

# Department of Health

## *Departmental Report 2008*

The Health and Personal  
Social Services Programmes



This is part of a series of Departmental Reports (Cm 7391 to 7408) which, along with the Main Estimates 2008-09, the document Public Expenditure: Statistical Analyses 2008 and the Supply Estimates 2008-09: Supplementary Budgetary Information, present the Government's outturn and planned expenditure for 2007-08 and 2008-09.



# Departmental Report 2008

## Department of Health

DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health  
by Command of Her Majesty  
May 2008

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The purpose of this report is to present to Parliament and the public a clear and informative account of the expenditure and activities of the Department of Health.

This report and those of 1998 to 2007 are available on the Internet at: [www.dh.gov.uk](http://www.dh.gov.uk)

The Department also has a Public Enquiry Office which deals with general queries, 020 7210 4850.

# Foreword by the Secretary of State



It gives me great pleasure to present the Department's eighteenth annual report.

As we reach the key milestone of the NHS's 60th anniversary, this diamond jubilee year offers us an exceptional opportunity to celebrate a unique British institution. The NHS is a huge organisation, employing over 1.3 million members of staff, delivering over 14 million episodes of admitted patient care, 64 million outpatient and A&E attendances, across 70 consultant specialty areas in more than 300 NHS establishments plus third sector and independent sector providers. In general practice, there are 290 million consultations per year in around 5,200 GP practice premises. The size and complexity of the NHS makes it more of a challenge when meeting the needs of patients and therefore we can be truly proud of our progress.

- Waiting times have fallen to an all-time low.
- Clinical outcomes for killer diseases such as cancer and cardiovascular disease have improved dramatically.
- We have delivered the largest investment in hospital capital schemes in the NHS's history.
- We have transformed the planning of patient care, ensuring that local priorities and needs are at the heart of service commissioning.
- We have introduced health reforms such as patient choice, practice-based commissioning, payment by results, foundation trusts and independent sector treatment centres, which are generating a more responsive NHS.

Across social care, better partnership working has demonstrated the enormous benefits to people using services and to the health and social care economy.

- Early indications from the Partnerships for Older People Pilots (POPPs) (in partnership with primary care trusts, the voluntary, community and independent sector) show that they are having a significant effect on reducing hospital emergency bed-day use when compared with non-POPP sites.
- The Department also established the Preventative Technology Grant to enable councils to support people to remain in their own home.
- On 21 February 2007, the Government formally launched details of the New Deal for Carers (a commitment from *Our Health, Our Care, Our Say*). The Government announced a multi-million pound package of support for carers through a range of measures – recognising carers as real partners and valuing their contribution but also their needs as individuals.

Of course, all this cannot be achieved without a significant level of investment. In autumn 2007, the Chancellor announced the outcome of the Comprehensive Spending Review which set out the spending plans from 2008-09 to 2010-11. This continues a decade of unprecedented investment. NHS expenditure will grow in real terms by 4 per cent per annum over the three years, taking expenditure to a record £110 billion by 2010-11. The Department's funding for adult social care will grow by 2.3 per cent over the same period, taking investment to £1.5 billion; in addition, the local authority revenue grant will grow by £2.6 billion by 2010-11, providing additional resources for local

authorities to invest in adult social care. This funding will provide a solid platform for us to continually improve health and social care services.

We also must not forget the significant contribution and commitment of our health and social care workforce – a key resource necessary for the delivery of our immense achievements. Significant investment and contractual changes have enabled us to secure the right number of appropriately trained staff; there is an increasing trend in the number of clinical staff working in the NHS. Looking forward, we must now ensure greater integration of the NHS, independent sector and social care workforce to enable the delivery of new models of care centred around the needs of the patients, families and carers.

As we move towards the next decade, reform continues to be vital for us to achieve a world class NHS. Our interim NHS Next Stage Review report, *Our NHS, Our Future*, sets out our vision for the NHS reflecting what we've heard from patients, staff and the public. We will move away from a one-size-fits-all service to one that is tailored around the needs of patients, focusing on quality and prevention while ensuring equitable access.

We have high ambitions for delivering further service improvements, which will serve patients through their journey from birth to the end of life. We will:

- modernise maternity services, providing choice for women on how to access maternity care, antenatal care, place of birth, postnatal care and the support of an expanded maternity workforce;
- increase support to children and families to tackle child obesity by raising awareness, working with local partners and developing knowledge of what works to tackle obesity;
- improve access through achievement of the 18-week referral-to-treatment pledge, and improving access (including at evenings and weekends) to GP services;
- reduce further healthcare-associated infections with additional investment to tackle increases in cases of *Clostridium difficile* and sustaining progress we have made in reducing MRSA, including the introduction of MRSA screening for all elective patients in 2008-09 and all emergency

admissions as soon as possible within the next three years;

- further reduce cancer waiting times and double investment in palliative care;
- improve the health outcomes of people with long-term conditions by offering personalised care plans for people most at risk through improved care in primary and community settings;
- expand the current programme of work on improving access to psychological therapy services for people suffering from the prevalent long-term depression and anxiety disorders;
- further expansion of care tailored to the individual, including individual budgets, enabling people to stay as independent and in control of their life as much as possible;
- support service development in the social care sector through the production of a Green Paper, later in the year, setting out key issues and options for reform as part of the Social Care Strategy Unit's work on reform of the funding system.

In the summer, we will publish the final report of the NHS Next Stage Review, which will set out our strategy, over the next ten years, to develop a health and social care service that meets the changing demographic and social challenges of healthcare in the 21st century.

Sixty years on, we remain true to our values that NHS services are universally available, tax-funded and free at the point of need. However, we want to take this a step further and build a lasting legacy of a service that meets the growing needs and expectations of patients, whilst being the envy of the world.



Rt Hon Alan Johnson  
Secretary of State for Health

# Ministerial Responsibilities



## **The Rt Hon Alan Johnson MP**

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### **Secretary of State**

Overall strategic responsibility for the work of the Department with particular responsibility for: NHS and social care delivery and system reforms; finance and resources; and strategic communications.

## **Ben Bradshaw MP**

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### **Minister of State for Health Services, MS(H)**

Responsibilities include: NHS policy and strategy; finance (including capital); system management and regulation; commissioning; commercial policy; Connecting for Health; urgent, emergency and primary care; 18 weeks; and departmental management.



## **The Rt Hon Dawn Primarolo MP**

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### **Minister of State for Public Health, MS(PH)**

Responsibilities include: public health; health protection and emergency preparedness; Food Standards Agency; health improvement national programmes; health inequalities; fertility; international and European Union business; research and development; medicines and pharmaceuticals; National Institute for Health and Clinical Excellence; asylum seekers; and vascular screening.

