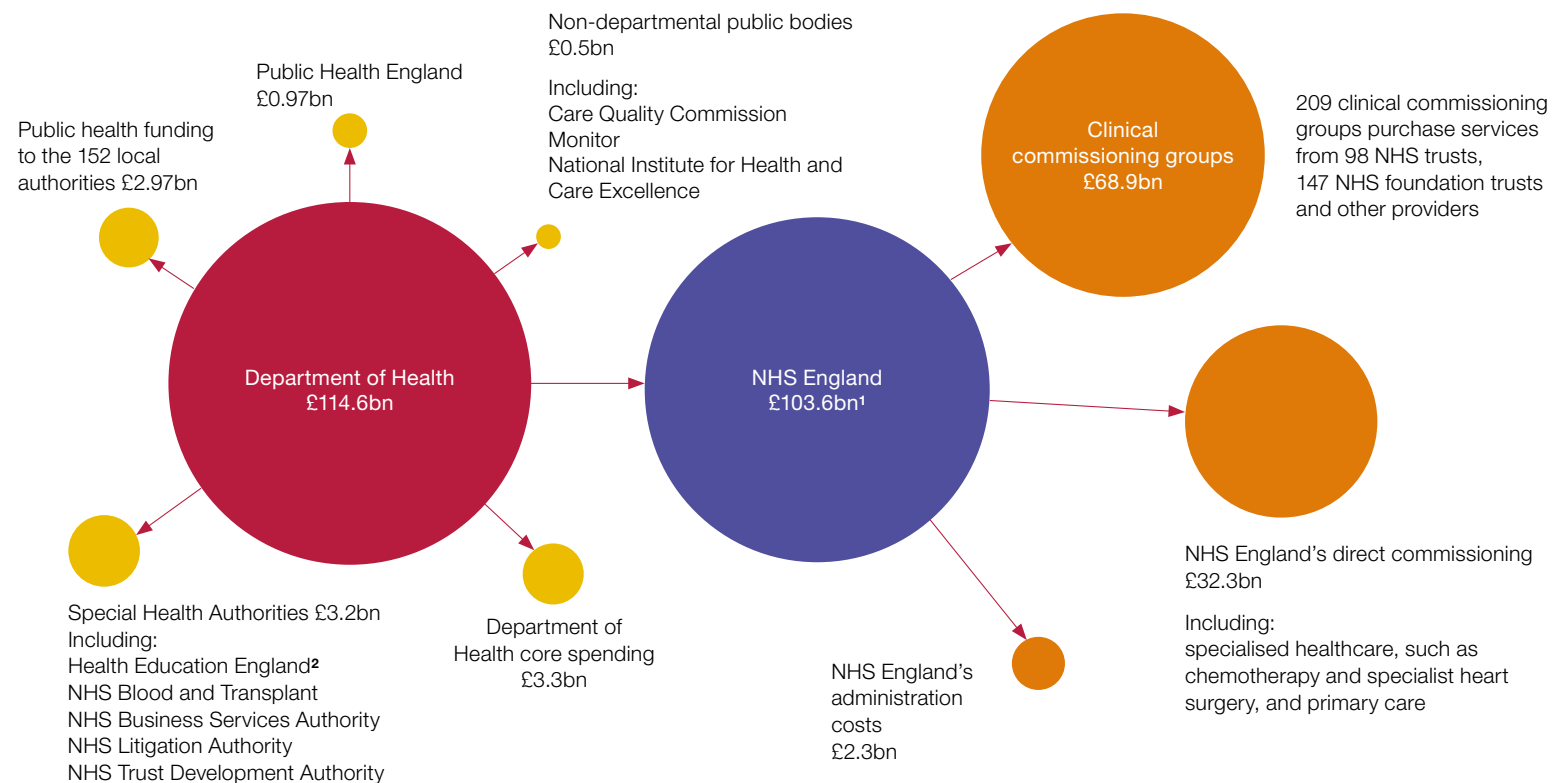
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## 2014-15 planned spending



### Notes

- 1 £18.7 billion of the NHS England spend is funded by National Insurance.
- 2 Health Education England became a non-departmental public body on 1 April 2015.
- 3 The spending figures may not add up precisely to the totals provided due to rounding.

Source: Department of Health 2014-15 Supplementary Estimate of spending, February 2015

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There was sustained and significant growth in the Department of Health's budget in the early part of the past decade, but the increase has slowed in recent years. In the 4 years to 2007-08, the budget grew by 5.9% a year on average in real terms. In the 4 years to 2014-15, funding increased by 1.2% a year in real terms.

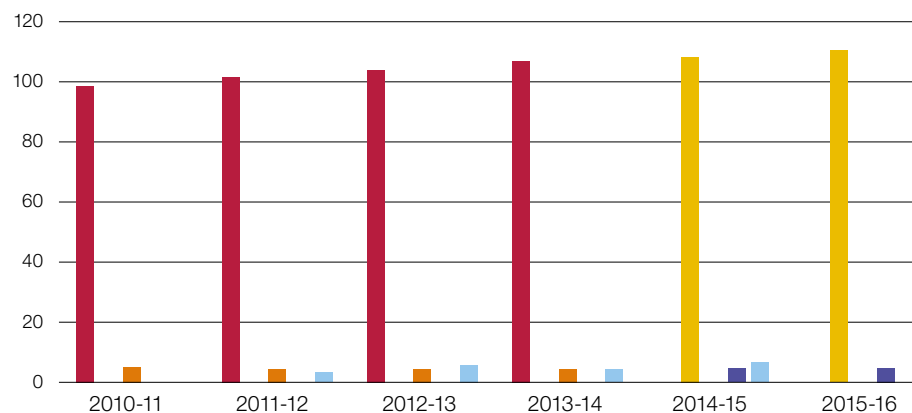
While health has been protected compared with most other areas of government spending, the financial position is increasingly tight. At the same time, the demand for healthcare continues to grow, partly because of: the ageing population and increases in the number of people with long-term health conditions; developments in drugs and medical technology; rising public expectations for high-quality and accessible care; and rising activity levels (see opposite).

In October 2014, the 'NHS Five Year Forward View' estimated that growing demand would produce a gap between resources and patient needs of nearly £30 billion a year by 2020-21 unless there were further efficiencies or increases in real-terms funding or both. In its risk register for March 2015, NHS England rated as 'red' the risk of inadequate funding to meet commitments.

In the Queen's Speech in May 2015, the new government committed to increase funding for the NHS by £8 billion a year by 2020-21. The NHS will therefore have to look for efficiency savings of some £22 billion by: reducing the need for healthcare through better prevention; redesigning health and care services; and achieving greater efficiency.

## Departmental budget for the Department of Health (net of income)

£ billion



### Spending Review

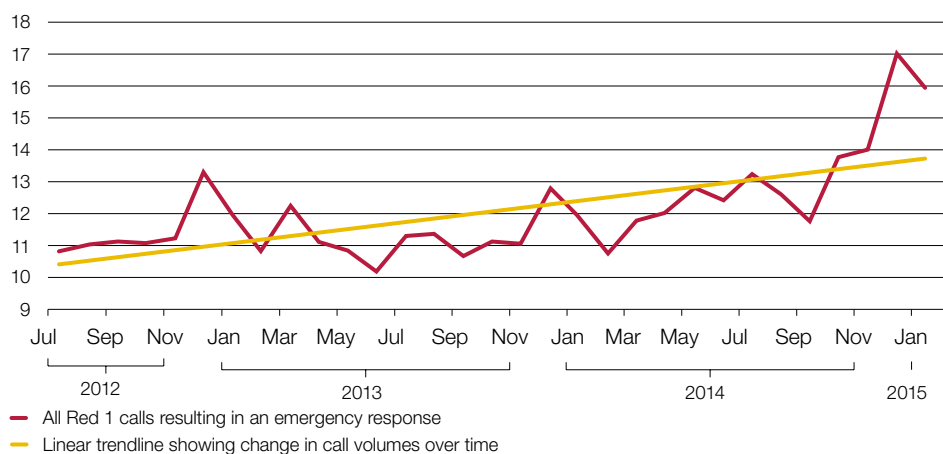
■ 2010 - Resource DEL
 ■ 2010 - Capital DEL
 ■ Resource AME
 ■ 2013 - Resource DEL
 ■ 2013 - Capital DEL

### Note

1 The Spending Review 2010 fixed the budget for each year up to and including 2013-14. The Spending Review 2013 fixed the budget for each year up to 2015-16.

## All Red 1 calls resulting in an emergency response

Thousands





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# Potential years of life lost that are amenable to healthcare

NHS England's data indicate that there is considerable geographical variation for both men and women in the potential years of life lost that are amenable to healthcare. In 2013 the potential years of life lost varied from less than 1 year for women to more than 4 years for men.

