
# Baseline spending estimates for the new NHS and Public Health Commissioning Architecture

**DH INFORMATION READER BOX**

| | | |
|---|---|---|
| Policy | Clinical | Estates |
| HR / Workforce | Commissioner Development | IM & T |
| Management | Provider Development | **Finance** |
| Planning / Performance | Improvement and Efficiency | Social Care / Partnership Working |

| | |
|---|---|
| **Document Purpose** | For Information |
| **Gateway Reference** | 17129 |
| **Title** | Baseline spending estimates for the new NHS and Public Health Commissioning Architecture |
| **Author** | Resource Allocation Team |
| **Publication Date** | **07 February 2012** |
| **Target Audience** | PCT Cluster CEs, SHA Cluster CEs, Directors of PH, Local Authority CEs, Directors of Finance, Local Authority Directors of Finance |
| **Circulation List** | |
| **Description** | This document provides estimates of 2010-11 spend on services that will be allocated to different commissioners in the commissioning structure proposed under the Health and Social Care Bill. |
| **Cross Ref** | N/A |
| **Superseded Docs** | N/A |
| **Action Required** | We would welcome feedback on the data or on our approach to the analysis. |
| **Timing** | **N/A** |
| **Contact Details** | Resource Allocation Team<br>Policy, Strategy & Finance Directorate<br>Department of Health<br>4W07 Quarry House<br>Leeds<br>LS2 7UE<br><br>allocations@dh.gsi.gov.uk |
| **For Recipient's Use** | |


First published [February 2012]

Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

# Baseline spending estimates for the new NHS and Public Health Commissioning Architecture

Prepared by
Department of Health
Resource Allocation team

# Contents

# Summary

1.1. We have brought together two separate collections of 2010-11 Primary Care Trust spend that focused on public health and NHS Commissioning Board or Clinical Commissioning Groups to estimate how those resources would be deployed under the commissioning architecture proposed in the Health and Social Care Bill.

1.2. While these should be recognised as estimates at this stage, and further analysis is needed before 2013-14 allocations can be set, they do support initial planning by emerging Clinical Commissioning Groups and Local Authorities.

## Introduction

1.3. At the moment over 80% of all NHS funding goes to primary care trusts (PCTs), who are then responsible for meeting health and public health needs. The government remains committed to real terms growth in health spending in each year of the current Parliament but the Health and Social Care Bill would create distinct responsibilities for commissioning different services. In particular:

- The NHS Commissioning Board (NHSCB) would commission a number of services, such as specialised services, primary medical services and dental services. The NHSCB budget was previously estimated to be in the region of £20bn. [1]
- Clinical Commissioning Groups (CCGs) would be responsible for commissioning most local services, by value, in particular hospital and community health services. We have previously estimated that they will control budgets of around £60bn.[2]
- The total spend on Public Health Services, including Public Health England (PHE), was estimated to be in excess of £4bn.[3]
- This also includes services provided or commissioned locally by local authorities (LAs), funded by a ring-fenced grant.

1.4. The Secretary of State would be responsible for setting the size of the budget available to NHSCB and PHE, as well as the size of the ring-fenced public health grants provided

[1] Transcript of oral evidence before Health Committee (HC 796-v): *Third Report into Commissioning*.
[2] Ibid 1
[3] *Healthy Lives, Healthy People* – Consultation on the Funding and Commissioning Routes for Public Health.

to LAs. NHSCB would determine the size of the budget available to each CCG, from within the total NHS commissioning budget.

1.5. The estimates described above were high level. But a good understanding of baseline spend is critical to a smooth transition to the new commissioning architecture. It is the starting point for decisions on how much funding should be available in different parts of the system and how that funding should be distributed locally. We therefore needed to go beyond these high-level estimates and during September we completed two major collections of information from PCTs: one focused on the public health system and one focused on NHSCB and CCG responsibilities.

1.6. In this paper, we bring the results of these collections together with information from accounts and other sources to provide the best available estimate of how spend by PCTs during 2010-11, adjusted to a hypothetical break-even position, would map on to the new commissioning architecture. Our analysis is broken down to regional and individual PCT level. When uplifted to 2012-13 levels these offer a first indicative estimate of local baselines, supporting planning and the further development of the commissioning architecture.

1.7. The analysis also gives us the first reliable estimate of the current spend in areas that would be the responsibility of the public health system. Adding spend from central budgets to the spend by PCTs in Table 1, and adjusting for spend we believe it has not been possible to separate from CCG spend, we estimate that during 2012-13 the NHS will spend £4.6bn on public health services[4]. Of this, about £2.2bn will be spent on services that would fall in the future within the responsibilities of local authorities. This paper includes our estimates of how this baseline spend is distributed across local authorities.

1.8. The information we have collected has also allowed us to estimate the size of spend on future CCG responsibilities, around £64.7bn, as well as estimates of the spend in some significant areas that NHSCB will directly commission. However, our analysis does not include some areas that are currently funded through Strategic Health Authorities, such as primary care in prisons.

