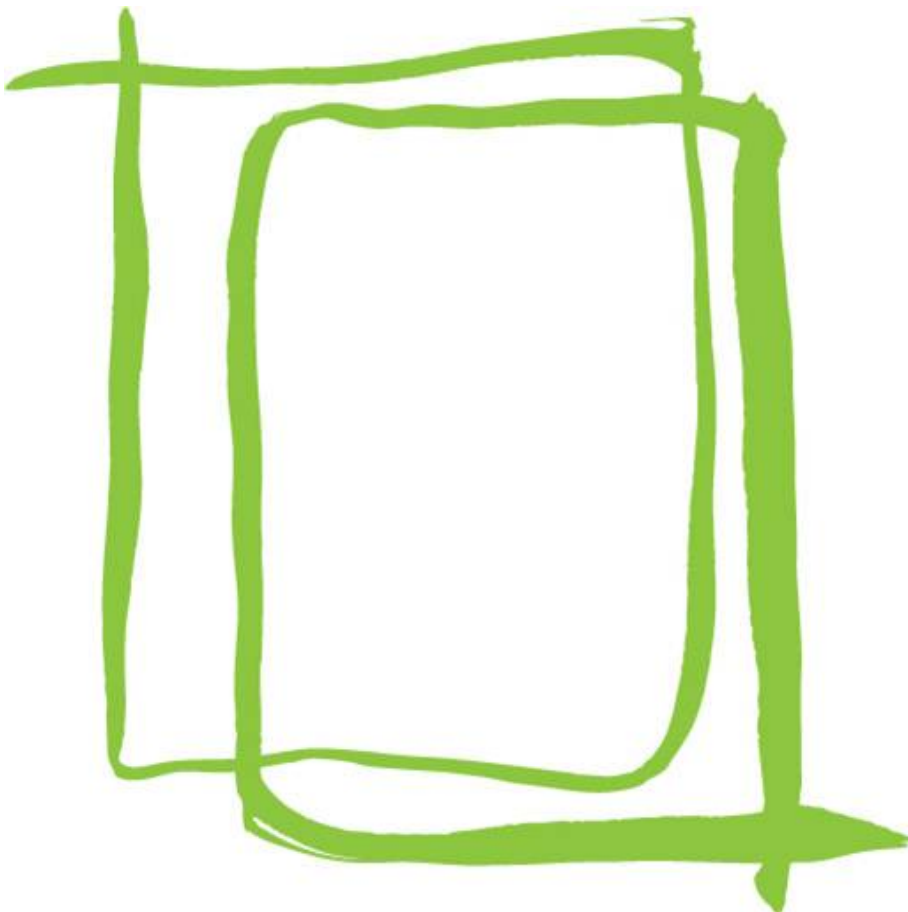


# Use of Resources Profile

Hounslow Primary Care Trust

Audit 2008/09

November 2008



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# Introduction

- 1 PCTs are expected to use a wealth of data to improve commissioning and performance, and in doing so, to benchmark themselves against their peers. The Audit Commission has selected some data which may give an indication of performance (but which would need much more local explanation). More importantly, PCTs could reasonably be expected to have reviewed the data themselves to address:
  - service and financial planning (using programme budgets);
  - health improvement (using a variety of outcome proxies); and
  - management of their own provider arm to produce greater efficiency (using reference costs).
- 2 In making their judgements on PCTs' use of resources, the Commission requires that its auditors follow a series of Key Lines of Enquiry (KLOE), which are common across all audited bodies. Further information on these can be found on the Audit Commission website ([www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)). The Commission also issues guidance to auditors in each sector to support the assessment, including possible sources of evidence. For PCTs, relevant sources of evidence include the following.
  - Programme budgets (how are you spending the money?)
  - Output/outcome proxies (what's the money achieving?)
  - Reference cost index (how efficient is your own service provision?)
- 3 All the material we have selected is included in the Department of Health's (DH's) World Class Commissioning (WCC) data pack, except for the reference costs which are a standard way of measuring relative efficiency.
- 4 The WCC process covers the topic of commissioning, and so to avoid duplication, PCT auditors are not required to come to a scored judgement on KLOE 2.1 (Commissioning and Procurement). They are, however, required to come to judgements on other KLOEs (such as understanding costs and achieving efficiency), and need to consider relevant evidence on costs, together with outputs or outcomes, as the following table illustrates. In each case, auditors need to assess whether PCTs are aware of this kind of information; whether they have already examined it (in rather more detail than can be presented here); and whether they are using it to achieve the best possible use of resources.