## **Ann Keen MP**

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### **Parliamentary Under Secretary of State for Health Services, PS(H)**

Responsibilities include: healthcare quality; patient safety; workforce; National Clinical Directors and programmes; dentistry; partnership, experience and involvement; optical; chronic diseases and long-term conditions; workforce reconfigurations; and children's health and maternity.





## **Ivan Lewis MP**

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### **Parliamentary Under Secretary of State for Care Services, PS(CS)**

Responsibilities include: social care, local government and care partnerships; mental health; prison/offender health; third sector; carers; dignity and respect; sustainable development; equality and human rights; end-of-life care; audiology; disabled children; children and adolescents' mental health services; and the NHS constitution.

## **Professor The Lord Darzi KBE**

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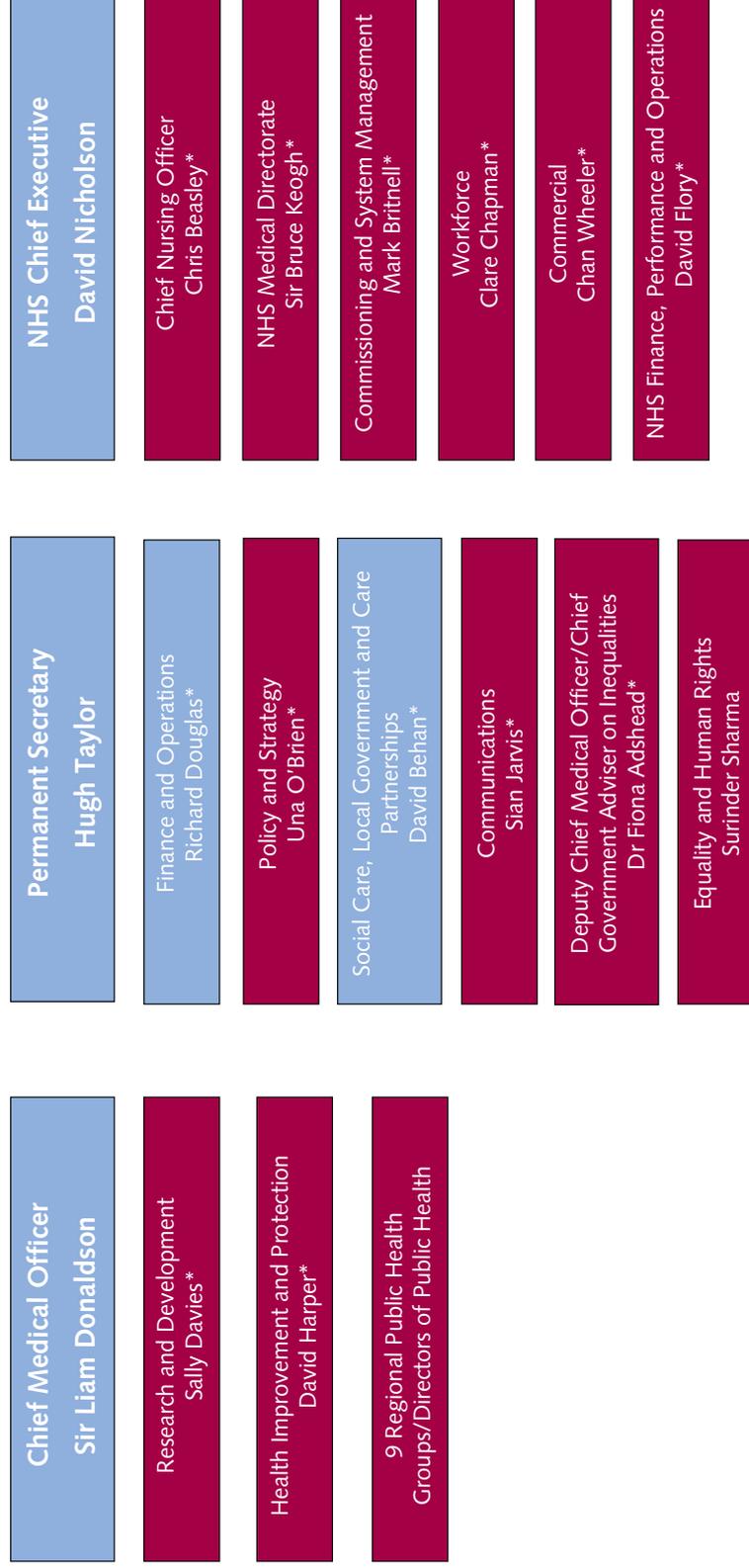
### **Parliamentary Under Secretary of State, PS(L)**

Responsibilities include: NHS Next Stage Review.