1.9. The aggregate breakdown for England is shown in **Table 1**. The estimated breakdown of 2010-11 spend by PCT and Strategic Health Authority is presented in the accompanying Excel workbook,[5] while the estimated spend on public health in LA

[4] Corresponds to the Local Authorities, NHS Commissioning Board and Public Health England lines in Table 2.
[5] http://www.dh.gov.uk/health/2011/12/pct-allocations

areas (for relevant responsibilities) is shown in the Table at **Annex A**. The original data returns for each PCT are being placed on the Department of Health Website..[6]

[6] Ibid 4

## Table 1: Estimated spend 2010-11 by PCTs by future commissioning architecture

| | Source of data | £000s | Uplifted to 2012-13 £000s |
|---|---|---|---|
| **CCG list based responsibilities** | | | |
| Secondary and community care [1, 2] | (1) & (4) | 52,124,374 | |
| Out-of-hours primary care [1,2] | (1) &( 4) | 412,274 | |
| Prescribing costs [1,2] | (1) & (4) | 7,847,956 | |
| Services currently commissioned through local enhanced services (excluding public health) [1,2] | (1) | 392,663 | |
| **Total** | | 60,777,267 | 63,984,056 |
| **CCG geographical responsibilities** | | | |
| Secondary care for prisoners [3, 4, 9] | (1) | 98,454 | |
| Unregistered populations [3, 4] | (1) | 310,538 | |
| Charge exempt overseas visitors [3, 4] | (1) | 39,495 | |
| Non-rechargeable services [3, 4] | (1) | 66,079 | |
| Adjustment for transfer of responsibilities for termination of pregnancy, sterilisation and vasectomy | (4) | 151,534 | |
| **Total** | | 666,101 | 700,756 |
| **NHSCB direct commissioning** | | | |
| Specialised services [5] | (1) | 8,573,609 | |
| Secondary dental care [5] | (1) | 485,847 | |
| GP services excluding local enhanced services and out-of-hours services[6] | (1),(2) | 6,660,565 | |
| General Dental Services (net of patient charges) | (2) | 2,203,027 | |
| General Ophthalmic Services | (2) | 478,194 | |
| Pharmaceutical Services (net of patient charges) | (2) | 1,544,721 | |
| Armed forces [5, 10] | (1) | 23,257 | |
| Other Primary Care | (2) | 124,650 | |
| **Total** | | 20,093,870 | 21,152,829 |
| **Public health system** | | | |
| LA responsibilities | (3) | 2,112,456 | |
| Commissioned through NHSCB[7] | (3) | 1,614,283 | |
| PHE | (3) | 17,828 | |
| **Total** | | 3,744,567 | 3,941,912 |
| **Admin spend other than public health** | | | |
| Admin[8] | (2) | 2,717,671 | |
| **TOTAL** | | 87,999,475 | |
| **Reconciliation to PCT Revenue Resource Limit for 2010-11** | | | |
| **Total resource Limit for 2010-11** | (2) | 90,335,595 | |
| Less transfer to LAs for social care of people with learning disabilities | (2) | 1,294,173 | |
| Revised total resources | | 89,041,422 | |
| Unattributed spend/income | | -1,041,947 | |
| % unattributed spend/income | | -1.2% | |

Sources:

(1) CCG focused returns
(2) Accounts
(3) Public health focused returns
(4) DH analysis

*Notes:*
1. Expenditure net of (ie after subtracting) income from other NHS organisations and other organisations. Includes spend from both recurrent allocations, non-recurrent allocations and inter authority transfers.
2. Each row in this group was adjusted by increasing spend if the surplus was higher at the end of 2010-11 than 2009-10, or deficits lower, and reducing spend if the surplus was lower or the deficit higher. Similar adjustments were made for net lodgements.
3. Expenditure net of (ie after subtracting) income from other NHS organisations and other organisations. Includes spend from both recurrent allocations, non-recurrent allocations and inter authority transfers.
4. Each row in this group was adjusted by increasing spend if the surplus was higher at the end of 2010-11 than 2009-10, or deficits lower, and reducing spend if the surplus was lower or the deficit higher. Similar adjustments were made for net lodgements.
5. Expenditure net of (ie after subtracting) income from other NHS organisations and other organisations. Includes spend from both recurrent allocations, non-recurrent allocations and inter authority transfers.
6. Gross expenditure. Excludes estimated purchase of public health from primary care. Includes non-GMS services, eg secondary care, from GPs. Non –GMS spend was £135m in England.
7. We estimate that a further £420m of expenditure is included in CCG spend estimates, due to the difficulty of separating spend on different areas commissioned through a single contract.
8. Gross expenditure.
9. Working assumption on future commissioning route.
10. Precise route for armed forces for discharging commissioning responsibilities in association with CCG contracts to be determined

1.10. This paper does not discuss the advice of the Advisory Committee on Resource Allocation (ACRA), nor 'pace-of-change' policy (but see the section on Next Steps on page 14).

1.11. Baseline spend estimates for CCGs and NHSCB do not include administrative costs; they refer only to programme spend. Where 2010-11 administrative costs are included in PCT breakdowns this is only to facilitate the reconciliation of our estimates against resource limits.