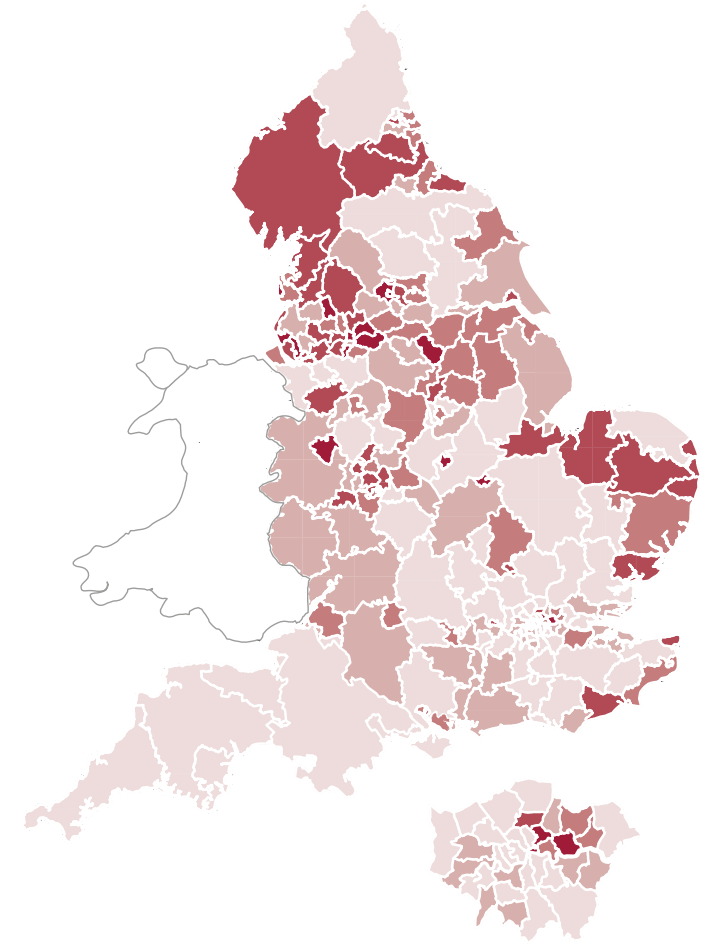
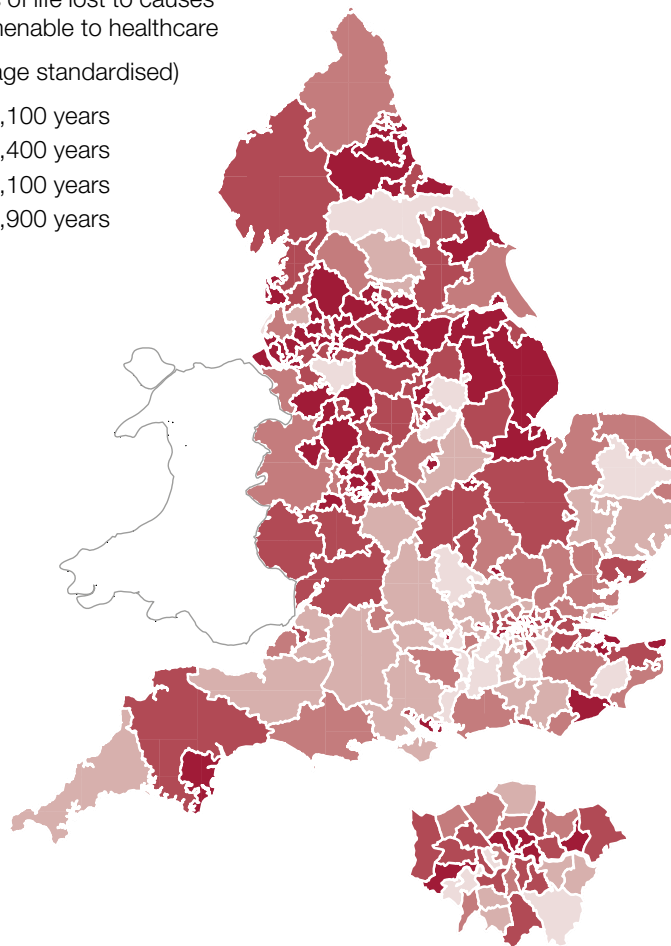
## Male, 2013

## Female, 2013

Potential years of life lost to causes considered amenable to healthcare

Per 100,000 (age standardised)

- 2,400 to 4,100 years
- 2,100 to 2,400 years
- 1,900 to 2,100 years
- 1,700 to 1,900 years



## Key facts

The Department of Health group (which includes arm's-length bodies and NHS providers) spent £48 billion in 2013-14 on staff costs, including £41 billion on wages and salaries.

## About the Department of Health

The Department of Health itself employs around 2,000 people and NHS England another 6,000 people. The NHS in England employs more than 1.2 million people.

## Key trends

Both the Department and NHS England employ significantly more women than men. 6 per cent of the Department's staff and 3% of NHS England's staff have disclosed a disability, compared with 10.5% in the UK workforce as a whole.

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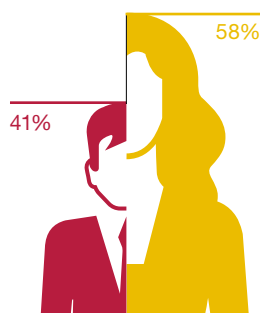
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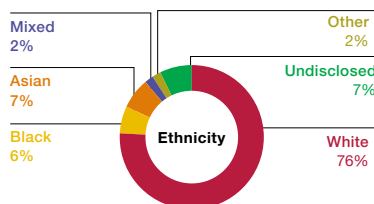
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### Staff profile: Department of Health 2,000 staff

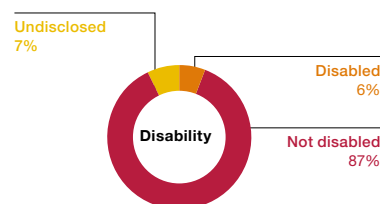
Staff gender



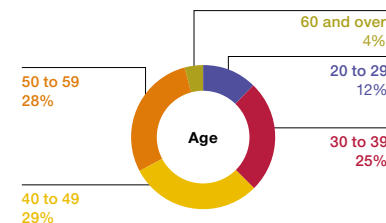
Ethnicity



Disability status

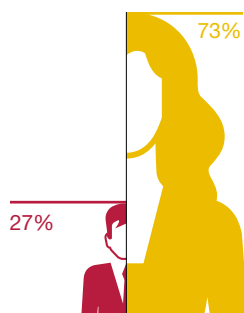


Age of staff

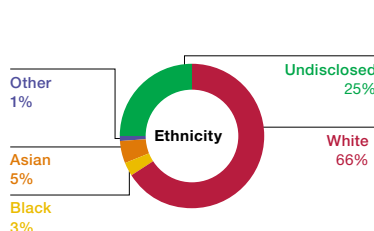


### Staff profile: NHS England 6,000 staff

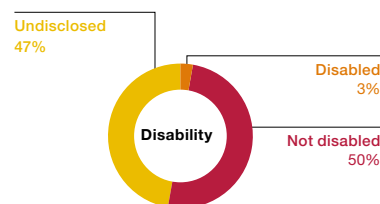
Staff gender



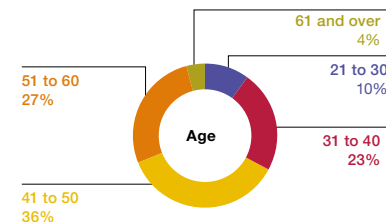
Ethnicity



Disability status



Age of staff



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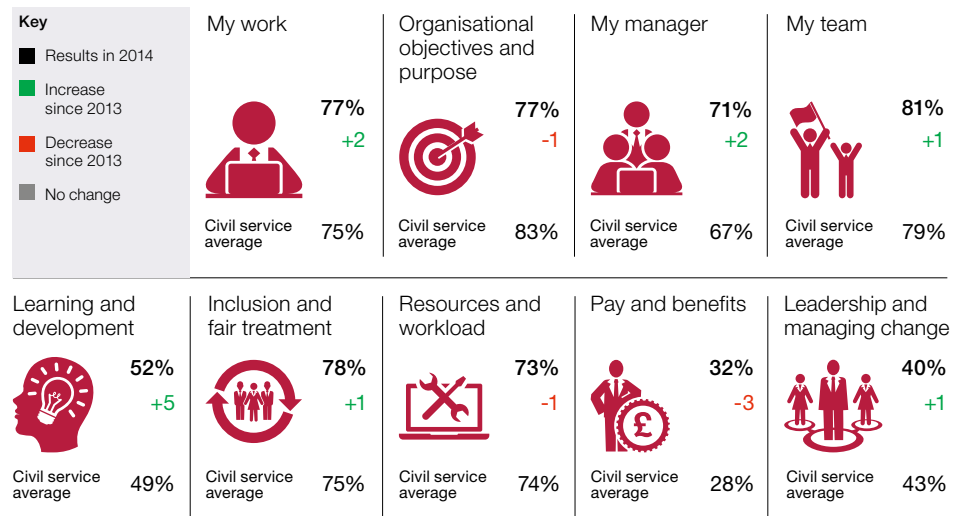
The government conducts an annual Civil Service People Survey. The most recent survey was in October 2014, and covered the Department of Health and its two executive agencies (Public Health England, and the Medicines and Healthcare Products Regulatory Agency).

The Department of Health's results in the 2014 Civil Service People Survey showed little change from the results in 2013, and were close to the civil service benchmark in both 2013 and 2014.

The main measure in the People Survey is the 'employee engagement index', which measures an employee's emotional response to working for their organisation.

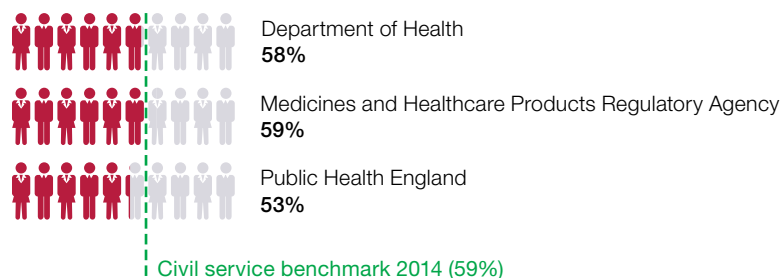
The engagement index for Public Health England was 5 percentage points lower than that for the Department of Health. The Department's own index was similar to the civil service benchmark.

## Attitudes of staff in 2014 compared with 2013 – Department of Health



## Engagement index 2014

The engagement index is a weighted average of employee agreement with 5 questions on their attachment to their job and employer



Sources: Civil Service People Survey 2013 and 2014

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## Major developments

The **Health and Social Care Act 2012** provides for widespread reform of the health system in England, with the aim of improving the quality of care provided to patients.

### October 2014

The NHS Five Year Forward View was developed and published by the organisations that deliver and oversee health and care services.

The **Care Act 2014** introduces a duty on local authorities to ensure people's wellbeing; enables people to be in greater control of the services they receive; and standardises eligibility for state-funded social care services across England. In April 2015, the Act introduced the right for anyone to request a local authority assessment of their needs.

2012

2013

2014

2015

2016

### April 2013

211 (now 209) clinical commissioning groups became responsible for commissioning most healthcare.

Local authorities became responsible for commissioning public health services in addition to their existing responsibility for social care.