# Department of Health Organisation Chart

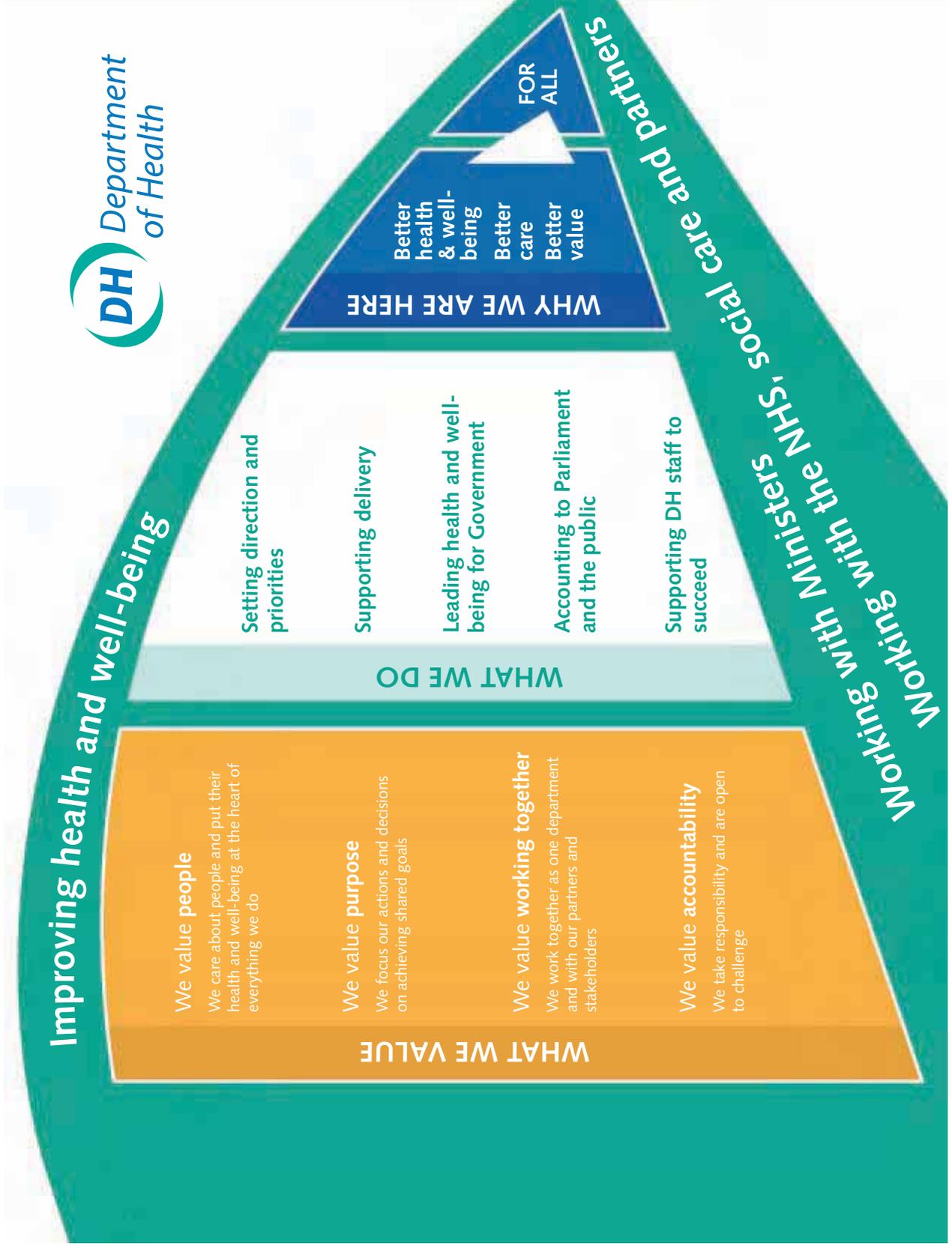
The Department's structure is arranged under three permanent secretaries



\* Directors General

Blue boxes show Departmental Board members

# Department of Health Purpose, Roles and Values



# 1 Introduction

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## Introduction

**1.1** This report, the Department of Health's eighteenth annual report, plays a key role in the Department's accountability to Parliament for its management of the public money invested in health and social care.

**1.2** It provides a comprehensive overview of spending and investment programmes and of the system reforms accompanying this investment. It focuses on the continuous improvements being delivered for people using health and social care services and on the Department's progress against its Public Service Agreements (PSAs).

**1.3** The report also sets out the Department's plans for future years. In particular, this focuses on activities and improvements planned for 2008-09. The October 2007 Comprehensive Spending Review (CSR 2007) set the future financial context for health and social care.

**1.4** This report was produced and published under the reporting framework issued by HM Treasury.

## Department of Health

**1.5** The Department is responsible for the stewardship of over £90 billion of public funds. It advises ministers on how best to use this funding to achieve and inform their decisions and carry out their objectives. Its staff are responsible for leading and driving forward change in the NHS and social care, as well as improving standards in public health.

**1.6** The Department is accountable to the public and the Government for the overall performance of the NHS, adult personal social services and the work of the Department itself.

**1.7** Health and social care services are delivered through the NHS, local authorities, arm's length bodies and other public and private sector organisations.

## The Department's aim

**1.8** The Department's overall aim is to improve the health and well-being of the people of England. Its work includes setting national standards and shaping the direction of the NHS and social care services, and promoting healthier living.

**1.9** The Department has four distinct but inter-related roles in support of this aim:

- It sets direction for the NHS, for adult social care and public health.
- It finds the best way to support and mobilise the health and social care system to deliver improvements for patients and the public.
- It leads on the integration of health and well-being into wider government policy and the integration of wider public policy into health and social care services by working with other sectors, systems and government departments.
- It supports ministers in accounting to the public and Parliament for health and social care.

**1.10** The Department has been shaped to help it fulfil these roles, make key decisions and meet its top priorities. The Department's top-level structure is set out on page 5 of this report. More information on the way that the Department is structured and operates can be found in chapter 11.

## The Department's objectives

**1.11** The Department's 2007-08 delivery objectives, derived from its 2004 PSA with HM Treasury, are as follows:

- Objective 1 – health of the population.
  - By 2010, increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.
  - By 2010, substantially reduce mortality rates:
    - from heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a 40 per cent reduction in the inequalities gap between the fifth of

- from cancer by at least 20 per cent in people under 75 with a reduction in the inequalities gap of at least 6 per cent between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
    - from suicide and undetermined injury by at least 20 per cent.
  - Reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.
  - Tackle the underlying determinants of health and health inequalities by:
    - reducing adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less;
    - halting the year-on-year rise in obesity among children under 11 by 2010; and
    - reducing the under-18 conception rate by 50 per cent by 2010.
  - Objective 2 – long-term conditions.
    - Improve the health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk, and reduce emergency bed days by 5 per cent by 2008, through improved care in primary care and community settings for people with long-term conditions.
  - Objective 3 – access to services.
    - Ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of treatment unless it is clinically appropriate to do so or they choose to wait longer.
    - Increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
  - Objective 4 – the patient and user experience.
    - Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.
    - Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:
      - increasing the proportion of older people being supported to live in their own home by 1 per cent annually in 2007 and 2008; and
      - increasing by 2008 the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care.
- 1.12** A report on progress against each of these objectives can be found in annex B. Expenditure against each of them can be found in chapter 9. The Department has agreed a new set of departmental strategic objectives (DSOs) and PSAs as part of the CSR 2007 settlement. The Department will report on delivery against these in future annual reports. Details of the new DSOs and PSAs can be found in chapter 11.

## National Health Service

**1.13** The Department is responsible for the provision of health services through the National Health Service (NHS). Services are delivered locally by 1.3 million staff in more than 300 organisations and through approximately 5,200 GP practice premises, as well as other primary care services. These services are in contact every day with over 1.5 million patients and their families.

**1.14** In CSR 2007, the Chancellor announced the three-year funding settlement for the NHS from 2008-09 to 2010-11.

**1.15** NHS funding will increase by an average of 4 per cent a year over and above inflation for the three-year period of the CSR. This will take NHS

expenditure from £90.4 billion in 2007-08 to £109.8 billion in 2010-11.