## Collections

1.12. The principal sources for our estimates are the collections run between August and September 2011. These provided us with information around how the 2010-11 spend by PCTs would have been distributed under the new commissioning architecture. However, to build a complete picture of current spend we have had to combine these returns with other data sources. For instance the returns did not include information on the main primary care contract spend and so this has been estimated using accounts data. We are also aware of a limited number of areas where an alternative data source suggests that the returns may have underestimated or misattributed spend and where possible, we have approximated an adjustment. The effect of such adjustments has generally been to increase our estimates of the spend on public health.

*Public Health*

1.13. Public health 2010-11 spend information was collected twice during 2011: as part of the end of year audit and again in August/September, after working with PCT Directors of Finance and Directors of Public Health to improve the design of the return and the guidance. A key part of this second return was that we also asked local authorities to write to us with details of any areas of concern about the information PCTs were providing.

1.14. Our analysis suggests that the second collection was of significantly better quality. However, consistent with some of the feedback we received from local authorities, there were still areas where there may have been an underestimation of public health spend. This may be consistent with, for instance, the difficulty of disaggregating services currently commissioned through a single contract. We also had to correct for changes in the range of services included in the responsibilities of the public health system. To give the most reliable estimate of 2010-11 spend in the public health system we therefore made a number of adjustments to the returns. These are described in detail at Annex B, but they included:

- Correction of responsibility for abortion, sterilisation and vasectomy services. These were not separately identified in the returns but were part of a broader category. At the time of the collection they were proposed to be part of LA responsibilities. They are now initially expected to be part of CCGs' responsibilities. This reduced the total spend on public health services by around £150m.

- Some services were not included in the return but have been added to the specification of services to be delivered through the public health system subsequently. These have been estimated from other sources and add £168m to the total public health system spend[7].

- Imputing values where an unlikely zero value was reported. The returns included some services where zero spend was reported but we would expect all PCTs to be providing the service; it is also unlikely that the spend has been included in another category. In this case we have imputed the spend per head using the average of other PCTs in the same SHA. These add only around £34m to the total spend, suggesting that the returns are reasonably complete at least for high-spend categories.

- For a small number of services a reliable alternative estimate, or part estimate, exists. Where this suggests a significant error in the total spend, we adopted this estimate. This is a significant adjustment, mainly in the cost of screening, adding

[7] The £168m relates to services expected to be commissioned through the NHSCB .

approximately £430m to the total spend projected on to the public health system. We are unable to make a compensating correction to CCG spend estimates at a local level but as these services are expected to be commissioned through NHSCB this does not undermine this analysis as a tool for further planning.

1.15. For the relevant services, we have projected the spend on to LA areas to provide an estimate of baseline spend relevant to the ring-fenced public health grants. This is based on the proportion of registrations residing in each PCT's area living in each local authority.

1.16. The analysis discussed here focuses on revenue. Separate work is looking at the need for capital and we will make further updates at a later stage. However, local authorities' principal role will be as commissioners rather than providers of public health services, and so we would not expect their capital needs, typically, to be significant. This work also does not address the one-off costs of transition.

1.17. Most LAs highlighted one or more concerns about the information the PCT had returned to us. However, we do not believe, given the corrections suggested here, that most will have a large effect on the size of the ring-fenced grant.

1.18. Particular concerns included:

- 2010-11 was atypical because some policies had not been fully rolled out: this does not affect the accuracy of 2010-11 figures as a baseline spend estimate and all years would have suffered from this to some extent. This will need to be considered when confirming the size of the actual budget in 2013-14, along with potential for efficiency savings and the pressures in other parts of the comprehensive health service.
- Overheads costs have not been properly included: Most of the budget is for the commissioning of services from other bodies (such as sexual health services) and so do not require overheads. Other returns suggest that nationally public health's contribution to overheads is around £60m or 1½%. We therefore believe that any error on what is already a small component of the budget would not have a material effect on the size of the future ring-fenced grant.

*CCGs and NHSCB*

1.19. The second return focused on services that will in future be the responsibility of either CCGs or NHSCB. As CCGs have not yet been established we requested data at

practice level for future CCG commissioning responsibilities for their registered lists; we can then establish a baseline for whatever configuration of practice should ultimately be established. Spend on services that will be commissioned on the basis of CCGs' geographical areas (such as prison secondary care) or that will be the responsibility of NHSCB (such as specialised services) were collected at PCT level.

1.20. We asked PCTs to make an assessment of what the spend would have been in each area if they had been in balance in 2010-11, ie, no net change in their surplus or deficit position. This proved to be a technically difficult correction, where our own guidance could also have been clearer. We have therefore worked, in particular, with SHA clusters to understand the change in each PCT's position and then ensure that an appropriate adjustment is made; full details of this adjustment are at **Annex C**.

1.21. There were also uncertainties at the time of collection about which specialised services would be commissioned by NHSCB and that the available definitions of specialised services were not precise enough to get a good estimate of spend on these services. A comparison with HES data does suggest that in some areas specialised services spend has been underestimated, presumably with a compensating over-estimation in the estimates for CCGs' list based responsibilities. Since then the proposed scope of specialised services has increased further, making any under-estimation greater. In addition, some PCTs may have omitted from the returns spend on healthcare through pooled budgets arrangements with local authorities.

1.22. Many PCTs also reported difficulties in allocating spending on CCGs' list-based responsibilities to practices and so apportioned a significant amount of spending on a nominal population basis. Data at this level should therefore be used with caution.