Table 1

	Programme budgets	Output/outcome proxies	Reference cost index
1.1 Planning for financial health	•	•	
1.2 Understanding costs & achieving efficiency	•	•	•
1.3 Financial reporting			
2.1 Commissioning & procurement	not scored this year	not scored this year	not scored this year
2.2 Use of information	•	•	•
2.3 Good governance			
2.4 Risk management & internal control			
3.1 Natural resources (no assessment required for PCTs)	na	na	na
3.2 Strategic asset management (where significant)			•
3.3 Workforce			•

# Summary

5 A summary of the metrics presented in this profile is shown in the table below.

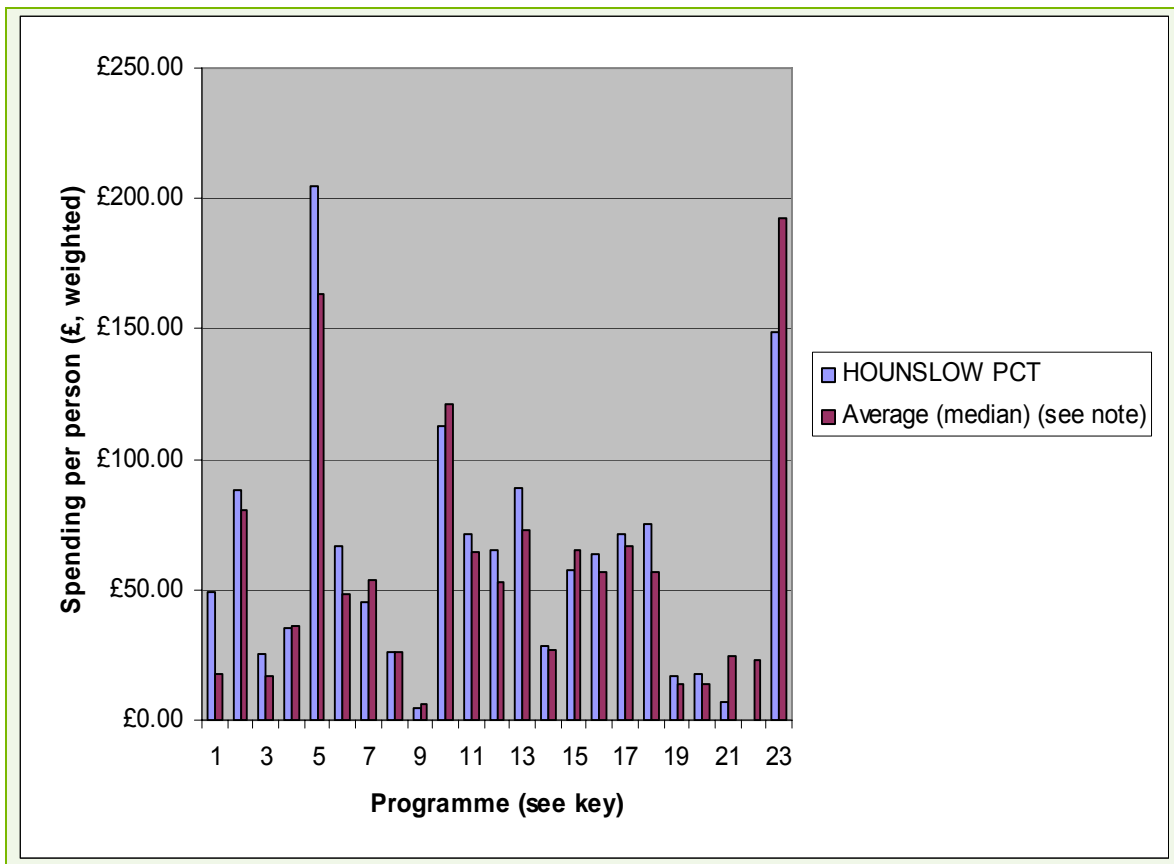
**Table 2**

		Hounslow PCT	Average (median)
<b>Spending</b>			
	Total spending per head (unified, weighted) £ 2006/07	1,370	1,336
<b>Primary care</b>			
	GPs per 000 weighted population 2006/07	0.53	0.58
	Non GP staff per 000 weighted population 2006/07	1.13	1.47
<b>Patient perception (2007 survey)</b>			
	Offered choice of provider %	94.6	93.4
	Phone access %	81.3	84.5
	Able to get appointment within 48 hours %	75.8	84.3
	Opening hours %	77.8	84.6
<b>Mortality (per 100,000, directly standardised)</b>			
	All causes (2004/06)	662	627
	Amenable causes (2004/06)	124	115
<b>Avoidable admissions</b>			
	% emergency admissions with ACS diagnosis 2007	11.3	11.6
<b>Reference costs</b>			
	Reference cost index 2006/07 (inc MFF)	84.9	101.5

# How are you spending the money?

6 The following exhibit shows your PCT's spending per head of population (unified, weighted) by disease group, compared with national averages.