## Personal Social Services

**1.16** The Department also sets the strategic framework for adult social care. It gives advice and guidance to local authorities, whose responsibility it is to manage social care funding according to local priorities and the principles of local accountability. Almost 1 million staff work in the social care sector, providing services to 1.7 million users, most of whom are elderly, through 25,000 social care providers, of which the great majority are small, independent sector organisations.

**1.17** In CSR 2007, the Government allowed for continued growth in Personal Social Services (PSS) resources in England.

**1.18** The social care settlement is made in two parts: the local government revenue grant allocated by the Department for Communities and Local Government and funding provided directly by the Department of Health.

**1.19** Overall, local authority funding is to increase by £2.6 billion by 2010-11. In addition, direct funding from the Department, for social care for older people and support services for carers, will increase by £190 million to £1.5 billion by 2010.

## Content summary

**1.20** The following chapters in this report provide Parliament and the public with an account of how the Department has spent the resources allocated to it, as well as its future plans. It also describes the Department's policies and programmes and gives a breakdown of spending within these programmes.

## Chapter 2 (Health Promotion and Protection)

This chapter reports progress against health improvement and protection in England. However, where appropriate, it also covers developments further afield, including global and European Union developments, as well as related topics such as emergency preparedness, scientific development and bioethics.

## Chapter 3 (Improving Health Services for NHS Patients)

One of the Department's objectives is to deliver an improved care experience for patients and users, including those with long-term conditions. This chapter provides an overview of the policies and programmes which are delivering improvements in patients' access to, and experience of, the care they receive from the NHS. This includes improvements within specific clinical areas, for example cancer care and children and young people's services.

## Chapter 4 (System Reforms in Health and Social Care)

*Our Health, Our Care, Our Say: A New Direction for Community Services* (DH, January 2006) set a strategic vision for community health and social care services. This chapter reports on the progress being made against the ongoing, comprehensive programme of modernisation in health and social care that aims to deliver better care, better patient experience and better value for money. It also provides an update on the recommendations for service improvements.

## Chapter 5 (Transforming Adult Social Care)

This chapter shows how the profile of social care, both in a number of the Department's key strategies – including planning for pandemic influenza, improving cancer and stroke services – as well as in wider government activity such as performance assessment in local government and the NHS, has been strengthened.

## Chapter 6 (Research and Development)

This chapter provides an overview of the programme of health research funded by the Department. In particular, it includes a progress report on implementation of the Government's health research strategy, *Best Research for Best Health: A New National Health Research Strategy* (DH, January 2006). It also details progress on the implementation of the Sir David Cooksey report recommendations.

## Chapter 7 (Workforce)

The Department continues to play a central role in securing the right number of appropriately trained and motivated staff to deliver high-quality care for patients and people who access services. This chapter includes information on both the health and social care workforce and, among other issues, addresses: modernising education and training; modernising the regulation of healthcare workers; and pay and pensions in the NHS.

## Chapter 8 (NHS Connecting for Health – National Programme for IT)

NHS Connecting for Health is responsible for delivering the National Programme for IT, which is using new technology and information systems to give patients more choice, and health professionals more efficient access to information thereby enabling them to deliver better patient care. It provides an overview of the main deliverables for the programme including the NHS Care Record Service, Choose and Book, Electronic Prescription Service, Picture Archiving and Communications System, N3 network and NHS Mail.

## Chapter 9 (Revenue Finance)

This chapter looks at NHS and PSS revenue finance and efficiency. It details the level of investment in both areas and shows how these funds have been spent across the various programmes and how outputs have increased. It also highlights increases in NHS output and movements in NHS productivity and efficiency.

## Chapter 10 (Capital Finance)

This chapter reports on the priorities with NHS capital investment. It explains the changes to the capital investment regime and details the overall level of capital available and how it is being put to use. It provides an update on the hospital building programme and the various ways that capital funding is provided in the NHS and PSS.

## Chapter 11 (Managing the Department of Health and Developing Policy)

This chapter is concerned with the management of the Department and its development of policy. It outlines the running costs, staffing, recruitment policy and Senior Civil Service salaries of the Department. It also describes how well the Department manages risk, handles correspondence from the public and the environment in which it operates.

## Annexes

The annexes provide the spending and administrative core data tables; the Department's current PSA targets and operating standards along with progress reports on each; and a list of the agencies that help the Department discharge its functions. There is also a note of the Public Accounts Committee reports in 2007 and an account of the Department's spend on publicity and advertising and a list of sponsorship received.

## 2 Health Promotion and Protection

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## Introduction

**2.1** This chapter reports progress against health improvement and protection in England. However, where appropriate, it also covers developments further afield, including global and European Union developments, as well as related topics such as emergency preparedness, scientific development and bioethics.

## Choosing Health

**2.2** *Health Challenge England – Next Steps for Choosing Health* (DH, October 2006) set out the next steps in the Department of Health's strategy to support the changes that everyone needs to make in their lives to enjoy the best possible health. A series of workshops formed the regional roll-out of *Health Challenge England*, kick-started a wider programme of outreach to regional health communities, and enabled the Department to reaffirm the principles set out in *Health Challenge England*. Stakeholders from each region received locally focused reports from their regional director of public health alongside the regional director's responses to the issues emerging from these workshops.

**2.3** The final report, issued in December 2007, identified a need for a greater focus on improving the effectiveness of existing partnerships as well as creating new partnerships. There was strong support for the principles set out in *Health Challenge England*, and good evidence that some work is already being done to deliver against these principles in all regions (particularly in relation to partnership working and understanding people).

## Health Challenge England – into action:

### Providing strong leadership across government at national and local levels and joining up policy

#### Tackling obesity

**2.4** Around 23 per cent of adults and 18 per cent of children are classified as obese. The Government Office for Science Foresight's *Tackling Obesities: Future Choices* report (October 2007) estimated that by 2050, 60 per cent of men and 50 per cent of women could be obese and that by 2050, 35 per cent of 11 to 15-year-old girls and 23 per cent of 11 to 15-year-old boys will be obese.

**2.5** Both being obese and being overweight increase the risk of a range of diseases that can have a significant health impact on individuals (e.g. type-2 diabetes, cancer), although the risks rise with body mass index and so are greater for obese people. These diseases ultimately curtail life expectancy. Foresight estimates that weight problems already cost the NHS £4.2 billion per year, and UK society as a whole in the region of £16 billion. The latter figure will rise to £50 billion per year by 2050, if current trends are left unchecked. Overall, the work of Foresight and others suggests that weight problems present society with a greater challenge than previously realised, and that, without additional action, the costs to individuals, the NHS and society will be massive.