*Other information*

1.23. To build a complete picture, our analysis also draws on information from accounts (for instance most spend on primary care services).

1.24. To test the validity of our estimates we have compared them with the PCTs' revenue resource limits. As some estimation has been required we do not expect a perfect reconciliation, but nationally we reconcile to 1.2% below the relevant revenue resource limit, and most PCTs are in the range 7% below to 2% above, although there are some outliers (the full range is 19% below - 6% above). This suggests that these estimates are generally robust and is testament to the high quality of information supplied by PCTs and SHAs.

## Results of the analysis

1.25. The breakdown of each PCT's spend across the new commissioning architecture, and the reconciliation of our analysis against the relevant resource limit, is presented in the accompanying excel workbook. Non-NHS income has been deducted. Each PCT can be selected by entering its code. Aggregate information for SHAs can also be selected, or the aggregate position for England (by entering 'Eng'). Sub-totals have also been uplifted to approximate 2012-13 values using the relevant PCT recurrent allocation growth for 2011-12 and 2012-13, which is typically around 5¼%.

1.26. Each PCT's analysis also includes an estimated baseline for prospective CCGs in its area, based on future responsibilities for registered populations. All CCGs are shown that include one or more practice drawn from that PCT, and so some CCGs appear on more than one PCT's summary. CCGs whose proposed configurations have recently been rated as Amber or Green as part of the recent SHA risk assessment are included. CCGs whose proposed configurations were red-rated have been excluded unless SHAs have advised us that they are in the process of making minor adjustments to membership that they expect to deliver Amber or Green status. Unaffiliated practices have also been excluded.

1.27. The Table at Annex A shows the relevant part of the public health spend projected on to local authority areas. This is split between the different commissioning routes in Table 2 below. The detailed division of responsibilities between PHE and DH remains to be decided in some cases. Spend identified as 'Department of Health' includes a range of budgets that could also ultimately be held by PHE. However, it does not include the administration costs of public health functions currently within DH.

**Table 2: Estimated 2010-11 public health spend (with adjustments to PCT survey)**

| Future commissioning route | Estimated baseline expenditure | Uplifted to 2012-13 |
|---|---|---|
| Local Authorities | £2.1bn | £2.2bn |
| NHS Commissioning Board | £2.0bn | £2.2bn |
| Public Health England | £210m | £210m |
| Department of Health | £620m | £620m |
| **Total** | **£5.0bn** | **£5.2bn** |

*Notes:*

1. Expenditure by PCTs has been uplifted in line with PCT recurrent allocation growth. Spend from central budgets in total has been assumed constant.. Central budgets includes grant-in-aid to organisations such as HPA..
2. These figures include the corrections discussed above and so do not necessarily match the values reported in Table 1.

## Next steps

1.28. Understanding how 2010-11 spend projects on to the new architecture is an important step in implementing the transition proposed in the Health and Social Care Bill. But these figures do not necessarily represent the final budgets for 2013-14; these will need to take account of a number of other factors and final allocations for 2013-14 will be set later this year. We also expect to say more about ACRA's recommendations for how we should aim to distribute resources in the longer term in due course.

1.29. However, these do offer a sensible basis for initial planning, particularly when uplifted to 2012-13 values. In particular, we would not expect the LA public health ring-fenced grants to fall in real terms from the values in Annex A, other than in exceptional circumstances such as a gross error or following a technical adjustment with major consequences for budgets, such as a significant adjustment for NHS income, a change in planned responsibilities or a large shift in the incentive payment for drugs treatment. In particular, we may need to do further work to confirm the adjustment we have made to take account of abortion, sterilisation and vasectomy services initially being the responsibility of CCGs rather than LAs.

1.30. We are not planning to update the public health baseline described here through a repeat collection. However, where PCTs and LAs agree that significant errors have been made or our approach does not take sufficient account of local circumstances (such as how we project resources on to LA geographies) we will consider making appropriate updates.

1.31. For CCGs the position is more complex. Actual allocations will depend, for example, on the final configurations of CCGs and on final decisions on the balance of funding for nationally and locally commissioned services, both of which will be a matter for NHSCB. The likely underestimation of specialised and public health services has probably also led to an overestimation of CCG spend levels. Conversely, the addition of non-list based spend, estimated here for PCTs but not attributed to individual CCGs, would lead to an increase in the CCG baseline.

1.32. These and other uncertainties mean that CCG baselines need to be treated with caution. Nevertheless, we believe this analysis can be used for initial planning. We expect there to be a further collection of 2011-12 spend levels, not least to reflect GP practice changes, such as closures, mergers and new practices.

1.33. We would welcome feedback on our estimates, including updates to previously submitted information. These should be sent to allocations@dh.gsi.gov.uk. Any change to the data should be agreed by the PCT Cluster Chief Executive and Director

of Finance. For public health data changes, the relevant local authorities should also be involved.