**Figure 1 Programme budgets**



## How are you spending the money?

**Table 3**

Key	Programme spend per weighted head	Hounslow PCT	Average (median) (see note)	Hounslow PCT	Average (median) (see note)
1	Infectious Diseases	£48.75	£17.53	3.6%	1.3%
2	Cancers and Tumours	£87.93	£80.17	6.4%	6.0%
3	Disorders of Blood	£25.37	£16.52	1.9%	1.2%
4	Endocrine, Nutritional and Metabolic	£35.17	£35.87	2.6%	2.7%
5	Mental Health Disorders	£204.66	£163.16	14.9%	12.2%
6	Problems of Learning Disability	£66.44	£47.99	4.8%	3.6%
7	Neurological	£45.05	£53.34	3.3%	4.0%
8	Problems of Vision	£26.31	£26.16	1.9%	2.0%
9	Problems of Hearing	£4.98	£6.26	0.4%	0.5%
10	Problems of Circulation	£113.00	£121.08	8.2%	9.1%
11	Problems of the Respiratory System	£71.35	£64.52	5.2%	4.8%
12	Dental Problems	£65.29	£53.13	4.8%	4.0%
13	Problems of Gastro Intestinal System	£89.06	£72.62	6.5%	5.4%
14	Problems of the Skin	£28.74	£26.58	2.1%	2.0%
15	Problems of Musculo Skeletal System	£57.52	£65.26	4.2%	4.9%
16	Problems due to Trauma and Injuries	£64.00	£56.42	4.7%	4.2%
17	Problems of Genito Urinary System	£71.43	£66.61	5.2%	5.0%
18	Maternity and Reproductive Health	£75.49	£56.84	5.5%	4.3%
19	Conditions of Neonates	£16.49	£13.55	1.2%	1.0%
20	Adverse effects and poisoning	£17.27	£13.96	1.3%	1.0%
21	Healthy individuals	£6.68	£24.43	0.5%	1.8%
22	Social Care Needs	£0.15	£22.79	0.0%	1.7%
23	Other (including GMS/PMS)	£148.85	£192.68	10.9%	14.4%
	<b>Total</b>	<b>£1,369.99</b>	<b>£1,336.16</b>	<b>100.0%</b>	<b>100.0%</b>

Source: Programme budgets 2006/07 and allocations (WCC indicators 4.01 – 4.23)

Note: Totals of median columns do not sum due to skewed distributions

- 7** Unified weighted population takes account of more needy populations, of the age profile of the population, and of extra costs associated with market forces, and is used as the basis for resource allocation by the DH. However, total spending per head may nevertheless be somewhat higher or lower than the national average. Such differences arise firstly because government allocations move only gradually towards the long term target. At any one time, therefore, each PCT's allocation is therefore some distance (up to 10 per cent, even more in a handful of cases) from this target. Secondly, in addition to a variety of technical adjustments, PCTs may, of course, spend more or less than their allocation within the year, giving rise to a deficit or surplus.
- 8** Most importantly, the spending pattern should bear some relationship to strategic objectives. In particular, where significant variations exist (as a rule of thumb, a difference of £10 per head, or around one percentage point of expenditure, equates to £3 million for a typical PCT serving 300,000 people), the PCT should be able to explain, with reference to its strategic objectives and/or any particularly unique circumstances, why it chooses to do so.

# What's the money achieving?

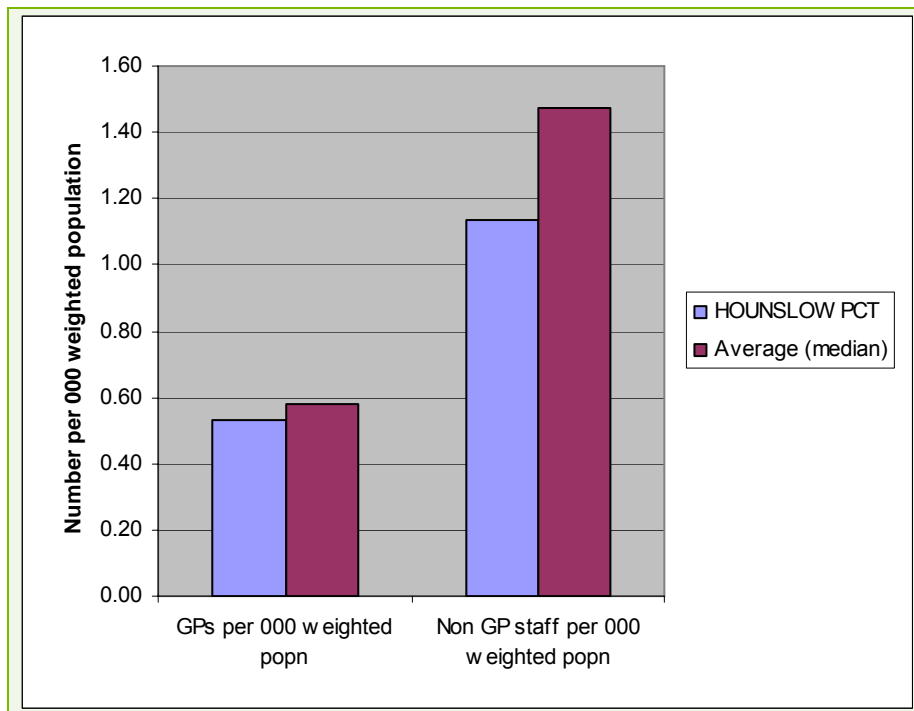
9 Linking spending with outputs and outcomes is notoriously difficult, not least because of the impact of variables which are beyond the management control of the PCT, and also because of the time between cause and effect, which in health may be years. Nevertheless, the Department of Health together with the Office of National Statistics collects a wide range of information which is relevant. A small selection of this information is provided here, in respect of three key areas, each of which represents a DH priority area for improvement:

- access to primary care;
- mortality (health inequalities); and
- avoidable emergency admissions.

## Access to primary care

10 The number of GPs (whole time equivalents) per head of population (weighted to reflect differences in health need in primary care) is shown below, along with a similar analysis for other clinical practice staff.