**2.6** The Government has already launched a number of programmes, many of which are demonstrating some success:

- The Department has introduced front-of-pack food labelling, making it simpler for families to make healthier food choices, and this system has been adopted by many major retailers and manufacturers.
- In April 2007, the Office of Communications introduced new restrictions on advertising foods

high in fat, salt and sugar to children under 10 years of age. These rules were extended to cover children under 16 on 1 January 2008. Restrictions on the content of advertising food and drink to children in non-broadcast media were also introduced in July 2007.

- Almost 90 per cent of schoolchildren now do at least two hours of quality school sport a week – this beats the Government’s target to increase the proportion to 85 per cent by 2008. The Government is now aiming to offer every child and young person the chance of five hours of sport a week by 2010.
- The National Child Measurement Programme, now in its third year, is one of the largest collections of data on children’s height and weight in the world.

**2.7** The findings of the Foresight report, together with a review of the available evidence by the Department of Health and the Department for Children, Schools and Families, demonstrated the need for a stronger new commitment to tackling obesity across government. The 2007 Comprehensive Spending Review announced a new long-term ambition on obesity, including a commitment in the child health Public Service Agreement (PSA). Tackling child obesity will be a national priority for primary care trusts (PCTs) from April 2008, as set out in the *NHS Operating Framework for 2008-09* (DH, December 2007).

**2.8** *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* was launched on 23 January 2008 and is the first step in a sustained programme to support people to maintain a healthy weight. It is committing £372 million in extra funding between 2008 and 2011. It sets out a range of policies, to build on progress already made and start to reverse the trends of increasing excess weight. The strategy will be followed by a public annual report that assesses progress, looks at the latest evidence and trends, and makes recommendations for further action.

## Nutrition

### Maternal and child nutrition

**2.9** There is extensive scientific evidence to support the consensus that breastfeeding is the best form of nutrition for infants for the first six months of life. Breastfeeding confers significant short- and long-term health benefits for both mother and infants beyond the period of breastfeeding itself.

**2.10** Findings from the Infant Feeding Survey 2005 show that more mothers are starting to breastfeed and the breastfeeding initiation rates went up from 69 per cent in 2000 to 76 per cent in 2005. According to the 2005 survey, there was also a marked trend towards mothers introducing solid foods later, compared with the 2000 Infant Feeding Survey.

**2.11** The Department is committed to increasing breastfeeding initiation and duration rates. A new key indicator – ‘Prevalence of breastfeeding at 6–8 weeks postnatally’ – was recently announced in the new Child Health and Well-being PSA. In light of the new indicator and the significant health benefits of breastfeeding, the Department of Health’s main focus is to encourage and support more mothers to breastfeed for longer, particularly mothers belonging to the disadvantaged groups.

**2.12** The Department works in partnership with UNICEF, professional bodies, non-governmental organisations and other government departments in delivering high-standard services. A range of planned and ongoing initiatives are in place to promote breastfeeding initiation and duration rates – these are outlined in *Healthy Weight, Healthy Lives*.

### Healthy Start

**2.13** The Healthy Start scheme provides nutritional support and encouragement for breastfeeding and healthy family diet to around half a million pregnant women and under four-year-olds across the UK. The scheme was implemented across all of the UK from 27 November 2006 and replaced

the milk tokens element of the old Welfare Foods scheme. Healthy Start vouchers can be used to purchase milk, fresh fruit, vegetables and infant formula.

## Fruit and vegetable consumption

**2.14** The healthy food code of good practice in *Healthy Weight, Healthy Lives* calls for the increased consumption of healthy foods, particularly fruit and vegetables.

**2.15** The Department's 5 A DAY Programme, which promotes increased consumption of fruit and vegetables, sits alongside initiatives to reduce the amount of salt, fat and sugar in the diet, to promote a healthy diet.

**2.16** A key aspect of the 5 A DAY Programme's work is to target and focus messages to particular population groups with low intakes of fruit and vegetables. Since March 2007, the Department has run the Top Tips for Top Mums Campaign to help families get more fruit and vegetables into their children's diets. The campaign aims to help families, by sharing tips from mums, dads and carers on how they got their kids to eat more fruit and vegetables.

**2.17** There is evidence of progress having been made in increasing fruit and vegetable consumption in England. The Food Standards Agency's Consumer Attitudes Survey 2006 showed that 72 per cent of people are now aware that they should eat at least five portions of fruit and vegetables a day, up from 43 per cent in 2000. The Department for Environment, Food and Rural Affairs annual Household Expenditure Survey for 2005-06 recorded the biggest increase in fruit and vegetable purchases (7.7 per cent) for over 20 years. This increase was set against a 6 per cent decrease in confectionery sales.

**2.18** The School Fruit and Vegetable Scheme provides nearly 2 million children in over 16,500 schools with a free portion of fruit or vegetables each school day. A survey of children who were participating, or had participated, in the scheme

found the numbers achieving 5 A DAY increased from 27 per cent in March 2004 to 44 per cent in November 2006.

## Increasing the competence of the wider workforce

**2.19** The Department has funded the development of a number of nutrition programmes to increase the competence of the wider workforce. These include:

- the Department of Health and the Department for Children, Schools and Families funding the HENRY (health, exercise and nutrition for the really young) Programme for pre-school children, which offers intensive training and support to children's centres and takes an approach that combines the key elements of a healthy lifestyle with parenting/relationship skills and emotional well-being; and
- Southampton University's work to develop an e-nutrition programme.

## Physical activity

**2.20** The *Choosing Health* White Paper in November 2004 and *Choosing Activity: A Physical Activity Action Plan* (DH, March 2005) set out a series of projects aimed at increasing levels of physical activity.

**2.21** In April 2006, the Prime Minister asked the Minister of State for Public Health to lead a cross-government group to look at what had been achieved since publication of *Choosing Activity*, and to develop plans to achieve a fitter nation in the run-up to the 2012 Olympic and Paralympic Games. The outputs from this review have influenced the strengthened commitment to physical activity set out in *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*, including:

- a Walking into Health Programme with the aim of getting at least a third of people in England walking at least 1,000 more steps a day by 2012;

- seizing the opportunity of the London 2012 Olympic and Paralympic Games to develop a number of physical activity initiatives that will inspire people to be more active;
- working with planners, architects and designers to ensure that health and physical activity are built more robustly into the fabric of our urban and rural spaces;
- exploring with the fitness industry how to increase off-peak access to facilities; and
- developing a *Let's Get Moving* resource pack for GPs and practice nurses, based on lessons from the London pilots to support the promotion of physical activity in primary care.