1.34. In setting PCT allocations, we have adopted a process that includes estimating a long term aim for the most efficient distribution of resources, based on a formula set by an independent group of NHS managers, GPs and academics – currently the Advisory Committee on Resource Allocation (ACRA). The independence and influence of this group were praised in a recent Public Accounts Committee report on the use of allocation formulae in the public sector.[8]

1.35. During transition, the Secretary of State has asked ACRA to continue to provide advice, covering both allocations to CCGs and to LAs. They have completed their initial work and we are working through the implications of their recommendations, including a detailed comparison with the baseline spend estimated here. The full details of their recommendations and their implications are to be published in due course although we already know that there will be further work to do, such as considering how non-resident populations impact on the resources LAs need to provide public health services. We will welcome feedback on ACRA's recommendations.

1.36. It would however be too early to assess options for how quickly each area can be moved towards target; this will depend on the decisions about high level budgets that are not yet available. This will feed in to the final announcements of actual 2013-14 allocations for CCGs and local authority ring fenced grants, which are expected to be made around the end of the year.

[8] *Formula funding of Local Public Services*: Fifty-fifth Report of Session 2010-2012 – HOC 1502.

## Annex A: Relevant public health baseline spend projected on to local authority areas

| | 2010-11 | | | 2012-13 |
|---|---|---|---|---|
| Local Authority | Spend £000 | Population* 1000s | Spend per head £ | Spend £000 |
| Hartlepool | 7,300 | 91.3 | 80 | 7,685 |
| Middlesbrough | 14,136 | 142.4 | 99 | 14,872 |
| Redcar and Cleveland | 9,630 | 137.4 | 70 | 10,110 |
| Stockton-on-Tees | 11,318 | 192.4 | 59 | 11,914 |
| Darlington | 6,158 | 100.8 | 61 | 6,482 |
| County Durham | 40,755 | 510.8 | 80 | 42,905 |
| Northumberland | 10,419 | 312.0 | 33 | 10,969 |
| Gateshead | 13,806 | 191.7 | 72 | 14,496 |
| Newcastle upon Tyne | 17,348 | 292.2 | 59 | 18,213 |
| North Tyneside | 8,099 | 198.5 | 41 | 8,513 |
| South Tyneside | 11,400 | 153.7 | 74 | 11,970 |
| Sunderland | 18,508 | 283.5 | 65 | 19,468 |
| North East | 168,878 | 2,606.6 | 65 | 177,598 |
| | | | | |
| Halton | 7,080 | 119.3 | 59 | 7,453 |
| Warrington | 7,520 | 198.9 | 38 | 7,917 |
| Blackburn with Darwen | 10,988 | 140.0 | 78 | 11,567 |
| Blackpool | 15,711 | 140.0 | 112 | 16,539 |
| Cheshire East | 10,181 | 363.8 | 28 | 10,704 |
| Cheshire West and Chester | 9,819 | 327.3 | 30 | 10,313 |
| Bolton | 15,126 | 266.5 | 57 | 15,924 |
| Bury | 5,778 | 183.8 | 31 | 6,082 |
| Manchester | 28,406 | 498.8 | 57 | 29,904 |
| Oldham | 8,854 | 219.8 | 40 | 9,306 |
| Rochdale | 11,836 | 205.2 | 58 | 12,460 |
| Salford | 13,507 | 229.0 | 59 | 14,220 |
| Stockport | 8,672 | 284.6 | 30 | 9,113 |
| Tameside | 8,857 | 216.9 | 41 | 9,324 |
| Trafford | 9,008 | 217.3 | 41 | 9,457 |
| Wigan | 17,712 | 307.6 | 58 | 18,646 |
| Knowsley | 14,478 | 149.1 | 97 | 15,202 |
| Liverpool | 32,537 | 445.2 | 73 | 34,159 |
| St. Helens | 10,533 | 177.4 | 59 | 11,088 |
| Sefton | 17,028 | 272.9 | 62 | 17,877 |
| Wirral | 21,207 | 308.8 | 69 | 22,264 |
| Cumbria | 11,979 | 494.4 | 24 | 12,611 |
| Lancashire | 43,626 | 1,169.3 | 37 | 45,891 |
| North West | 340,441 | 6,935.7 | 49 | 358,019 |
| | | | | |
| Kingston upon Hull, City of | 19,154 | 263.9 | 73 | 20,164 |
| East Riding of Yorkshire | 7,058 | 338.7 | 21 | 7,430 |
| North East Lincolnshire | 8,344 | 157.3 | 53 | 8,762 |
| North Lincolnshire | 6,996 | 161.3 | 43 | 7,364 |
| York | 5,338 | 202.4 | 26 | 5,620 |
| Barnsley | 11,571 | 227.6 | 51 | 12,181 |
| Doncaster | 15,870 | 290.6 | 55 | 16,707 |
| Rotherham | 12,339 | 254.6 | 48 | 12,990 |
| Sheffield | 24,509 | 555.5 | 44 | 25,730 |