Figure 2 GP staffing levels



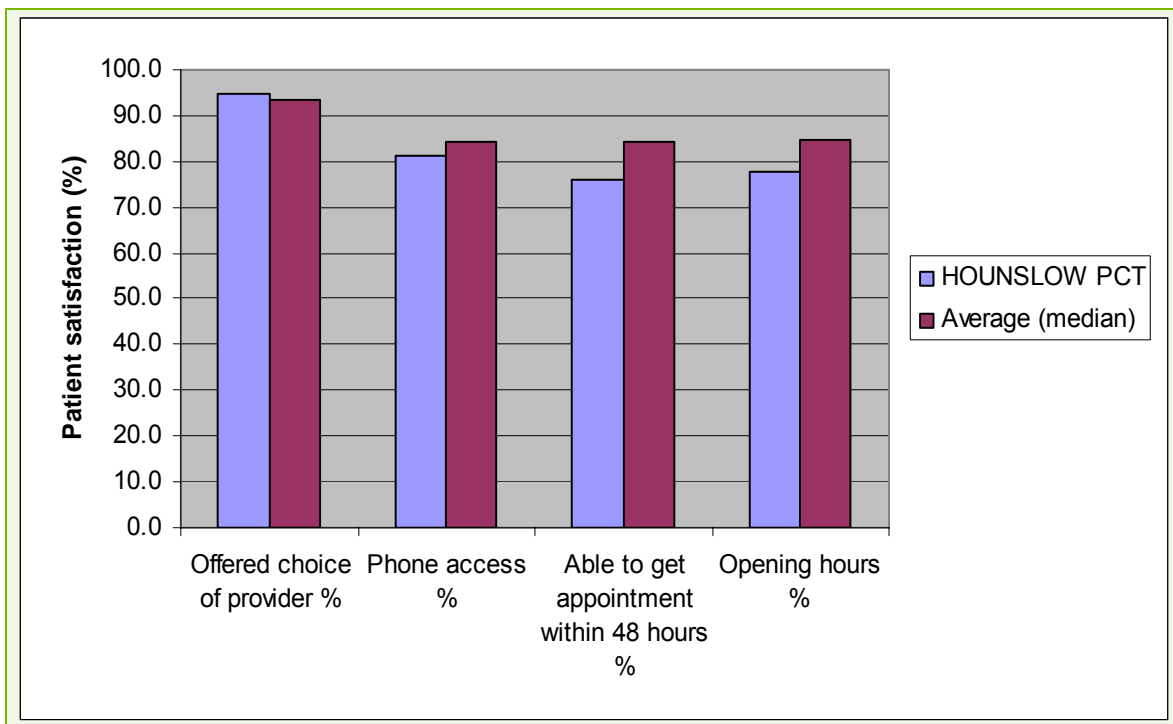
**Table 4**

	Hounslow PCT	Average (median)
GPs per 000 weighted popn	0.53	0.58
Non GP staff per 000 weighted popn	1.13	1.47

Source: GP staffing census 2006/07 (WCC indicators 5.01,5.02)

- 11 Nationally, there is substantial variation in this indicator – some areas have almost twice as many GPs for the population/need, as others. Practice costs would normally be included in the ‘other’ category of programme budget spend (WCC 4.23), so it may be useful to consider the two indicators (provision and cost) together.
- 12 However, the provision of GPs is neither an output nor an outcome. Though there may be a link between provision of GPs and patient perception of ease of access, the degree to which patients perceive they have good access to a GP might be an equally relevant measure. A comparative analysis of the results from the GP patient survey in respect of four key questions is shown below.

**Figure 3 GP access**



## What's the money achieving?

**Table 5**

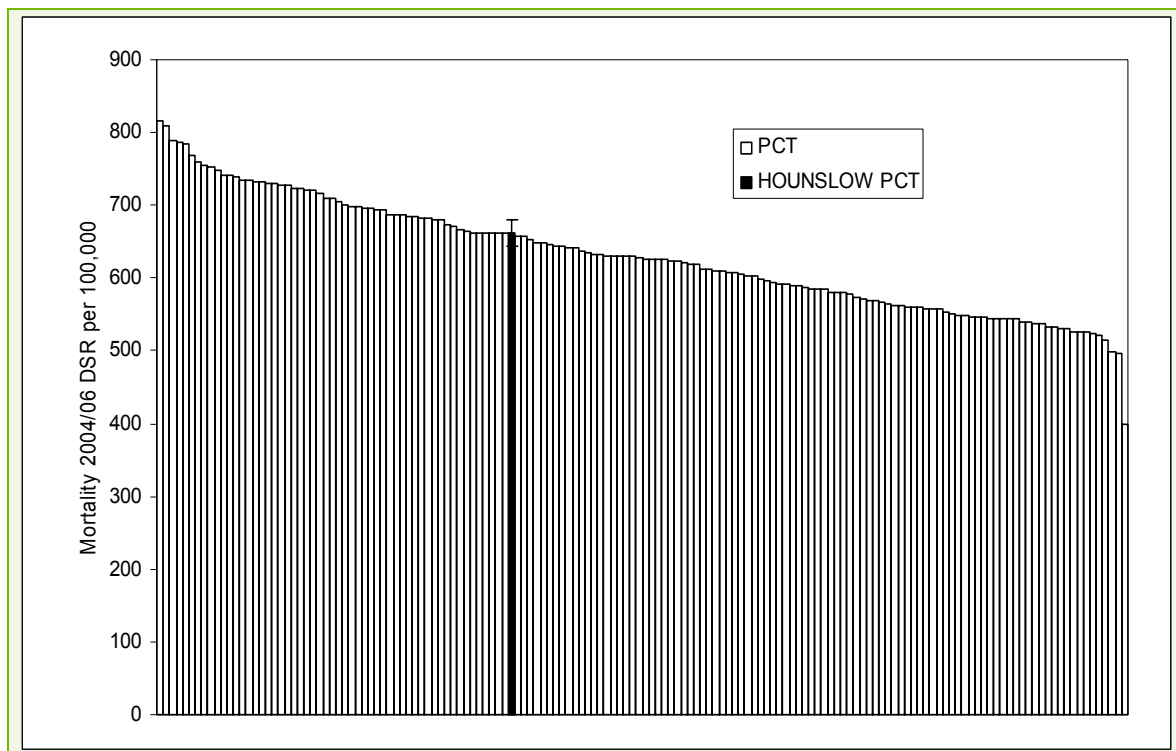
	Hounslow PCT	Average (median)
Offered choice of provider %	94.6	93.4
Phone access %	81.3	84.5
Able to get appointment within 48 hours %	75.8	84.3
Opening hours %	77.8	84.6