152 health and wellbeing boards were set up to improve the health and wellbeing of their local population.

Public Health England created to provide leadership in improving and protecting public health.

### April 2014

Monitor became the sector regulator for health services. It took on responsibility for ensuring the continuity of services, setting prices for NHS-funded care jointly with NHS England, and enforcing rules to prevent anti-competitive behaviour by healthcare commissioners and providers.

### April 2015

The Better Care Fund starts to fund community health and social care in accordance with plans approved by local health and wellbeing boards.

More than 70% of clinical commissioning groups take on greater responsibility for commissioning GP services.

### April 2016

Planned introduction of a £72,000 cap on the amount that a person contributes to their care costs during the course of their lifetime.

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### **The financial and service sustainability of NHS bodies has become increasingly challenging**

We have reported several times on the financial sustainability of NHS bodies over recent years. A growing number of providers and commissioners are in financial difficulty and in 2014 we concluded that we could not be confident that value for money, in terms of financial and service sustainability, would be achieved over the next 5 years. Also in 2014, we reported that many local areas receive funding that is considerably above or below their target allocation based on need, and that there is a correlation between whether clinical commissioning groups have a financial surplus or deficit and whether they receive more or less than their target allocation. See [The financial sustainability of NHS bodies, 2012-13 update on indicators of financial sustainability in the NHS](#), [Funding healthcare: Making allocations to local areas](#) for more information.

### **The reforms to the health system are still settling down**

The reforms to the health system in 2013 are regarded as the most wide-ranging and complex since the NHS was created. The new arrangements for commissioning NHS care are still bedding in – for example, our work on cancer services in 2014 found that it was unclear how in practice NHS England was monitoring performance against the outcomes indicators that have been put in place. The reforms also introduced new arrangements for public health. Our review in 2014 found that Public Health England has been set up without direct, timely levers to secure the public health outcomes the Department expects. Public Health England therefore seeks to help local authorities to meet public health objectives by providing tools and data, support and advice. See [Progress in improving cancer services and outcomes in England](#), [Public Health England's grant to local authorities](#) for more information.

### **Better integration of health and social care is key to improving services**

The 2013 Spending Review announced the creation of the Better Care Fund to increase integration between health and social care with the aim, for example, of reducing emergency admissions. In 2013 we reported that there were 5.3 million emergency admissions to hospitals in 2012-13, costing approximately £12.5 billion. Our 2014 report on the Better Care Fund concluded that the Fund had real potential to help integrate health and social care, but to offer value for money the Department of Health and the Department for Communities and Local Government needed to ensure: more effective support to local areas; better joint working between health and local government; and improved evidence on the effectiveness of integration schemes. See [Planning for the Better Care Fund](#), [Emergency admissions to hospitals](#) for more information.



## NHS services

## Who commissions and provides services

Since 1 April 2013 NHS services have been commissioned by NHS England, through its area teams, and by clinical commissioning groups. The Department of Health sets objectives for NHS England through an annual mandate and measures progress through indicators set out in the NHS outcomes framework. NHS England's main responsibilities are to:

- set the framework for commissioning healthcare services;
- directly commission specialised health services, healthcare for those in prison or custody and in the armed forces, and some primary care services; and
- fund and support clinical commissioning groups, and hold them to account for delivering their statutory functions, through an assurance process.

The providers of healthcare range from NHS trusts and NHS foundation trusts providing hospital, community and mental health services, to GPs, opticians and pharmacists. In addition, in some localities, commercial organisations and social enterprises are contracted to deliver some health services. In 2012, Circle became the first private company to run an NHS hospital, but in 2015 it withdrew from the contract to run Hinchingsbrooke Health Care NHS Trust in Cambridgeshire, 3 years into the 10-year franchise.

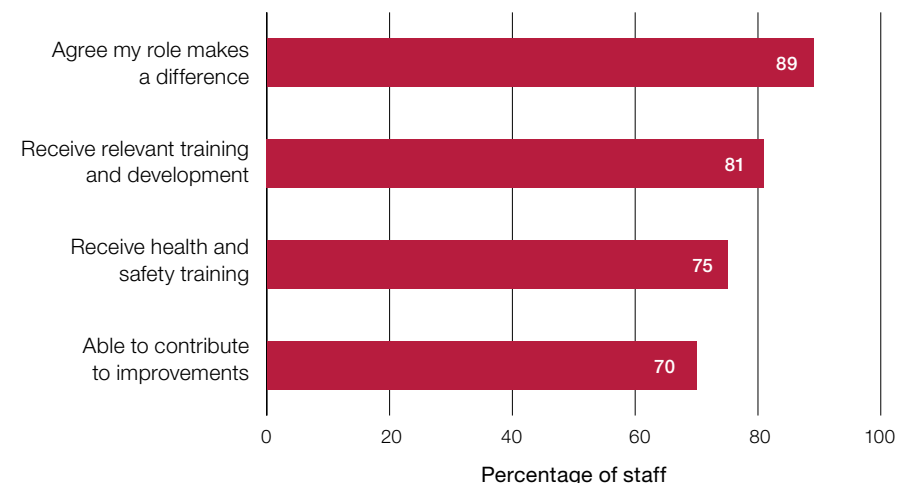
## Staff

The NHS is the biggest employer in England with more than 1.2 million staff, including more than 350,000 nurses.

The NHS Constitution makes 4 pledges to staff:

- Pledge 1: To provide staff with clear roles and responsibilities.
- Pledge 2: To provide staff with personal development, education and training, and management support.
- Pledge 3: To maintain their health, wellbeing and safety.
- Pledge 4: To engage staff in decisions that affect them and the services they provide.

## Highlights from the 2014 NHS staff survey, relating to the 4 pledges to NHS staff





## NHS services

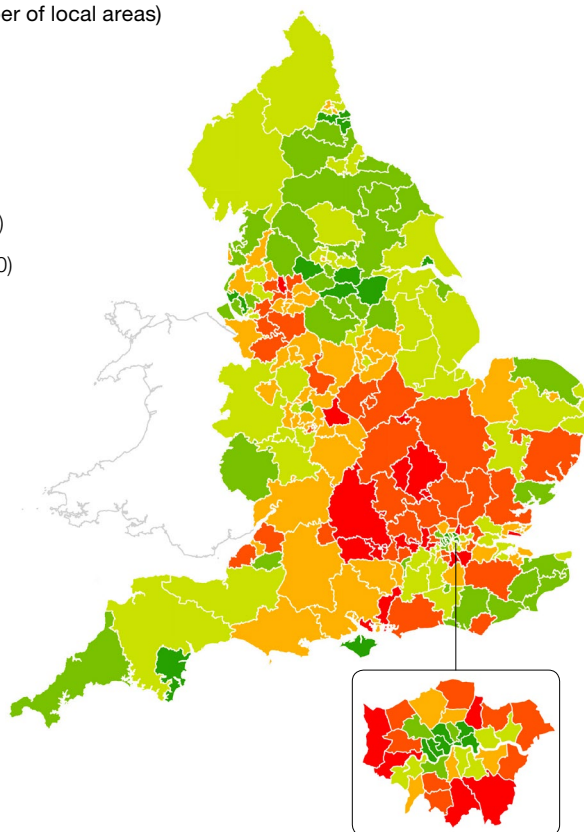
## Variations

**Aggregated distances from target funding allocations for healthcare by local area, 2013-14**

Eighteen local areas received at least £100 more per person than their target funding allocation, while 20 received at least £100 per person less

£ per head (number of local areas)

- 100 to 508 (18)
- 50 to 100 (39)
- 0 to 50 (45)
- 50 to 0 (51)
- 100 to -50 (38)
- 186 to -100 (20)



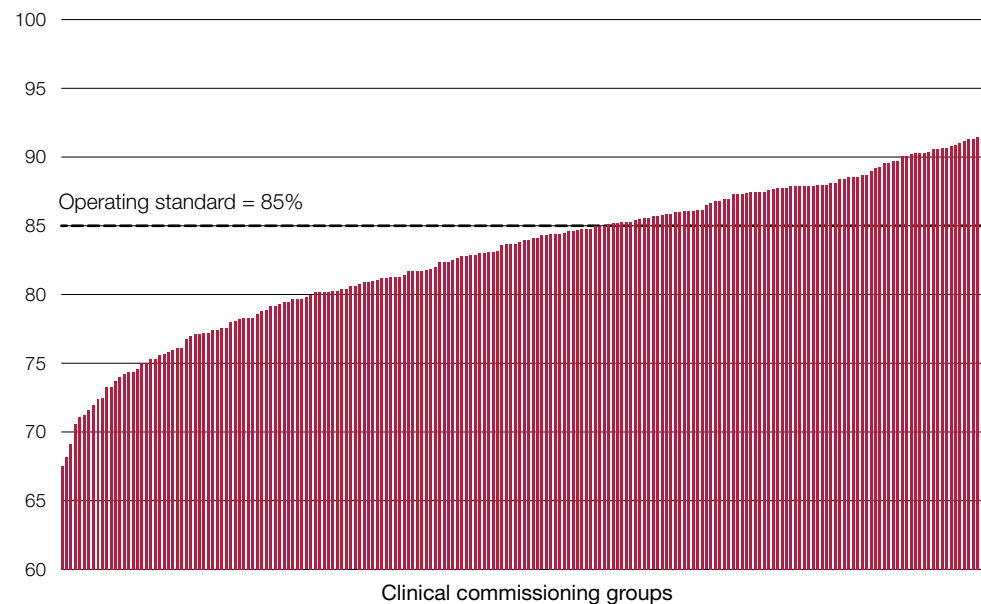
Source: National Audit Office analysis of Department of Health, NHS England and Office for National Statistics data

Our work on Funding healthcare: making allocations to local areas found that there are variations across England in terms of the extent to which clinical commissioning groups receive less or more than their target funding allocations, which are calculated on the basis of need.

Similarly, our work on Progress in improving cancer services and outcomes indicates there is variation between the performance of different clinical commissioning groups against key operating standards.