**2.22** Alongside the development of a new strategy for Sport England, announced in November 2007, ministers have also agreed to work closely over the next few months to ensure that all relevant government departments are working together to deliver a physical activity strategy for all. This review of sport and physical activity is being led by HM Treasury and is due to report later this year.

**2.23** Key achievements in the past year include:

- all maintained schools are now in a schools sports partnership; 86 per cent of pupils are now participating in at least two hours of high-quality physical education and sport in a typical week;
- more than 14,000 schools (56 per cent) in England have active travel plans, and these are helping more children to walk or cycle safely to school;
- launch of the first wave of Let's Get Moving pilots in London in October 2007, which are building upon brief interventions in primary care by providing GPs with the tools to identify inactive patients, help patients to identify their own exercise goals and signpost them to community-based opportunities for physical activity;
- delivery of a national school pedometer programme, Schools on the Move, with 250 schools in deprived areas being given around

40,000 pedometers, to encourage children to become more active; and

- 6,500 primary care health professionals, across 90 per cent of PCTs, have been trained in motivational behaviour change as part of the ongoing roll-out of the National Step-O-Meter Programme, launched in 2006.

### Alcohol harm reduction strategy

**2.24** Preventing alcohol-related harm is a priority for public health. Harmful drinking greatly increases the risks of heart disease, stroke, cancers and liver disease, and involvement in accidents or violent crime. Total annual healthcare costs related to alcohol misuse add up to £1.7 billion per year for the NHS alone. The social impacts – on individuals, the family, public services and the economy – are greater still.

**2.25** Progress has been made since the Government published the *Alcohol Harm Reduction Strategy for England* in 2004, including new police and licensing powers, a new voluntary alcohol-labelling scheme, effective and popular advertising campaigns, creation of the Drinkaware Trust and improving alcohol treatment services. The Department is already beginning to see the benefits of this, including reductions in crime and city centre violence, and early signs of an end to the continued increase in levels of alcohol consumption.

**2.26** In June 2007, the Government built upon these successes with the publication of *Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy*. The Department and the Home Office are jointly leading a cross-government programme of work, together with the Department for Children, Schools and Families, the Department for Culture, Media and Sport, the Ministry of Justice and the Department for Transport.

**2.27** Following the 2007 Comprehensive Spending Review, the Department of Health put in place a new PSA target to reduce drug and alcohol harm that includes a new national indicator to

measure change in the rate of hospital admissions for alcohol-related conditions (hospital episode statistics data) – the first-ever national commitment to monitor how the NHS is tackling alcohol harms. This indicator is expected to encourage earlier identification of people who drink too much, linked to advice and support from GPs or hospitals – shown to be the best way of reducing the kind of ‘everyday’ drinking which over time leads to liver disease and other problems.

**2.28** The National Audit Office will carry out an audit of NHS alcohol spend on interventions and specialist treatment and this is expected to report in autumn 2008, identifying which areas are tackling this issue well and which are not.

**2.29** The Government continues to work in close partnership with a range of stakeholders, including the alcohol industry, non-governmental organisations and the voluntary sector. Progress on several fronts occurred during 2007:

- The new independent Drinkaware Trust became operational in spring 2007. The Trust aims to use industry funding to help positively change public behaviour and the national drinking culture.
- In May 2007, the Government announced its agreement with the alcohol industry that, by the end of 2008, all alcoholic drinks labels will include the drink’s unit content and the recommended Government sensible drinking guidelines. The Government will monitor this and consider the need for regulatory change, and will consult publicly on any proposals.
- The four UK chief medical officers have agreed consistent advice on drinking alcohol for those trying to conceive or who are pregnant. The drinks industry has been asked to include a short version of this advice on alcoholic drinks labels.

**2.30** In January 2008, the Government commissioned an independent national review, by a research team at the University of Sheffield, of the evidence on how and in what circumstances price,

discounting, advertising and other forms of promotion drive overall consumption of alcohol and alcohol-related harm. Following its report in 2008, the Government will consider the need for regulatory change and will consult publicly on any proposals.

**2.31** The Know Your Limits Campaign, launched in 2006, has proved successful. Its memorable television and cinema advertising is recalled by 84 per cent of the target audience, and has been broadcast in a second burst since. A sustained national campaign to raise the public’s knowledge of alcohol units and ability to estimate how much they drink will launch in May 2008. Discrete campaign elements will also target pregnant and harmful drinkers.

**2.32** Over the next three years, the Government will actively support the full implementation of the published guidance, *Substance Misuse in the Undergraduate Medical Curriculum* (International Centre for Drugs Policy, April 2007). This major development will, over the next ten years, ensure that around 60,000 new doctors leaving medical training in England will be able to deliver competent practice in both drug and alcohol misuse, including – as a crucial priority for implementation – the recognition and the management of risky and harmful alcohol consumption. The Department has allocated £650,000 in 2008-09 for the developmental work that medical schools will need to carry out to embed such an integrated substance misuse curriculum into their own core teaching and training programmes.

### Pharmacy and public health

**2.33** The educational tools and resources launched in February 2007 to help pharmacists and their teams provide brief advice and interventions in the key areas of stopping smoking, weight management, alcohol reduction, improved nutrition and diet, and increased physical activity have been well received. Others are now planned, which will cover sustainable development, mental health and sexual health.

## Healthy Schools

**2.34** The national Healthy Schools Programme is a successful non-statutory programme – with 57 per cent of the nation’s schools achieving National Healthy School status, engaging 3.7 million pupils and 97 per cent of schools in working towards achieving National Healthy School status. This means that an estimated 7 million pupils either are enjoying the benefits of a healthy school or are gaining some benefits from their school working towards being a healthy school. The Department is on track to achieve the *Choosing Health* commitments to have all schools working towards National Healthy School status by 2009, with 75 per cent having achieved National Healthy School status by then.

## Local Area Agreements

**2.35** Local Area Agreements (LAAs) are three-year compacts, based on local sustainable community strategies, that set out the priorities for a local area. They are agreed between central government (represented by the Government Office) and a local area represented by the lead local authority and other key partners through Local Strategic Partnerships. They have been shown to have great potential in delivering improvements in health and social care outcomes, and have proved to be an important catalyst for improved partnership working. Since April 2007, every area in England has had their own tailored LAA in place. Their profile and importance will be raised further from June 2008, when LAAs will form the central delivery contract between central government and local government and its partners. From that date, LAAs will focus on a relatively small number of priorities for improvement. See also chapter 4.