Source: Patient survey 2007 (WCC indicators 5.10, 5.11, 5.12, 5.15)

### Mortality (health inequalities)

- 13** With life expectancy varying by over five years between PCTs, the Department of Health has set an objective to improve life expectancy in the worst areas towards the level of the best.
- 14** An analysis of all-cause mortality, or death rate (in practical terms, the converse of life expectancy), is shown below.

**Figure 4 Mortality**



**Table 6**

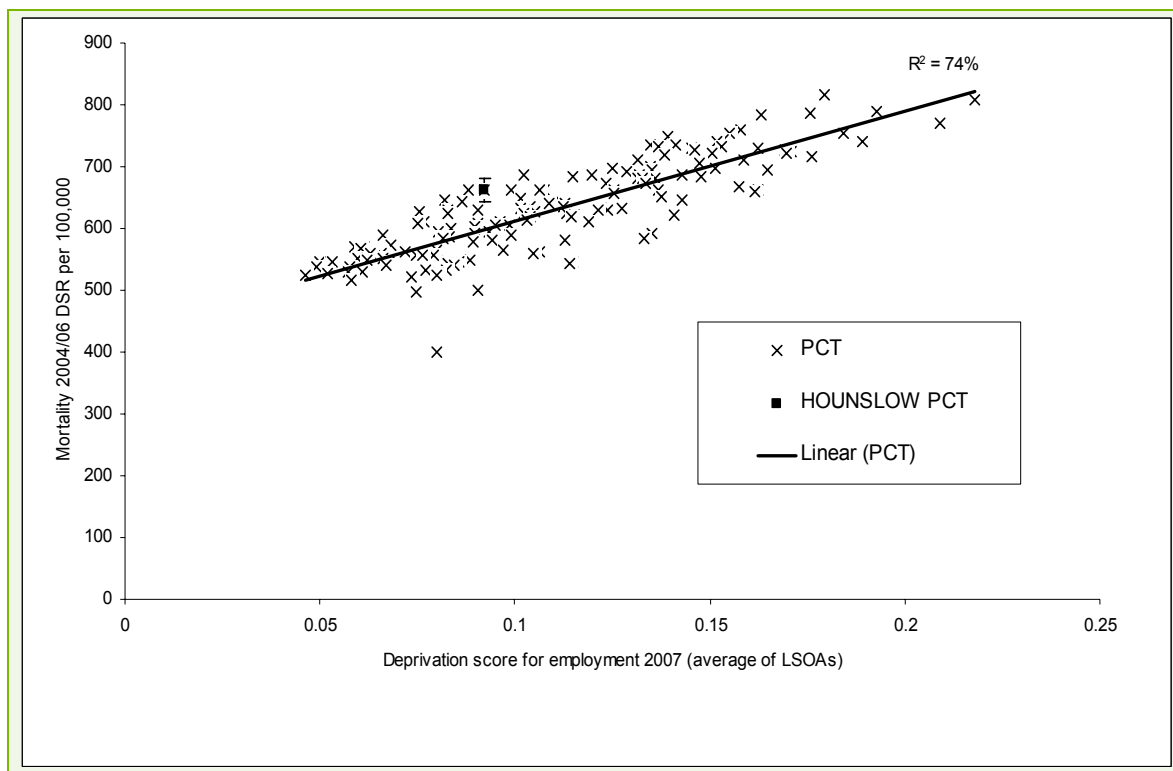
Hounslow PCT	Median
662	627

Source: ONS and National Centre for Health Outcomes Development (WCC indicator 3.13)

- 15** As mortality is greater in older people and higher in men than in women, the measure shown above is the directly standardised rate (DSR) which takes into account the age and sex distribution of the population. It reflects the number of deaths per year per 100,000 people after this adjustment has been made. The confidence interval indicates the uncertainty surrounding the metric as a result of the finite number of deaths observed. To minimise this uncertainty, deaths have been counted over a three-year period.
- 16** Deprivation and mortality are very strongly associated – the highest rates of mortality occur in areas of high deprivation. Whether or not to take account of deprivation in assessing whether mortality in a particular area is good (low) or bad (high) is the subject of political debate. Nevertheless, given the strength of the association, the same metric is shown overleaf to allow comparison of the rate at your PCT given its level of deprivation<sup>1</sup>.