**Percentage of urgent GP referrals for suspected cancer which started treatment within 62 days, by clinical commissioning group, July to September 2014**

Referrals starting treatment within 62 days (%)



Source: NHS England cancer waiting times statistics





## NHS services

# Costs and cost pressures

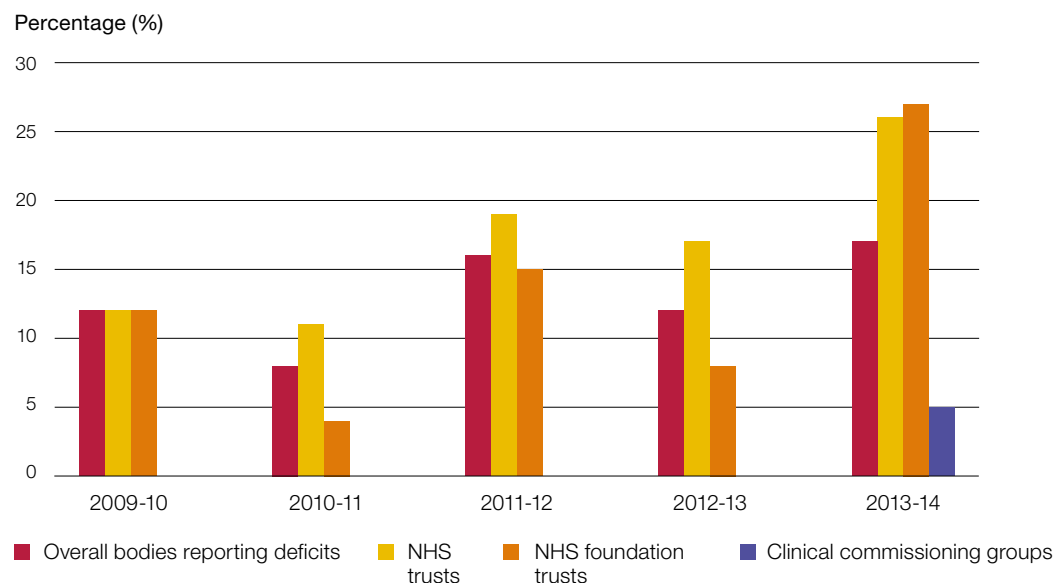
In 2013-14 NHS bodies achieved a net surplus of £722 million, made up of an £813 million underspend by commissioners and a £91 million net deficit by NHS trusts and NHS foundation trusts. The overall financial position had worsened since 2012-13, when the net surplus totalled £2.1 billion.

More trusts reported deficits in 2013-14 than in 2012-13 – the number of NHS trusts reporting deficits increased from 18 to 26, and the number of NHS foundation trusts reporting deficits increased from 12 to 40. For 2014-15, the unaudited results reported by Monitor and the NHS Trust Development Authority indicate an overall deficit of £822 million for NHS trusts and NHS foundation trusts combined.

Many trusts have increased spending on temporary staff to tackle staff shortages or maintain clinical standards. Total spending on temporary staff by trusts increased by 23% between 2012-13 and 2013-14. Past PFI/PPP deals can also impose constraints. Among organisations with PFI commitments, those with the highest capital charges, as a proportion of their income, were the most likely to report weak financial results in 2013-14.

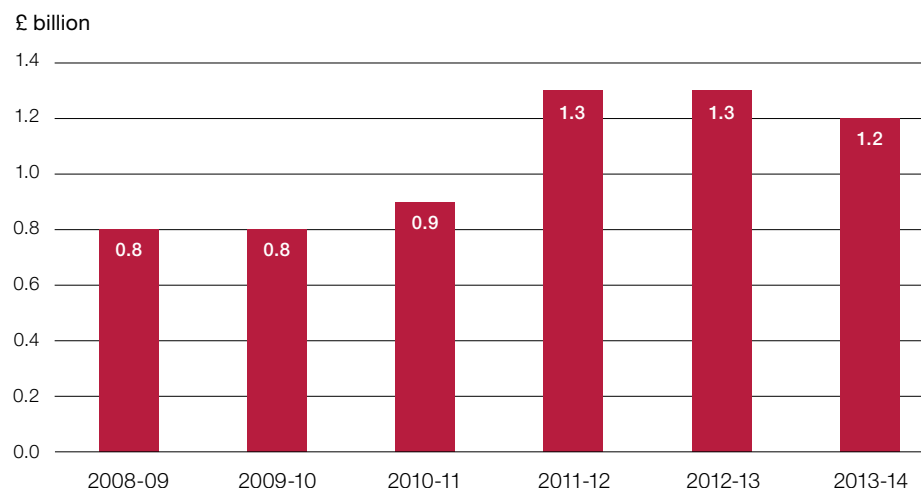
In 2013-14 providers paid £1 billion for clinical negligence cover. The costs of clinical negligence claims against the NHS have increased over time and in 2013-14 the NHS Litigation Authority made payments totalling £1.2 billion. At 31 March 2014, clinical negligence claims relating to obstetrics and gynaecology accounted for the greatest value – £8 billion of claims made since 1995.

The percentage of NHS trusts and NHS foundation trusts reporting deficits increased in 2013-14



Source: Department of Health Annual Reports and Accounts

Payments made by NHS Litigation Authority in respect of clinical negligence claims against the NHS



Source: NHS Litigation Authority



## NHS services

### Recent and future developments

In December 2012, NHS England set out the initial steps towards identifying how there might be better access to health services 7 days a week. The work focused, as a first stage, on improving diagnostics and urgent and emergency care. In May 2015 the new government stated its commitment to a '**seven-day-a-week NHS**'. The Queen's Speech stated that the 'GP Access Fund' would be used to extend opening hours in primary care.

In December 2012, the Department announced a '**digital first**' 10-year digital and information strategy, aimed at transforming the health and care system, and improving patient outcomes and the quality of care. The then Secretary of State set the NHS the challenge of being paperless by 2018. The first target towards achieving this ambition was for GP referrals to be paperless by 2015.

In October 2014, NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority published the **NHS Five Year Forward View**. It stated that the quality of care which patients receive could be variable, that preventable illnesses were widespread, and that health inequalities across England were deep-rooted. It emphasised that decisive steps are needed to break down the barriers in how care is provided, including between health and social care. It also announced proposals to support local innovation and delivery models where this offered potential for improvements. In the Queen's Speech, the government committed to implementing the NHS Five Year Forward View.

In February 2015, a Memorandum of Understanding was signed for the creation of a **Greater Manchester partnership board** for health and social care. The arrangement involves 12 clinical commissioning groups and 10 local authorities, together with the government and NHS England, and has support from 14 local NHS providers. It will potentially bring together £6 billion of health and social care spending for 2.8 million people.

From April 2015, the first 29 **vanguard groups** will put together new care models for local areas, covering 5 million people. The groups can draw on a £200 million fund and tailored national support to develop local health and care services to keep people well, and to bring home care, mental health, community nursing, GP services and hospital specialists closer together.



4/5





## NHS services

## Key things to look out for

## Issue

Are NHS services financially sustainable?

## Relevant findings from recent NAO work

Our most recent report on [The financial sustainability of NHS bodies](#) found that headline measures of financial sustainability worsened between 2012-13 and 2013-14, largely due to growing financial stress in the NHS trusts and NHS foundation trusts that provide hospital, mental health and community services. We concluded that these trends were not sustainable.

Our report on [Funding healthcare: making allocations to local areas](#) found that the low real-terms growth in total funding for the health system had made it difficult for the Department of Health and NHS England to allocate funding in a way that achieved the twin aims of fairness and financial sustainability.

Does NHS England have the information it needs to inform decisions and assess value for money?

Our report on [Progress in improving cancer services and outcomes in England](#) found that better information was becoming available to strengthen the evidence base for cancer services, although important data gaps remained.

The sample of case files we audited for our report on [NHS waiting times for elective care in England](#) suggested that published waiting time figures needed to be viewed with a degree of caution. We concluded that value for money was being undermined by problems with the completeness, consistency and accuracy of waiting-times data.

Is NHS England's oversight of NHS services effective?

Our report on [Out of hours GP services in England](#) found that NHS England did little during 2013-14 to assure itself of the quality and value for money of out-of-hours GP services and recommended that it needed to develop a proportionate assurance framework for these services.

Do variations in the performance of NHS services suggest scope for improvements?

Our report on [Maternity services in England](#) concluded that there was significant and unexplained local variation in performance against indicators of quality and safety, cost, and efficiency. Taken together, these factors showed there was substantial scope for improvement.

Our report on [Progress in improving cancer services and outcomes in England](#) found that significant variations and inequalities in outcomes and access to services persisted. For example, there would be nearly 20,000 fewer deaths from cancer each year if mortality rates for all socio-economic groups were the same as for the least deprived.

## Adult social care services

# Who commissions and provides care

The Department of Health is responsible for setting national policy for adult social care in England. It also provides funding to local authorities for adult social care.

The 152 single tier and county councils provide a range of adult social care services, including day care, meals, residential care and home care.