| | 2010-11 | | | 2012-13 |
|---|---|---|---|---|
| Local Authority | Spend £000 | Population* 1000s | Spend per head £ | Spend £000 |
| Bradford | 23,971 | 512.6 | 47 | 25,225 |
| Calderdale | 6,679 | 202.7 | 33 | 7,013 |
| Kirklees | 18,511 | 409.8 | 45 | 19,487 |
| Leeds | 28,740 | 798.8 | 36 | 30,255 |
| Wakefield | 17,797 | 325.6 | 55 | 18,736 |
| North Yorkshire | 15,562 | 599.7 | 26 | 16,382 |
| Yorkshire and the Humber | 222,438 | 5,301.3 | 42 | 234,046 |
| | | | | |
| Derby | 10,897 | 246.9 | 44 | 11,636 |
| Leicester | 16,075 | 306.6 | 52 | 16,995 |
| Rutland | 861 | 38.6 | 22 | 906 |
| Nottingham | 22,011 | 306.7 | 72 | 23,422 |
| Derbyshire | 30,736 | 763.7 | 40 | 32,357 |
| Leicestershire | 15,412 | 648.7 | 24 | 16,225 |
| Lincolnshire | 23,452 | 703.0 | 33 | 24,689 |
| Northamptonshire | 21,511 | 687.3 | 31 | 22,645 |
| Nottinghamshire | 28,446 | 779.9 | 36 | 29,946 |
| East Midlands | 169,400 | 4,481.4 | 38 | 178,820 |
| | | | | |
| Herefordshire, County of | 6,324 | 179.3 | 35 | 6,657 |
| Telford and Wrekin | 7,383 | 162.6 | 45 | 7,773 |
| Stoke-on-Trent | 17,596 | 240.1 | 73 | 18,877 |
| Shropshire | 6,798 | 293.4 | 23 | 7,156 |
| Birmingham | 46,010 | 1,036.9 | 44 | 48,348 |
| Coventry | 13,479 | 315.7 | 43 | 14,150 |
| Dudley | 15,473 | 307.4 | 50 | 16,288 |
| Sandwell | 17,094 | 292.8 | 58 | 17,995 |
| Solihull | 7,336 | 206.1 | 36 | 7,723 |
| Walsall | 12,499 | 256.9 | 49 | 13,143 |
| Wolverhampton | 13,989 | 239.4 | 58 | 14,726 |
| Staffordshire | 27,675 | 831.3 | 33 | 29,472 |
| Warwickshire | 18,822 | 536.0 | 35 | 19,815 |
| Worcestershire | 21,291 | 557.4 | 35 | 22,414 |
| West Midlands | 231,769 | 5,455.2 | 42 | 244,538 |
| | | | | |
| Peterborough | 5,617 | 173.4 | 32 | 5,897 |
| Luton | 6,909 | 198.8 | 35 | 7,273 |
| Southend-on-Sea | 4,944 | 165.3 | 30 | 5,205 |
| Thurrock | 4,977 | 159.7 | 31 | 5,240 |
| Bedford | 4,921 | 160.8 | 31 | 5,207 |
| Central Bedfordshire | 7,783 | 255.2 | 30 | 8,234 |
| Cambridgeshire | 14,391 | 616.3 | 23 | 15,150 |
| Essex | 37,416 | 1,413.0 | 26 | 39,616 |
| Hertfordshire | 21,113 | 1,107.5 | 19 | 22,227 |
| Norfolk | 26,692 | 862.3 | 31 | 28,493 |
| Suffolk | 23,283 | 719.5 | 32 | 24,511 |
| East of England | 158,046 | 5,831.8 | 27 | 167,051 |
| | | | | |
| City of London | 1,355 | 11.7 | 116 | 1,422 |
| Barking and Dagenham | 10,485 | 179.7 | 58 | 11,019 |
| Barnet | 11,236 | 348.2 | 32 | 11,796 |