<sup>1</sup> Employment deprivation is the component of the index of multiple deprivation which is most strongly associated with mortality. The health component, though more strongly linked, should not be used for this purpose because it is itself based partly on mortality.

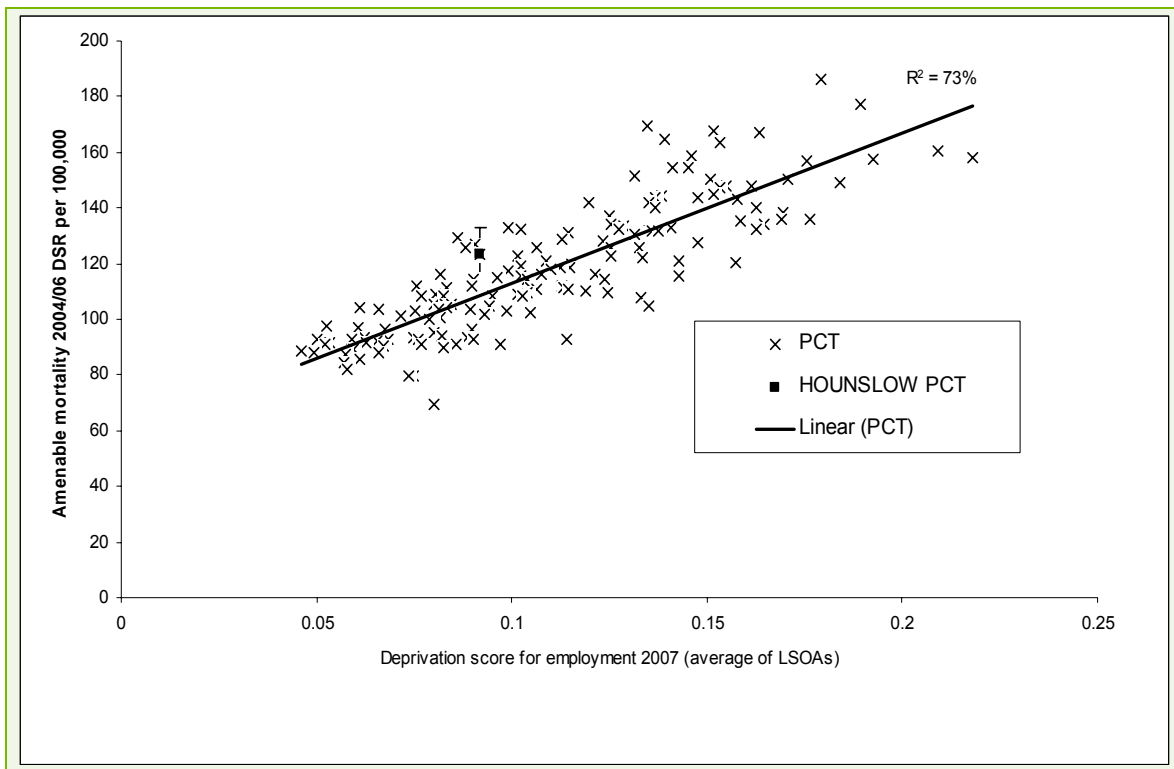
Figure 5 Mortality adjusted for deprivation



Source: WCC indicators 3.13 and 1.03c/4c

- 17 Placement of the PCT above the line of best fit indicates a higher death rate than expected, having controlled for the effect of deprivation. Placement below represents a better than expected outcome.
- 18 The degree to which health and other public services, rather than demographic factors, impact on mortality is not known. Clearly local public services cannot be held to account for every death. However, attempts have been made to list a range of conditions which are most amenable to health care interventions. Deaths from these causes are therefore considered to be a better measure of the effectiveness of health services in the local area. The corresponding analysis for this subset of deaths is shown overleaf.