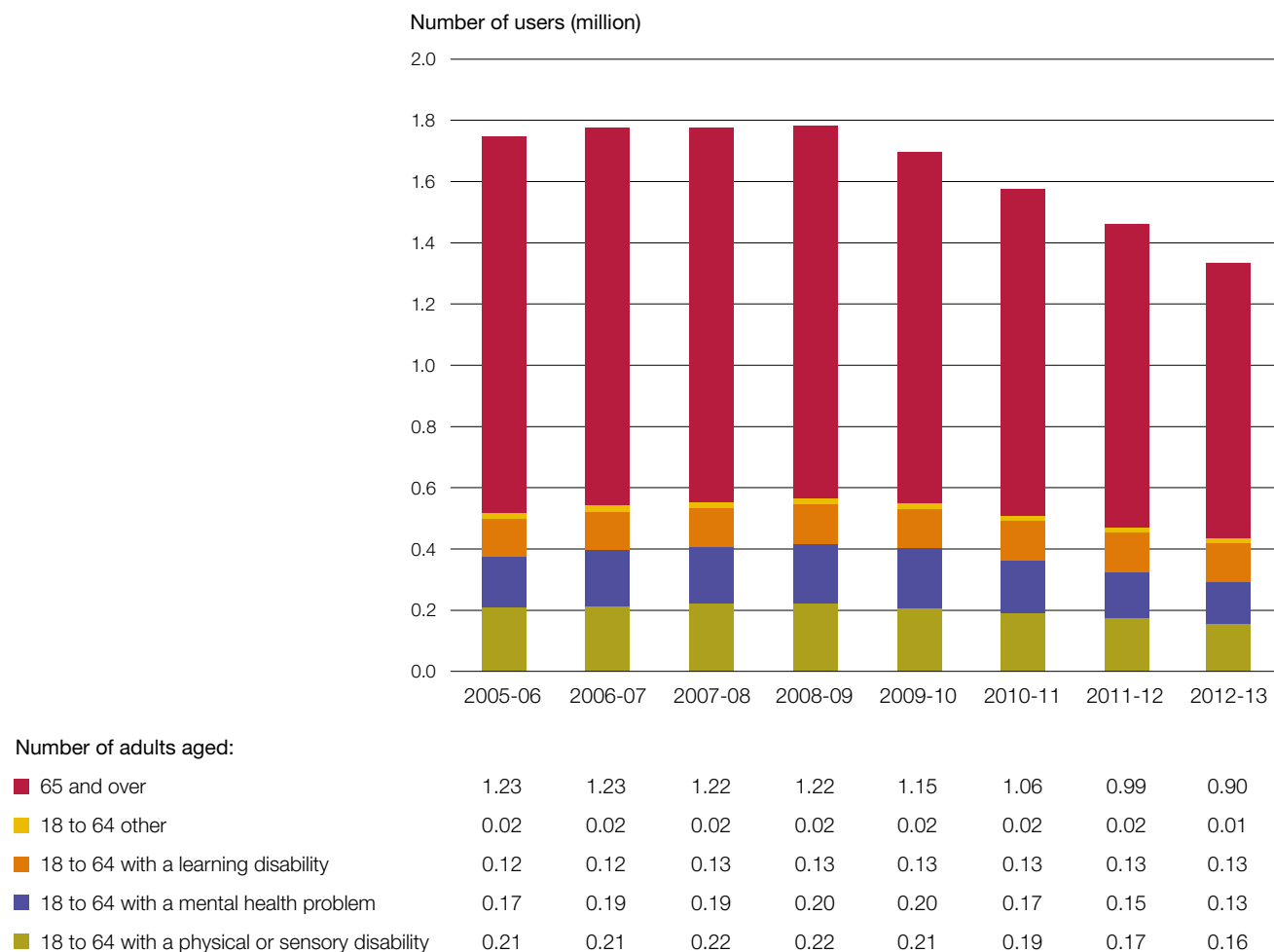
The main users of publicly funded adult social care are people with learning disabilities, those with mental health conditions, those with physical or sensory disabilities, and older people.

Local authorities typically only pay for individual packages of care for adults assessed as having high needs and limited means. Support has been more restricted recently due to financial pressures (see figure opposite, from the NAO's 2014 report, [Adult social care in England: overview](#)).

Local authorities commission most care from the private and voluntary sectors, with home care and care homes the most common services.

## Adults receiving local authority social care services, 2005-06 to 2012-13

The number of adults receiving state-funded care fell from around 1.8 million in 2008-09 to around 1.3 million in 2012-13



Source: National Audit Office analysis of Health and Social Care Information Centre data, Referrals, Assessment and Packages of Care 2005-06 to 2012-13

## Adult social care services

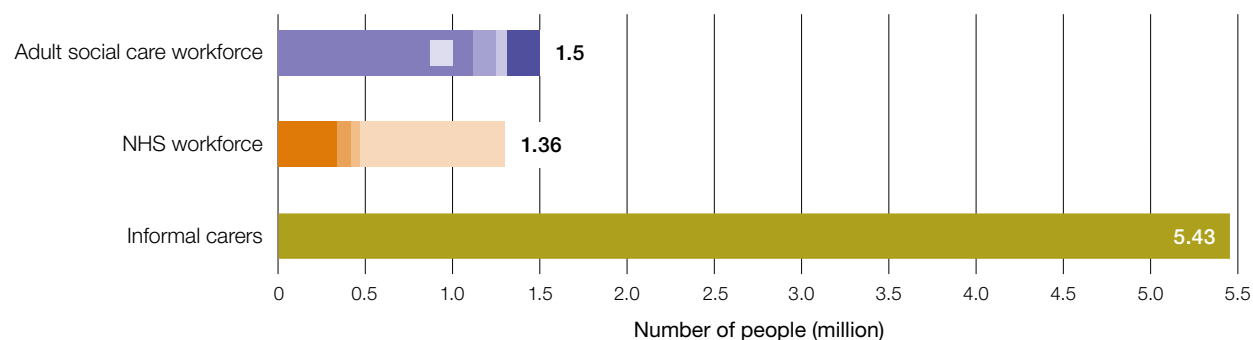
### Staff

There are around 1.5 million paid adult social care workers. Additionally, there are around 5.4 million unpaid informal carers.

Directors of adult social services are the senior local government employees with statutory responsibility for ensuring the delivery of adult social care by the local authority.

#### Scale of the adult social care workforce

The workforce includes a majority of people giving direct care, and a small number of professionals



- 1,110,000 provide direct care
  - Of which, 146,000 employed as personal assistants
  - 120,000 in management or supervisory roles
  - 90,000 professional staff, including social workers and occupational therapists
  - 180,000 employed in other roles
- 346,000 hospital and community-based nurses
- 106,000 doctors
- 63,000 GPs and general practice staff
- 845,000 other staff, including 17,000 occupational therapists, 8,000 speech therapists, and 4,000 chiropodists and podiatrists

Source: Skills for Care, *The size and structure of the adult social care sector and workforce in England in 2013*, September 2013; Health and Social Care Information Centre, *NHS Hospital and Community Health Service Workforce Statistics in England, as at September 2012*, March 2013; Office for National Statistics, *2011 Census: Local Characteristics on Health and Unpaid Care for Output Areas in England and Wales*, August 2013



## Adult social care services

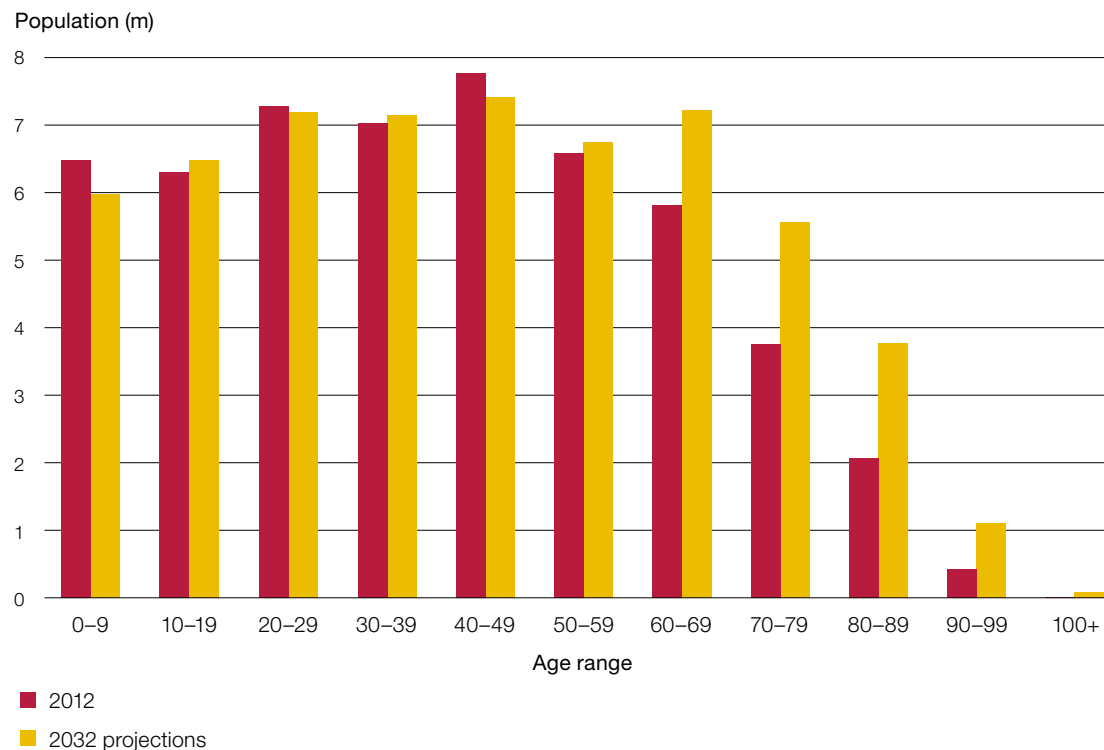
## Costs and cost pressures

Central government provides funding to local authorities intended to support adult social care spending. Expenditure on care homes for people aged over 65 is the largest category of spending. Funding includes:

- The non-ring-fenced Revenue Support Grant, which is provided by the Department for Communities and Local Government. Non-ring-fenced general grants come with no central expectation of how local authorities will spend this money (other than that it be spent lawfully).
- Non-ring-fenced targeted funding of £859 million in 2013-14 to support social care, which is provided by the Department of Health.

Local authorities can reallocate both the Revenue Support Grant and the targeted funding to meet other local priorities and do not have to report on how it was spent. Therefore, the amount which local authorities actually spend on social care is locally determined.