## Jointly appointed directors of public health

**2.36** The reconfiguration of the NHS in 2006 has led to new appointments of directors of public health. The majority of these appointments are joint posts between the PCT and the local authority. Following the publication of the *Local Government*

*and Public Involvement in Health Act 2007*, local government and PCTs have a statutory requirement to undertake joint strategic needs assessments. Directors of public health in their new roles will work in partnership with the directors of adult social services and the directors of children’s services to jointly undertake such assessments, which are vital to ensuring world class commissioning.

## Strengthening the public health workforce

**2.37** Teaching Public Health Networks were established in 2006. They aim to establish an integrated and inclusive approach to the development of public health education across organisations and sectors at all skill and professional levels. The networks have an important role in raising the awareness of public health education and in providing training opportunities for all professional groups, to help them understand how their job influences public health.

**2.38** *The Public Health Skills and Careers Framework* was published in April 2008. For the first time, public health competences and the underpinning knowledge base are set out for all nine NHS career framework levels. This much-needed document will provide a useful tool for development of not only the professional public health workforce but also the wider workforce, which can have a major influence on the wider determinants of health.

## Ensuring that system reform is aligned, to improve health and to tackle inequalities

**2.39** System reform levers need to assure that access and utilisation of healthcare services, quality of care, and health and well-being status equitably reflect needs, especially in relation to socioeconomic status, geographical area, ethnicity, gender, disability and age. Local need is assessed through the new duty of joint strategic needs assessment, shared between health authorities and local authorities.

**2.40** When combined with better and closer joint working between PCTs and local authorities (which is, in most cases, led by jointly appointed directors of public health), need will underpin local strategic planning. LAAs set local planning priorities and are linked to Local Strategic Partnerships, which bring together key local leaders for change. Stronger local commissioners, working in conjunction with all partners locally, will develop the commissioning strategies required to address need and reduce local health inequalities.

### Guidance on health and strategic environmental assessment

**2.41** European Parliament and Council Directive 2001/42/EC, known as the *Strategic Environmental Assessment (SEA) Directive*, requires environmental assessment of certain plans and programmes that are likely to have a significant effect on the environment, including population and human health. Following the consultation on the draft guidance on health in SEA, the response document, published in March 2008, requests health bodies to be made statutory consultees. This is actively being pursued with the Department for Communities and Local Government. Further work on deciding which health organisation should be a consultation body is being done, pending revision of the regulations. This is an opportunity for health to influence plans and programmes that shape the wider determinants of health.

### National Institute for Health and Clinical Excellence (NICE) public health guidance

**2.42** During 2007-08, NICE issued new public health guidance on a wide range of topics, including: substance misuse interventions; workplace smoking interventions; health behaviour change; alcohol and schools; physical activity and the environment; community engagement; maternal and child nutrition; smoking cessation; and the mental well-being of children in primary education.

**2.43** Conformity with NICE public health guidance is included in the NHS public health developmental standard in *Standards for Better Health* (DH, April 2006). The Healthcare Commission published its *NHS Annual Health Check 2006/07* report in October 2007. Based on a pilot self-assessment of PCTs' performance against the public health developmental standard, the Healthcare Commission assessed 3 per cent of the PCTs as excellent, and 30 per cent as good. This assessment took into account PCTs' uptake of early NICE guidance, published in 2006, on smoking, physical activity and obesity.

**2.44** During 2007-08, as part of the new topic selection process for NICE guidance, the Department asked NICE to develop new guidance in priority areas of public health, including: prevention of unintentional injury in children; prevention of cardiovascular disease at the population level; looked after children; promotion of the mental well-being of young people in secondary education; and prevention, early identification and initial management of alcohol use disorders in adults and adolescents. New public health guidance on these topics is expected to be issued by NICE in 2009-10.

**2.45** During 2008-09, the Department will continue working with other government departments to facilitate government support for implementation of NICE public health guidance across sectors, and to promote effective engagement with NICE's topic selection and consultation processes.

### Actions for a safer Europe

**2.46** The European Commission proposal for a Council Recommendation on the prevention of injury and the promotion of safety was approved by the Health Council in May 2007, after consultation with member states. The Council Recommendation looks to the combined efforts of the Commission and member states in taking forward *Actions for a*

*Safer Europe*. It provides a framework for action, for member states and the Commission, including:

- developing a national injury surveillance system;
- setting up national plans for preventing accidents and injuries;
- ensuring that injury prevention and safety promotion are included in the vocational training of healthcare professionals;
- establishing both a community-wide surveillance system for collecting injury data and a mechanism for the exchange of information on good practice; and
- supporting the development of good practice and policy actions.

## Focusing on key priorities for delivery

### Reducing the number of people who smoke

**2.47** Smoking is the single biggest preventable cause of death, killing around 87,000 people in England each year. Smoking significantly contributes to health inequalities between different socioeconomic and ethnic groups, as well as between the different regions of England. Under the PSA to promote better health and well-being for all, the Department of Health's target for smoking is to:

- reduce adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence in routine and manual groups to 26 per cent or less.

**2.48** Latest data on smoking prevalence (from the General Household Survey 2006) shows that the smoking rate for all adults is now at 22 per cent, a drop of 2 per cent on the previous year. Smoking rates within the routine and manual group also dropped 2 per cent, from 31 per cent to 29 per cent. These encouraging figures indicate that the Department is on track to achieve the adult smoking rate component for the PSA target by 2010, and with continued efforts and investment, can reach the routine and manual component of the PSA target by 2010.

**2.49** Measures undertaken include:

- On 1 July 2007, all enclosed parts of workplaces and public places in England became smoke-free. This measure has been shown to be highly popular, with three-quarters of adults supporting the new law. Figures show continuing high levels of compliance, with over 98 per cent of premises and vehicles inspected being fully compliant. Since July 2007, local authorities have inspected over 375,000 premises and vehicles.
- Regulations introducing hard-hitting picture warnings onto all tobacco products were passed in 2007, making the UK the first country in the EU to pass laws to introduce picture warnings on all tobacco products. Such warnings are required to appear on all tobacco products produced for the UK market from 1 October 2008.
- The age of sale for tobacco products was increased from 16 to 18 years of age on 1 October 2007. In late 2007, legislation was introduced into Parliament to strengthen sanctions against retailers who persistently sell tobacco to people under the legal age. The provisions, within the *Criminal Justice and Immigration Bill*, will continue their passage through Parliament in 2008.
- NHS Stop Smoking Services continue to provide vital support to smokers to quit. Statistics showed that around 165,000 smokers quit between April and September 2007, which was an increase of 28 per cent compared with the same period the previous year.
- Smokers can also quit with free support from the NHS Smoking Helpline and Together Programme, which provide information, advice and motivation by telephone, e-mail, post or by text message at key moments during the smoker's quitting process.
- The Department has run highly effective stop smoking social marketing campaigns to motivate and support smokers to quit, and in 2007 over a million people responded to these campaigns via the NHS Smoking Helpline, the GoSmokefree website and interactive television to ask for support to stop smoking.