**Figure 6 Amenable mortality adjusted for deprivation**

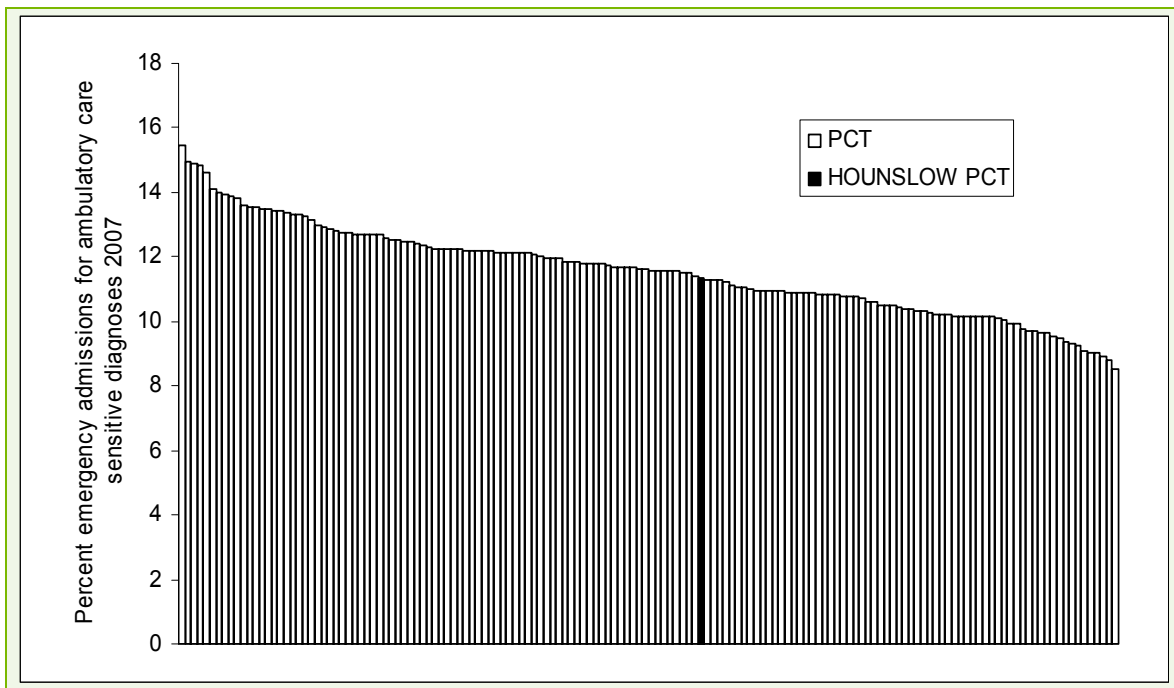


Source: WCC indicators 3.01 and 1.03c/4c (note: PCT data sourced directly from [www.nchod.nhs.uk](http://www.nchod.nhs.uk) as WCC lists data only by LA)

### Avoidable emergency admissions

**19** Within the range of emergency admissions, a subset of conditions known as ambulatory care sensitive (ACS) are considered to be amenable to treatment in primary care. Emergency admissions where the primary diagnosis is for one of these conditions are therefore considered to be theoretically avoidable. Depending on the definition used they account for 12 per cent to 15 per cent of all emergency admissions nationally. However there is significant variation between PCTs as the following analysis shows.

**Figure 7 Admissions from ACS conditions**



**Table 7**

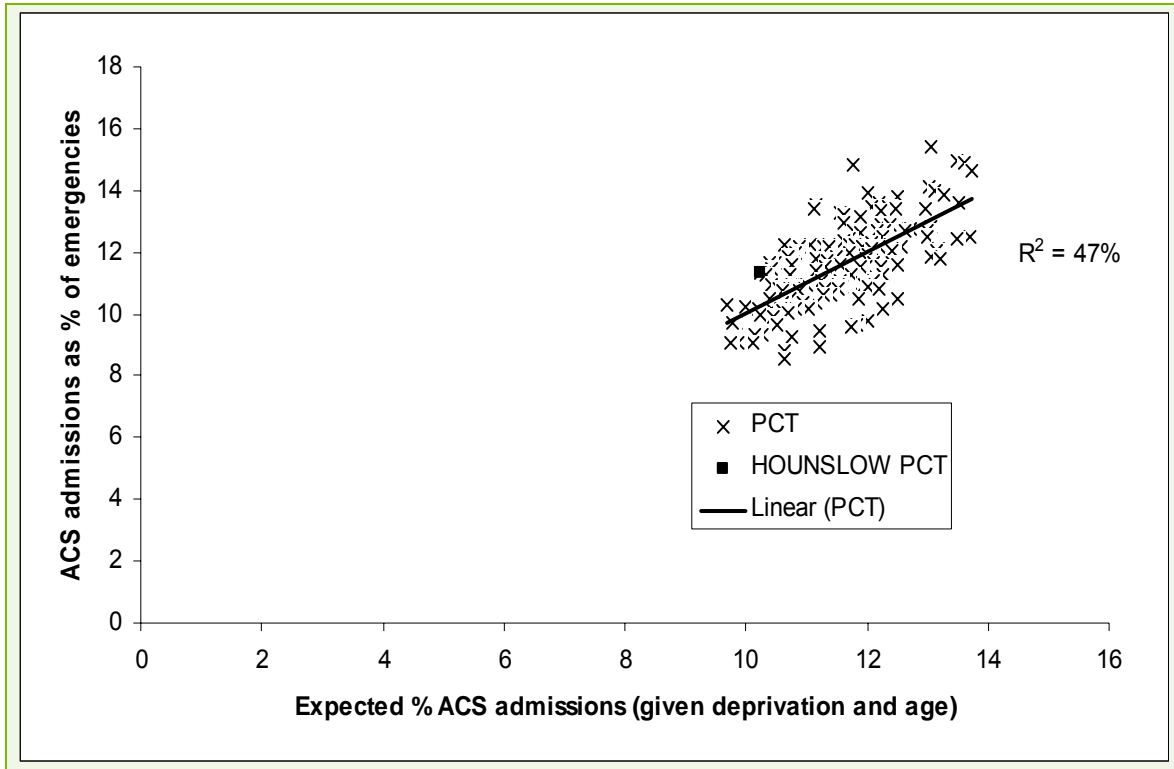
Hounslow PCT	Median
11.3	11.6

Source: Secondary Uses Service 2007 (WCC indicator 8.03)

**20** Some of the variation in the percentage is attributable to the nature of the population: Relatively elderly and more deprived populations tend to be associated with a higher proportion of admissions for ACS conditions. However, it is possible to compensate for this by comparing the percentage with the expected<sup>2</sup>, given the age and deprivation of the population. This analysis is shown overleaf.