The population is ageing, putting pressure on local authorities' social care services





## Adult social care services

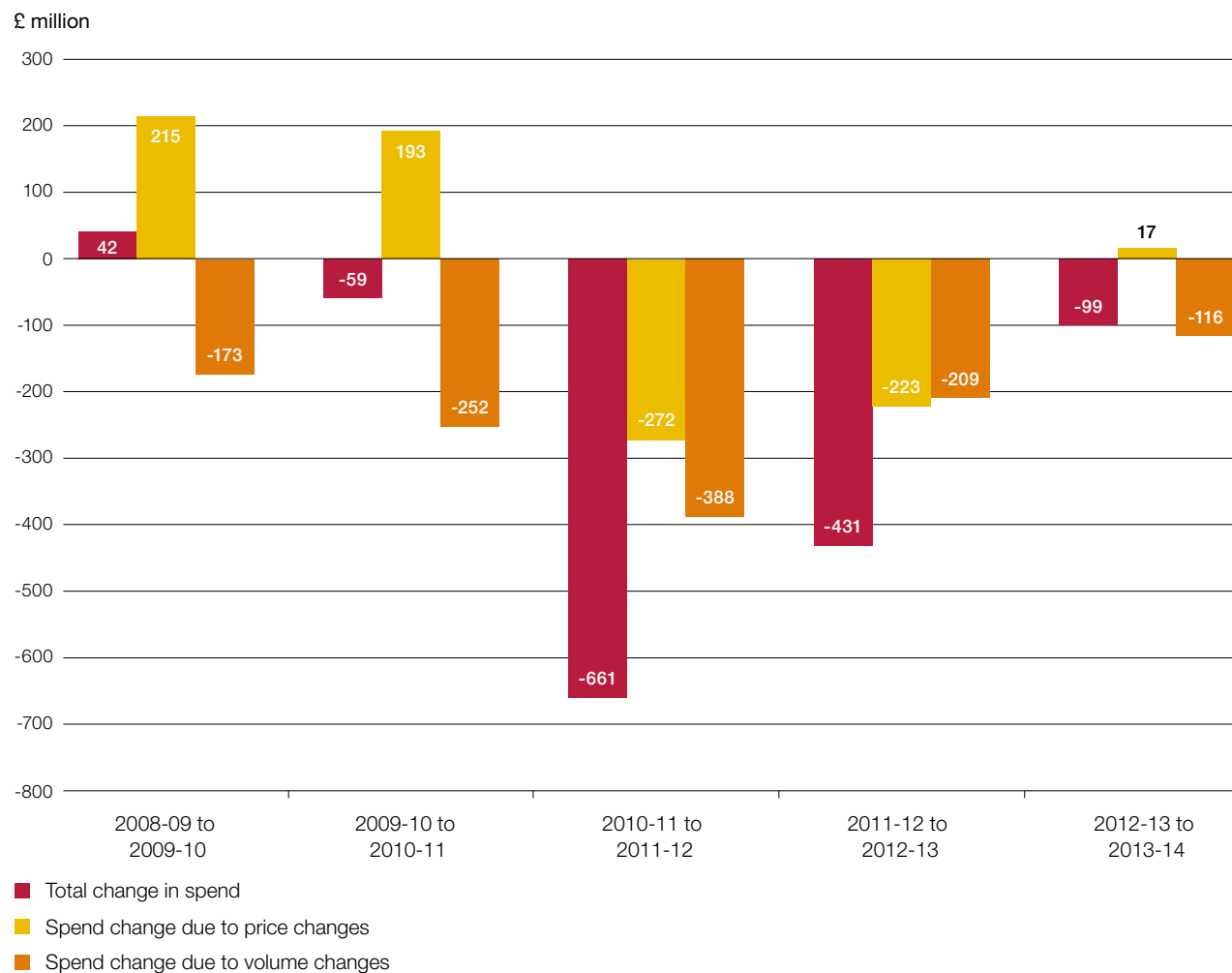
## Costs and cost pressures

In 2014-15, local authorities budgeted revenue spending of £15.5 billion on adult social care. Local authorities have made savings by providing services to fewer people and to some extent through reducing unit costs. The figure opposite from our 2014 report [The impact of funding reductions on local authorities](#) shows that:

- in 2011-12 to 2012-13, local authority spending reductions were from providing fewer services, which also cost less to provide; and
- in 2013-14, local authority spending reductions resulted entirely from reductions in activity, rather than price.

## Components of total savings in adult social care – price and volume

Change in spend (real terms at 2012-13 prices)



## Note

1 Chart includes spend and activity data for day care, homecare, residential care and nursing care for all user groups.

Source: National Audit Office analysis of Personal Social Services Expenditure data, Health and Social Care Information Centre



## Adult social care services

# Recent and future developments

The Health and Social Care Act 2012 established **health and wellbeing boards**, which took on their statutory functions from April 2013. Each of the 152 local authorities with adult social care responsibilities has a health and wellbeing board. The boards have a duty to encourage integrated working between commissioners of healthcare, social care, public health and children's services.

From April 2015 an **Integrated Personal Commissioning** programme will offer 10,000 people with complex needs greater power to decide how their own combined health and social care budget is spent. This approach is initially being piloted in 8 sites, over a 3-year period.

From April 2015 the **Better Care Fund** is operating with a single shared budget pooled between local authorities and clinical commissioning groups. The initial £5.3bn budget was formed from existing funding streams. As NHS and local authorities cooperate more effectively, outcomes for service users are expected to improve and emergency admissions to hospital to reduce.

From April 2015 the **first phase of the Care Act 2014** placed several new duties on local authorities. This included ensuring that carers (adults who provide support to others) are given the same recognition, respect and esteem as those whom they support. Local authorities also now have a duty to assess carers' own needs for support (regardless of their financial position) and the impact of their caring role on their situation. Local authorities must provide information and advice (including financial advice) on care and support services to everyone, regardless of care needs.

From April 2016 the **second phase of the Care Act 2014** places a cap on the costs which any individual is required to pay towards eligible care and support.



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## Adult social care services

## Key things to look out for

## Issue

Are adult social care services financially sustainable and is need being met?

Is information available to make informed decisions and assess the value for money of adult social care?

Are different parts of the health and social care system working well together?

Do local variations suggest scope for improvements in adult social care?

## Relevant findings from recent NAO work

Our report [Adult social care in England: overview](#) found that the need for social care is rising while public spending is falling, and there is unmet need. We concluded that the Department of Health and the Department for Communities and Local Government do not know if we are approaching the limits of the capacity of the system to continue to absorb these pressures.

Our report on [Planning for the Better Care Fund](#) found that there is limited information and evidence so far that the Better Care Fund will work as intended to make local authorities and the NHS work together better, and whether it will improve efficiency and lead to improved services.

Our report [Adult social care in England: overview](#) concluded that current monitoring tells us that most eligible adults have satisfactory or better experiences of statutory social care services. However, new monitoring and improvement arrangements are not fully established and they rely on insufficient information across some user groups and providers. As the changes take effect, central and local government risk not knowing if: services are deteriorating to unacceptable levels; needs are not being met; care quality is improving; and public funding is achieving value for money.

Our report on [Care services for people with learning disabilities and challenging behaviour](#) found that moving people out of hospital, where appropriate, is a complex process which defies short-term solutions. Unless all parts of the health and social care systems work effectively together, it is unlikely to happen. Despite government efforts, it did not achieve this central goal by the target date. This was partly because there are no mechanisms for systematically pooling resources to build sufficient capacity in the community for this to happen.

Our report on [Adult social care in England: overview](#) found that there are variations in the level of need for adult social care across local authorities, due to social, economic and demographic factors. These factors explain most of the variation in how much local authorities spend on care for older adults and some of the variation for younger adults. In some local authorities, social care spending covers only the critical, or substantial, needs of older adults.





## Public health

## Improvement and protection

The Health and Social Care Act 2012 introduced new arrangements for public health, which took effect from 1 April 2013. Responsibility for commissioning local public health services passed to local authorities (county councils and unitary authorities) from the NHS. They now have a statutory duty to improve the health of their populations.

Public Health England was established as an executive agency of the Department of Health. It brought together public health specialists from more than 100 organisations into a single public health service. It provides national leadership in protecting and improving the nation's health and wellbeing and reducing health inequalities. It works alongside local government and the NHS to support locally led public health initiatives and takes the lead on wider threats to the health of the population, such as emergencies and pandemics.

The Department of Health sets objectives for Public Health England through a remit letter setting out expectations, and measures progress through indicators set out in the public health outcomes framework.

## Staff

Public Health England employs 5,110 staff. Most are scientists, researchers and public health professionals. Of its staff, 1,850 work in microbiology. Its staff work in 15 local centres, and more than 100 locations, across 4 regions.

Staff attitudes were slightly less positive in 2014 than those in the Department and across the civil service, in all categories except 'pay and benefits'.

Directors of Public Health are the senior local government employees with statutory responsibility for public health.

## Attitudes of staff in 2014, Public Health England

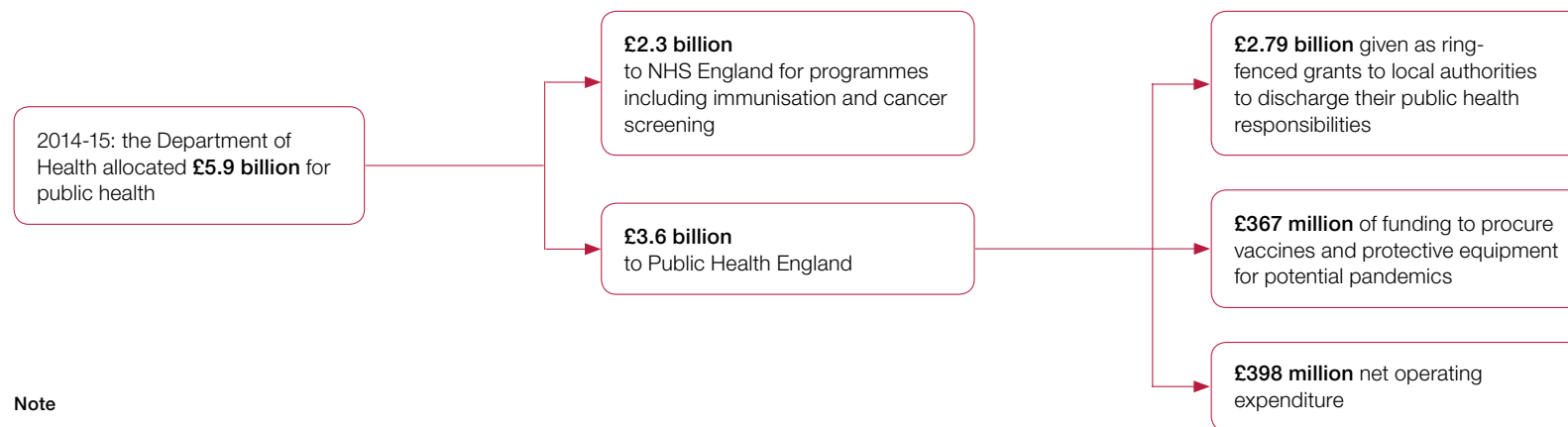


Source: National Audit Office analysis of Public Health England and Department of Health 2014 staff survey results