| | 2010-11 | | | 2012-13 |
|---|---|---|---|---|
| Local Authority | Spend £000 | Population* 1000s | Spend per head £ | Spend £000 |
| Bexley | 4,435 | 228.0 | 19 | 4,669 |
| Brent | 15,247 | 256.6 | 59 | 16,007 |
| Bromley | 9,520 | 312.4 | 30 | 9,994 |
| Camden | 22,657 | 235.4 | 96 | 23,786 |
| Croydon | 16,222 | 345.6 | 47 | 17,078 |
| Ealing | 17,169 | 318.5 | 54 | 18,025 |
| Enfield | 9,847 | 294.9 | 33 | 10,367 |
| Greenwich | 13,521 | 228.5 | 59 | 14,195 |
| Hackney | 25,455 | 219.2 | 116 | 26,724 |
| Hammersmith and Fulham | 16,748 | 169.7 | 99 | 17,583 |
| Haringey | 13,935 | 225.0 | 62 | 14,630 |
| Harrow | 7,489 | 230.1 | 33 | 7,862 |
| Havering | 6,566 | 236.1 | 28 | 6,912 |
| Hillingdon | 10,653 | 266.1 | 40 | 11,184 |
| Hounslow | 8,744 | 236.8 | 37 | 9,179 |
| Islington | 19,877 | 194.1 | 102 | 20,867 |
| Kensington and Chelsea | 14,377 | 169.5 | 85 | 15,094 |
| Kingston upon Thames | 7,686 | 169.0 | 45 | 8,069 |
| Lambeth | 20,617 | 284.5 | 72 | 21,645 |
| Lewisham | 16,671 | 266.5 | 63 | 17,502 |
| Merton | 7,114 | 208.8 | 34 | 7,469 |
| Newham | 18,739 | 240.1 | 78 | 19,673 |
| Redbridge | 7,519 | 270.5 | 28 | 7,915 |
| Richmond upon Thames | 6,994 | 190.9 | 37 | 7,343 |
| Southwark | 17,448 | 287.0 | 61 | 18,368 |
| Sutton | 6,620 | 194.2 | 34 | 6,950 |
| Tower Hamlets | 27,756 | 237.9 | 117 | 29,139 |
| Waltham Forest | 8,145 | 227.1 | 36 | 8,550 |
| Wandsworth | 22,136 | 289.6 | 76 | 23,240 |
| Westminster | 25,816 | 253.1 | 102 | 27,102 |
| London | 448,798 | 7,825.2 | 57 | 471,360 |
| | | | | |
| Medway | 9,882 | 256.7 | 38 | 10,403 |
| Bracknell Forest | 2,449 | 116.5 | 21 | 2,579 |
| West Berkshire | 3,925 | 154.0 | 25 | 4,132 |
| Reading | 3,942 | 154.2 | 26 | 4,150 |
| Slough | 2,778 | 131.1 | 21 | 2,925 |
| Windsor and Maidenhead | 3,078 | 146.1 | 21 | 3,240 |
| Wokingham | 4,139 | 163.2 | 25 | 4,357 |
| Milton Keynes | 5,459 | 241.5 | 23 | 5,747 |
| Brighton and Hove | 12,174 | 258.8 | 47 | 12,781 |
| Portsmouth | 14,123 | 207.1 | 68 | 14,868 |
| Southampton | 12,073 | 239.7 | 50 | 12,710 |
| Isle of Wight | 4,610 | 140.5 | 33 | 4,853 |
| Buckinghamshire | 7.624 | 498.1 | 15 | 8,026 |
| East Sussex | 20,302 | 515.5 | 39 | 21,318 |
| Hampshire | 26,829 | 1,296.8 | 21 | 28,244 |
| Kent | 34,669 | 1,427.4 | 24 | 36,484 |
| Oxfordshire | 19,906 | 648.7 | 31 | 20,899 |
| Surrey | 18,760 | 1,127.3 | 17 | 19,695 |
| West Sussex | 22,131 | 799.7 | 28 | 23,269 |

| | 2010-11 | | | 2012-13 |
|---|---|---|---|---|
| Local Authority | Spend £000 | Population* 1000s | Spend per head £ | Spend £000 |
| South East | 228,851 | 8,523.1 | 27 | 240,677 |
| Bath and North East Somerset | 4,986 | 179.7 | 28 | 5,235 |
| Bristol, City of | 16,590 | 441.3 | 38 | 17,465 |
| North Somerset | 4,989 | 212.2 | 24 | 5,352 |
| South Gloucestershire | 4,692 | 264.8 | 18 | 4,940 |
| Plymouth | 8,008 | 258.7 | 31 | 8,430 |
| Torbay | 6,162 | 134.3 | 46 | 6,486 |
| Bournemouth | 6,139 | 168.1 | 37 | 6,460 |
| Poole | 5,172 | 142.1 | 36 | 5,442 |
| Swindon | 6,261 | 201.8 | 31 | 6,591 |
| Cornwall | 16,018 | 535.3 | 30 | 16,863 |
| Isles of Scilly | 64 | 2.1 | 30 | 67 |
| Wiltshire | 11,272 | 459.8 | 25 | 11,866 |
| Devon | 16,014 | 749.9 | 21 | 16,840 |
| Dorset | 10,640 | 404.8 | 26 | 11,201 |
| Gloucestershire | 14,919 | 593.5 | 25 | 15,704 |
| Somerset | 11,910 | 525.2 | 23 | 12,538 |
| South West | 143,834 | 5,273.7 | 27 | 151,478 |
| England | 2,112,456 | 52,234.0 | 40 | 2,223,588 |

Notes: * Office for National Statistics 2010 Mid-year estimates for 2010-11 spend per head, rounded to nearest 100.

## Annex B: Technical adjustments to public health returns

*Imputing reported zeros*
While the second public health survey reduced the number of functions where some PCTs implausibly reported zero spend, some remained. To test the importance of the implausible zeros we imputed values based on the average spend per head for the other PCTs within the SHA.

This imputation raised the total spend only modestly (around £34m[9]), so we are confident that the coverage of the survey is reasonably complete in areas of significant spend. Imputed values have been retained in our analysis, although it has not been possible to make a compensating correction to the CCG focused returns.

*Variability in per capita spend*
While implausible reported zeros can be easily identified, it is less easy to identify implausibly high or low reported per capita spend (which might include simple data entry errors), as we would expect spend in some functions to vary markedly between PCTs, eg drugs treatment and prison public health.

For example, for alcohol misuse services, the PCT with the 10th highest spend per head reported a spend sixteen times higher per head than the PCT with the 10th lowest spend per head. This is a high range, but there is a high correlation between deprivation and high per capita spend. It was therefore not clear how plausible the reported spend is.

*Comparisons with other data sources*
For some public health functions we have alternative estimates of total spend. These include, amongst others: NAO reports and academic studies. Expenditure on a few functions was not covered in the collection and accounts data were used for these.

We have compared these with the total national spend for each function as reported in the PCT return and for the functions shown in Table B1 we believe other sources are more reliable than the PCT estimate.