<sup>2</sup> Formula derived using stepwise multiple regression technique based on the percentage of the population aged over 65 and employment deprivation.

**Figure 8 Admissions from ACS conditions, adjusted for deprivation and age**

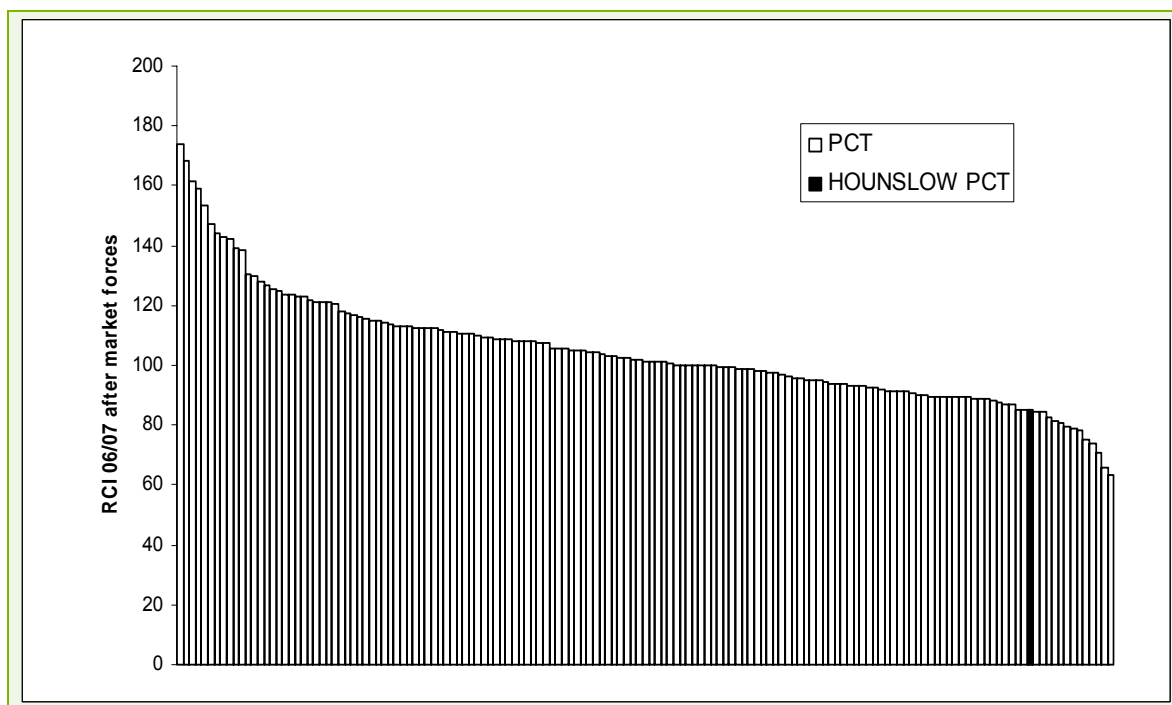


**21** PCTs above the line have a higher percentage of ACS admissions than expected. There may be several reasons for a high percentage, including for example, access to primary care or overstretched A&E services in local hospitals which in turn admit ACS patients rather than breach the four hour waiting target.

# How efficient is your own service provision?

22 The Department of Health’s reference cost index (RCI) provides a measure of the relative cost efficiency of directly provided services. An index of 100 indicates that the unit cost of delivering services is the same as the national average. An index of 110 indicates costs are 10 per cent higher. The index shown here discounts actual costs by a market forces factor to take account of higher costs for example in London.

**Figure 9 Reference cost index**



**Table 8**

Hounslow PCT	Median
84.9	101.5

Source: Department of Health reference costs 2006/07

## How efficient is your own service provision?

- 23** Clearly, this information will be most relevant at PCTs with substantial amounts of their own provision. As reference costs include expenditure on both staff and fixed assets, the information is relevant to both KLOEs 3.2 and 3.3.
- 24** Community services, where the majority of costs are labour, are provided at virtually all (151 out of 152) PCTs. However, at many PCTs, the index also includes outpatient and other acute services, for example because the PCT may run community hospitals. In these cases, reference costs will reflect the productivity of both staff and strategic assets. To see which services contribute to the overall reference cost index at your PCT, and the scores for each component, see the link to the DH reference costs website overleaf.

## Further information

- 25** Further information on programme budgets, is available from the Department of Health's website:

[http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH\\_075743](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743)

- 26** A wide range of outcome measures, is available from the National Centre for Health Outcome Development (NCHOD) website:

<http://www.nchod.nhs.uk>

The NHS net version of this site contains a wider range of metrics for PCTs and an interactive atlas tool to help you compare programme budget spending with outcomes.

[www.nchod.nhs.uk](http://www.nchod.nhs.uk)

- 27** Further information about reference costs, including a further breakdown of the overall index into its components (community services, outpatients, other acute, inpatient, etc.) is available on the Department of Health website.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082571](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082571)

- 28** Finally, all of the data used in this profile (except reference cost index) is also to be found on the Department of Health's world class commissioning website:

<http://www.wccassurance.dh.gov.uk/Pages/Public/Home.aspx>

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