## Public health

## Costs and cost pressures



## Note

1 The funding figures may not add up precisely to the totals provided due to rounding.

Source: Public Health England, Business Plan 2014-15, May 2014

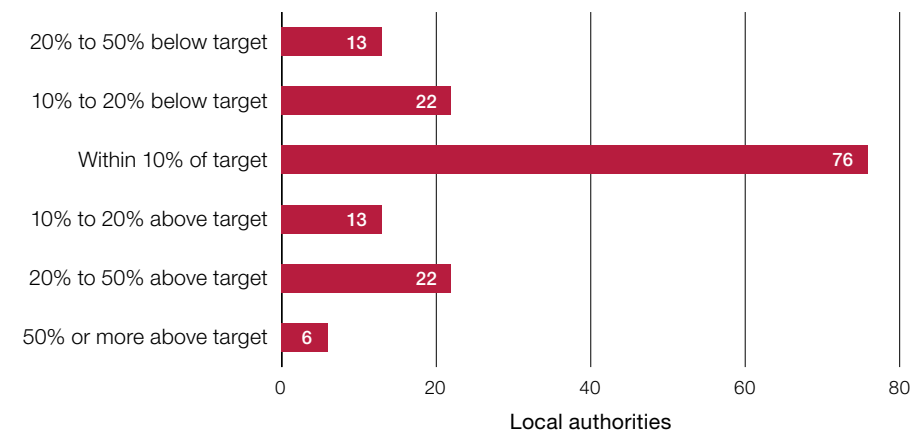
The ring-fenced grant is allocated by the Department of Health to the 152 local authorities to commission public health services. The Department's objectives in allocating funding are to reduce health inequalities and to ensure equal access for equal need. The Department calculates a target allocation for each local authority, based on the population and relative needs in each local area.

However, the Department has been concerned not to destabilise local areas by quickly shifting funding from historical patterns, and so some local authorities receive significantly more or less than their target allocations. In 2014-15, 41 local authorities were more than 20% from their target allocation, although this had fallen from 51 in 2013-14.

The Department of Health has not decided how long the ring-fence will remain in place and the impact, if the ring-fence is removed, is uncertain. Local authorities have funded some activities that promote public health from local budgets. There is a risk that total public health spending will decline as local authorities face continued budget reductions.

## Distance from target for public health allocations, 2014-15

28 local authorities received at least 20% more and 13 local authorities received at least 20% less than their target allocation



Source: National Audit Office analysis of Department of Health data



## Public health

# Recent and future developments

In October 2014, **Public Health England** published its strategy for the next 5 years, *From evidence to action*. The strategy set out 7 priorities for achieving improvements in the public's health:

1. tackling obesity
2. reducing smoking
3. reducing harmful drinking
4. ensuring every child has the best start in life
5. reducing dementia risk
6. tackling antimicrobial resistance
7. reducing tuberculosis

In October 2014, NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority in the health system published the **NHS Five Year Forward View**. It emphasised that a radical upgrade in protecting the public's health and tackling preventable illnesses is needed to secure the future health of children, the sustainability of the NHS, and the economic prosperity of Britain. It committed the NHS to back national action to reduce the levels of obesity, smoking, alcohol use and other major health risks to the public. In June 2015, the *NHS Five Year Forward View – Time to deliver* set out the initial progress achieved and the next steps to deliver the forward view.

In February 2015, Public Health England issued guidance on preventing the spread of **Ebola** virus to the UK.

In October 2015, responsibility for planning and commissioning **public health services for children** below the age of 5 will transfer from the NHS to local authorities.

By March 2016, Public Health England plans to complete its **internal change programme** *Securing our future* following a strategic review carried out in 2014-15. The work includes clarifying its vision, roles and governance; commissioning more expertise; and aligning geographical locations to best support local authorities and the NHS.

Also by March 2016, Public Health England should **report on the current operation of the public health system**, including the future capability, skills and experience of the public health workforce to operate across all the public health functions.



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## Public health

## Key things to look out for

## Issue

Are public health issues affecting the financial sustainability of NHS services?

## Relevant findings from recent NAO work

Our [Update on the government's approach to tackling obesity](#) found that the proportion of people who are obese or overweight is increasing. The cost to the NHS of treating people for health conditions related to their being overweight or obese has been estimated at more than £5 billion a year.

Our report on [Management of adult diabetes services in the NHS](#) found that treating diabetes is a significant and growing challenge for the NHS. An increase in the number of people with diabetes will have a major impact on NHS resources unless the efficiency and effectiveness of existing services is substantially improved.

Does Public Health England have the information it needs to inform decisions and assess value for money?

Our report on [Public Health England's grant to local authorities](#) found that the public health outcomes framework brings together public health datasets for the first time, increasing transparency and accountability, but some data limitations persist and there are time lags of at least 18 months for publishing much of the data.

Is Public Health England's influence and oversight effective?

Our report on [Public Health England's grant to local authorities](#) found that Public Health England has made a good start at building effective relationships with local authorities and other stakeholders. However, the autonomy of local authorities gives no guarantee that Public Health England can secure improvements in outcomes.

Do local variations in performance suggest scope for improvements in public health services?

Our report on [Public Health England's grant to local authorities](#) highlighted that spending on different aspects of public health varies significantly between local authorities. For example, our analysis showed local authorities where alcohol misuse worsened the most between 2010-11 and 2012-13 were spending significantly less on alcohol services in 2013-14.





## Regulation and oversight of health and social care

### The main bodies involved



#### Care Quality Commission

The regulator of health and adult social care in England, covering hospitals, mental health services, care homes, dental and general practices and other care services.

It registers care providers, monitors and inspects them against fundamental standards, and takes enforcement action if the standards are not being met. Its aim is to make sure that care is safe, effective, caring, responsive to people's needs and well led.

#### Monitor

The sector regulator for health services in England. It has a statutory duty to protect and promote the interests of people using healthcare services, including a role in ensuring service continuity.

It also regulates NHS foundation trusts. It assesses NHS trusts for foundation trust status and authorises those that meet the requirements. It operates a regulatory regime to ensure that NHS foundation trusts are financially sustainable, well led and locally accountable, and takes action if trusts are in significant breach of the conditions that it has set.

#### NHS Trust Development Authority

It oversees and supports the remaining NHS trusts which have not achieved foundation trust status, on behalf of the Department of Health.

It monitors the financial sustainability, governance and performance of NHS trusts, and supports their transition to foundation trust status.



## Regulation and oversight of health and social care

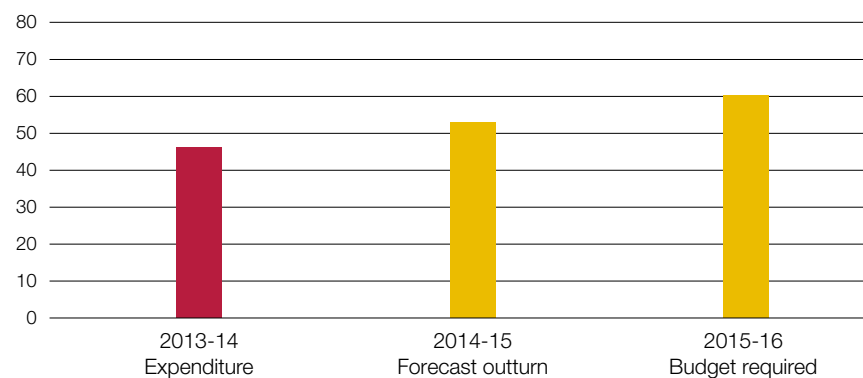
## Costs and cost pressures

The role of regulating or overseeing NHS trusts and NHS foundation trusts has become more challenging in recent years as trusts have come under increasing financial pressure and the focus on care quality and effective regulation has grown in the wake of the problems at Mid-Staffordshire NHS Foundation Trust.

In addition, the remit of both Monitor and the Care Quality Commission has expanded. For example, Monitor has significant new responsibilities relating to pricing and competition.

## Monitor

£ million



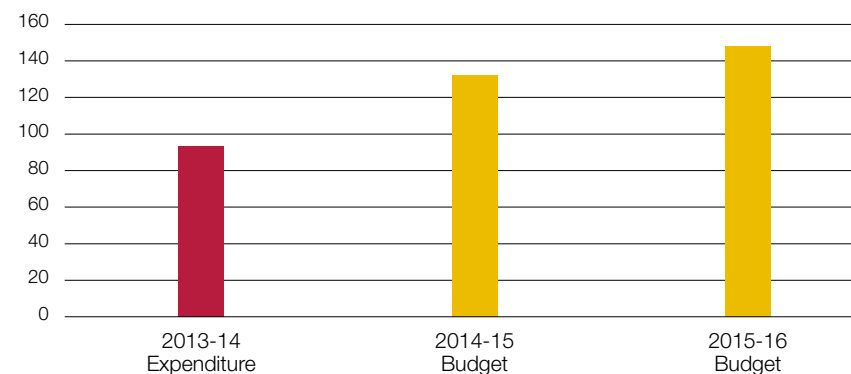
## Note

1 The totals above cover only Monitor's core running costs. They exclude additional funding to support trusts in special measures. In 2013-14, this amounted to £1.6 million. These amounts for 2014-15 and 2015-16 were still to be notified. For 2013-14, there was an additional budget of £16.4 million, and for 2014-15, an additional budget of £20 million, for contingency planning and special administration. For 2015-16, the Department has not yet determined the amounts for these activities.