**Table B1: Alternative and additional estimates**

| Public Health Function | Reported spend | Alternative estimate | Source & discussion |
|---|---|---|---|
| Non-cancer screening | £128m | £404m | Professor Adrian Davis at the Royal Hampstead NHS Trust has produced an estimate of total national spend. It includes a number of estimates e.g. % of patients requiring services and some staff costs. |
| Cancer screening | £271m | £377m | There is an alternative estimate from the National Audit Office. |

[9] Zero spend was imputed for: alcohol misuse, childhood immunisations, TD/IPV and HPV immunisation programmes; contraception additional service - GP contract; child health Information systems; preparedness, resilience and response for health protection incidents and emergencies; and PCT support for surveillance and control of infectious disease

| | | | |
|---|---|---|---|
| QOF elements | - | £164m | Not included in survey. This is taken from accounts. |
| Seasonal flu and pneumococal immunisation programme | £117m | £151m | The alternative estimate is drawn from accounts figures and a survey drawn from GP systems. We would have expected PCT estimates to be at least this high, since the alternative does not cover all aspects of this programme. However, the alternative estimate may still be an underestimate. |
| Contraception additional service GP contract | £68m | £85m | Accounts information suggest this has been slightly underestimated. |
| Alcohol DES | - | £3.6m | Taken from accounts as it was omitted from the survey |

If all of the above alternative and additional sources are accepted, the total public health system budget would be increased by approximately £600m, entirely in functions due to transfer to the NHS Commissioning Board (this corresponds to the £168m (QoF elements and alcohol DES) and £430m alternative sources cited in paragraph 1.14). These adjustments therefore do not affect the breakdown of PCT spend and no compensating adjustment has been made to CCG or NHSCB-focused returns.

*Abortion, sterilisation and vasectomy services*

Spend on abortion, sterilisation and vasectomy services was not separately identified in the returns but was part of a broader category. At the time of the collection they were proposed to be part of LA responsibilities. They are now expected to be part of CCG's responsibilities.

An estimate of spend on these services was made by multiplying activity levels by the most appropriate payment by result national tariffs. The national tariffs exclude the market forces factor for unavoidable costs due to location so the MFF for each PCT was also included.

Since the collection from PCTs, expenditure in the returns for preparedness, resilience and response for health protection incidents and emergencies, and part of the expenditure for PCT support for surveillance and control of infectious diseases has been included in the local authority figures. In the collection from PCTs they were not assigned to a future commissioning route as this was not known at the time.

*Administration spend*

So far we have concentrated on total outturn, ie, programme plus administration, as this will be the basis of grants to LAs. Feedback from PCTs suggests that there is a significant risk of misallocation of estimated spend between programme and administration in the collection. Our estimates of the breakdown of PCT spend therefore rely on other work mapping PCT functions and the resources they deploy on those functions.

## Annex C: Technical adjustments to NHSCB and CCG focused returns

The estimated 2010-11 baseline expenditure for GP practices, and hence CCGs, needs to reflect PCT 2010-11 expenditure under a hypothetical situation that the PCT was in financial balance: a situation where there was no difference between the surplus/deficit at the end of 2009-10 and the end of 2010-11, and similarly no difference between the lodgements at the end of 2009-10 and the end of 2010-11.

PCTs were asked to submit data on this basis (i.e. corrected for surplus/deficit and lodgements) in September 2011. Due to difficulties with the guidance the corrections were not made uniformly or correctly by all PCTs. Therefore, in November 2011 SHAs were asked to resubmit or confirm data on surplus/deficit and lodgements for PCTs in their areas.

If a PCT runs an increase in its surplus (or decrease in its deficit) from the start to the end of the financial year, then its expenditure on health care services needs to be adjusted upwards (i.e. the value of the increase in surplus needs to be added to net expenditure). Similar logic applies to the changes in lodgements with the SHA. Correspondingly, if a PCT had a higher deficit at the end of the year than at the start of the financial year, the PCT should have scaled down spend. In order to assure the data was correctly adjusted a number of steps were taken.

*Quality Assurance using accounts*
We have compared the total net surplus/deficit reported in the collection with information from PCT accounts information collated by DH. There were many significant differences. In some cases there are good reasons for the differences, since part of the net surplus may have been attributed to activities not covered in the collection, such as primary care; but this factor is unlikely to explain the scale of many of the differences. This led us to request additional verifying information from SHAs.

*Re-submission or confirmation of deficit/surplus and lodgements position*
SHAs were asked to re-submit or confirm data on surplus/deficit and lodgements for PCTs in their areas. Where the subsequent collection suggests that this correction has not been applied in the way we anticipated a correction has been made. In cases where the sign of the correction was incorrect, this adjustment can be significant.

*Adjustments to the data*
Where the original deficit/surplus and lodgements corrections were either of the wrong sign or magnitude and / or no apportionment was made across expenditure categories and a number of steps were taken in different cases:

- removing the original PCT correction from the expenditure returns
- re-applying a proportion of the re-submitted correction, based on the proportion of the total PCT primary and secondary care expenditure covered by the returns (compared to the totals in accounts)
- re-apportioning the estimates of the relevant categories of spend to each GP practice, within a PCT, proportionately to the estimates of GP expenditure originally submitted by PCTs in September 2011.