Sources: Annual reports and accounts and business plans for Monitor, the Care Quality Commission and the NHS Trust Development Authority

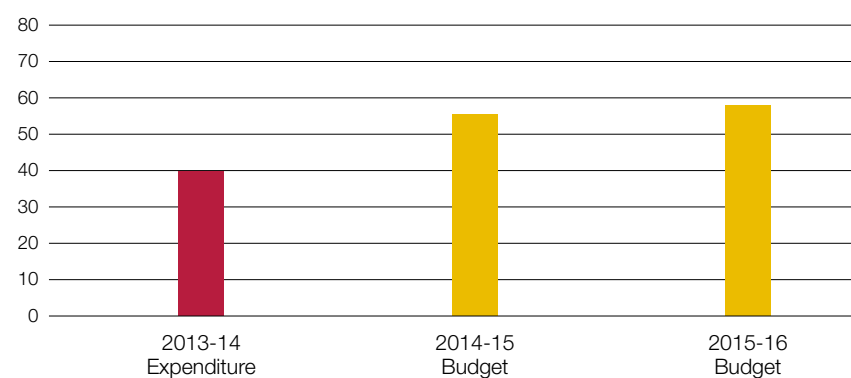
## Care Quality Commission

£ million



## NHS Trust Development Authority

£ million





## Regulation and oversight of health and social care

## Staff



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**Care Quality Commission**

2,500 staff (expected number by 2015,  
up from 2,300 in 2014)

31% male : 69% female

7.9% disclosed disability

12.3% black or minority ethnic

**Monitor**

500 staff (expected number by 2015,  
up from 370 staff in 2014)

47% male : 53% female

2% disclosed disability

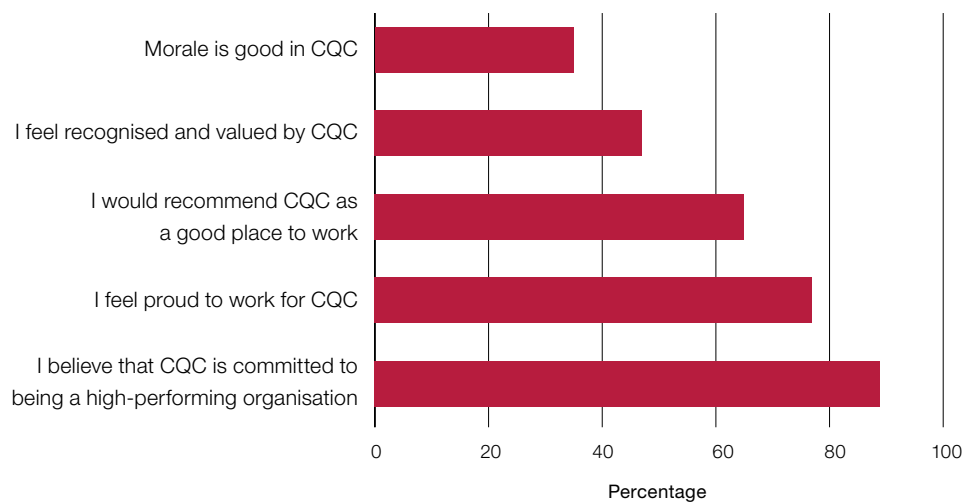
20% black or minority ethnic

**NHS Trust Development  
Authority**

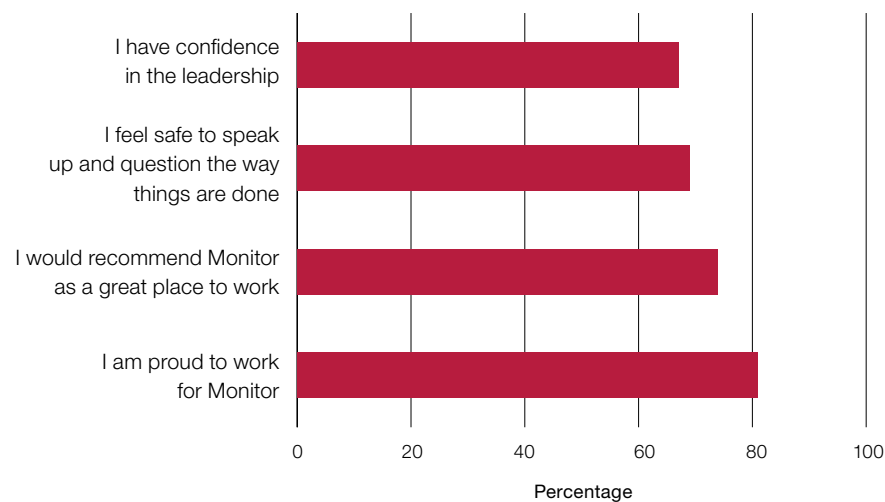
217 staff (in 2014)

37% male : 63% female

Care Quality Commission staff survey 2014



Monitor staff survey 2014

**Note**

1 The NHS Trust Development Authority has not published staff survey results.

## Regulation and oversight of health and social care

### Recent and future developments

In 2013, the **Care Quality Commission** strategy's changed its regulatory approach to focus on ensuring people received safe, effective, compassionate and high-quality care by well-led providers. In April 2015, in 'Shaping the future', the Commission developed its inspection approach to respond to new models of care in primary medical services, adult social care and the proposals for Greater Manchester and the Vanguard projects.

Between July and October 2013, the Care Quality Commission appointed three **chief inspectors** – of hospitals, general practice and adult social care – to lead national teams of expert inspectors and to develop the inspection regimes in response to the reports on failures in care at Winterbourne View (a private residential hospital for people with learning disabilities) and at Mid-Staffordshire NHS Foundation Trust.

In July 2013, **Monitor** and the **NHS Trust Development Authority** placed 11 trusts (6 NHS trusts and 5 NHS foundation trusts) into a new regime called special measures. A trigger for special measures is a recommendation from the Chief Inspector of Hospitals following an inspection. The 3 bodies support and improve leadership, care and patient safety at the trusts. Subsequently some trusts have left special measures and other trusts have been placed in special measures.

In May 2015 there were 13 trusts in **special measures**: Barking, Havering and Redbridge University Hospitals; Burton Hospitals NHS Foundation Trust; Colchester University Hospital NHS Foundation Trust; East Kent Hospitals University NHS Foundation Trust; Hinchingsbrooke Health Care NHS Trust; Medway NHS Foundation Trust; Norfolk and Suffolk NHS Foundation Trust; North Cumbria University Hospitals NHS Trust; Sherwood Forest Hospitals NHS Foundation Trust; Tameside Hospital NHS Foundation Trust; The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust; University Hospitals of Morecambe Bay; Wye Valley NHS Trust.

In October 2014, the Care Quality Commission started a regime to inspect every **GP practice** in England by April 2016.

In April 2015, the Care Quality Commission became responsible for monitoring the financial sustainability of the most difficult to replace **care providers**.

In April 2015, in 'Shaping the future', the Care Quality Commission developed its **inspection approach** to respond to new models of care in primary medical services, adult social care and the proposals for Greater Manchester and the vanguard projects. Also in April 2015, the Care Quality Commission became responsible for monitoring the financial sustainability of the most difficult to replace care providers.

In June 2015, the government announced the move to a single leader of **Monitor** and the **NHS Trust Development Authority**, meaning that all NHS providers are under the oversight of the same chief executive.



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## Regulation and oversight of health and social care

## Key things to look out for

## Issue

Are regulators and oversight bodies taking action to ensure services are financially sustainable?

Do regulators and oversight bodies have the information they need to monitor performance?

Are regulators and oversight bodies effective?

Do variations suggest scope for improvements?

## Relevant findings from recent NAO work

Our report on [Monitor: Regulating NHS foundation trusts](#) noted that for an increasing number of trusts in difficulty, the underlying causes are rooted in the local health economy, for example where commissioners are in financial difficulty. Monitor has changed its approach to intervening in these trusts and in some cases has started working with commissioners, the local authority and the NHS Trust Development Authority to find solutions to address these wider issues.

Our report on [The Care Quality Commission](#) found that the Commission has a systematic approach to assessing the risk that providers are not meeting essential standards of quality and safety, but that it depends on good quality information, which is not always available. The 'quality and risk profiles' for adult social care contain on average one-tenth of the data items of profiles for the NHS.

Our report on [Making a whistleblowing policy work](#) found that collating management information on whistleblowing cases can provide valuable intelligence on areas that need further examination or controls. Within the Department of Health family, concerns raised by employees can be made to many different bodies and, if they are not shared, can result in fragmented intelligence. This creates the risk that a pattern of incidents arising within a specific organisation can be missed.

Our report on [Monitor: Regulating NHS foundation trusts](#) concluded that Monitor's processes for assessing and monitoring trusts are robust, its judgements have mostly been sound, and it has refined its approach in the light of experience. The balance of evidence suggests that Monitor has generally been effective in helping trusts to improve.

Our report [Adult social care in England: overview](#) found that government is relying on new arrangements for monitoring, regulating and improving care services. The Care Quality Commission is moving to a risk-based inspection regime and is developing more ways to use available data to identify risks.

Our report on [The Care Quality Commission](#) found that some of the Commission's compliance inspectors did not have the expertise to assess risk effectively, and the variations in their approach led to inconsistency.



# Appendix One

## Department of Health sponsored bodies at 31 March 2015

### Executive agencies

Medicines and Healthcare Products Regulatory Agency  
Public Health England

### Executive non-departmental public bodies

Care Quality Commission  
Health and Social Care Information Centre  
Health Education England  
Human Fertilisation and Embryology Authority  
Human Tissue Authority  
Monitor  
NHS England  
National Institute for Health and Care Excellence

### Advisory non-departmental public bodies

Administration of Radioactive Substances Advisory Committee  
Advisory Committee on Clinical Excellence Awards  
British Pharmacopoeia Commission  
Commission on Human Medicines  
Committee on Mutagenicity of Chemicals in Food,  
Consumer Products and the Environment  
Independent Reconfiguration Panel  
NHS Pay Review Body  
Review Body on Doctors' and Dentists' Remuneration

### Other

Health Research Authority  
NHS Blood and Transplant  
NHS Business Services Authority  
NHS Litigation Authority  
NHS Property Services  
NHS Trust Development Authority  
National Information Board