- The Department also published revised guidance for the NHS Stop Smoking Services in 2007 to ensure more consistency in the delivery of the service and improve the collection of data on stop smoking support provided by the NHS.

**2.50** The UK continued to take a leading role in the World Health Organization (WHO) Framework Convention on Tobacco Control, the first-ever global health treaty. By the end of 2007, 152 countries had ratified the treaty. The *Cancer Reform Strategy* (DH, December 2007) announced the Department's intention to consult on the next steps in tobacco control and also announced the further regulation of tobacco products. The consultation will cover a wide range of issues and is due to take place in spring 2008. In collaboration with a wide range of stakeholders, the Department of Health has been able to achieve a great deal in tobacco control during 2007. According to a research report published in October 2007, the UK has the most comprehensive tobacco control measures of any country in Europe.

### Sexual health

**2.51** Significant progress has been made in taking forward the commitments for sexual health in *Choosing Health*. Improving access to genitourinary medicine clinics has been a priority for the NHS for the past two years, and sexual health will continue to be a priority in the *NHS Operating Framework for 2008-09*. By March 2008 excellent progress had been made towards the target to offer everyone who needs it an appointment at a genitourinary medicine clinic within 48 hours. In January 2008, 96 per cent of patients were offered an appointment to be seen, and 84 per cent were seen, within 48 hours.

**2.52** Condom Essential Wear, launched in 2006, showed significant success in starting to normalise condom use in its 18 to 24-year-old target audience. Initial evaluation showed:

- 85 per cent of people stated that "... it made me think it was normal to use a condom"; and

- 23 per cent of those who had sex in the past 12 months claimed that they would use condoms more often as a result of the Condom Essential Wear advertising.

**2.53** The study also showed that the key reason for condom use had shifted from contraception to prevention of sexually transmitted infections (STIs) among all age groups. A key component of the campaign (in association with the teenage pregnancy campaigns 'R U Thinking?' and 'Want Respect? Use a Condom') is the working group of condom manufacturers and the key condom retailers. This has been looking at a number of initiatives to develop new retail opportunities and to increase the profile of condoms in retail environments.

**2.54** Progress continued to be made in rolling out the National Chlamydia Screening Programme. In April 2007, local delivery plans (which had been deferred from the previous two years) were required for chlamydia screening, and PCTs were asked to screen at least 15 per cent of 15 to 24-year-olds in their area. The Health Protection Agency, which is responsible for the operational management of the programme, has recruited a strengthened national and regional team to support implementation.

**2.55** On HIV, it has been announced that the AIDS Support Grant will increase over the next three years. Allocations will total £19.8 million in 2008-09, £21.8 million in 2009-10, and £25.5 million in 2010-11. The Department has also continued to support HIV and STI prevention work, especially for the two groups at greatest risk of HIV transmission – gay men and people from African communities living in England. The National Strategy for Sexual Health and HIV identified tackling stigma and discrimination for those with HIV as a key area for action. In May 2007, following extensive consultation, the Department published its *HIV Stigma and Discrimination Action Plan*, and it has allocated £250,000 over two years to three voluntary organisations to undertake work to reduce stigma in a variety of settings.

**2.56** In response to concerns about the late diagnosis of HIV, in September 2007 the Chief Medical Officer and the Chief Nursing Officer wrote to all doctors and nurses setting out good practice and reminding them of the need to offer an HIV test in non-HIV settings, where appropriate. The Department also undertook a consultation to clarify policy on patient confidentiality and disclosure of information on STIs, including HIV. The results of the consultation were published in 2007 and next steps will be published in 2008.

**2.57** Approximately 4 million people use NHS contraception services each year. Roughly, three-quarters see a GP and the remainder attend specialist, community contraception services (family planning clinics). During 2006, the Department undertook a baseline review of contraception provision, to which 82 per cent of PCTs responded. The results were published in April 2007 and have helped PCTs to determine how best to meet gaps in local services. The Department will also publish *Best Practice Guidance on Reproductive Healthcare* in spring 2008.

### Teenage pregnancy

**2.58** The Government's Teenage Pregnancy Strategy represents the first coordinated attempt to tackle both the causes and consequences of teenage pregnancy. It has two targets:

- to halve the under-18 conception rate by 2010, and establish a firm downward trend in the under-16 rate; and
- to increase the proportion of teenage parents in education, training or employment to 60 per cent by 2010, to reduce their risk of long-term social exclusion.

**2.59** Local delivery is supported by two national media campaigns: 'R U Thinking?' and 'Want Respect? Use a Condom'. There has been steady progress on reducing the under-18 conception rate. Latest annual data (2006) shows that the rate has fallen by 13.3 per cent since the 1998 baseline year

to its lowest level for over 20 years. The under-16 rate has fallen by 13 per cent over the same period. The Teenage Pregnancy Strategy also includes measures designed to improve outcomes for teenage parents and their children. The Department for Children, Schools and Families and the Department of Health published guidance in July 2007, setting out what needed to be in place locally to improve outcomes.

### Drug treatment

**2.60** Tackling drug misuse is a major priority for the Government. Massive strides have been made in reducing the harms that drug misuse causes to both individuals and society as a whole. The numbers of people entering drug treatment has increased, drug-related deaths are down, the numbers being retained in treatment have risen and the level of crime associated with drug misuse has fallen substantially.

**2.61** The Government has made substantial investment in drug treatment, with £610 million being spent in 2007-08. High-quality drug treatment is the most effective way of reducing illegal drug misuse. Every £1 spent on drug treatment saves £9.50 to the rest of society. The number of drug misusers receiving treatment has expanded from 85,000 in 1998 to 195,000 in 2006-07. These figures mean that the Department has exceeded by 30 per cent its target to double the numbers in drug treatment by 2008.

**2.62** The Department has seen demonstrable benefits to drug misusers and the wider community as a result of improvements to the treatment system. Data released by the Office for National Statistics in November 2007 shows that drug-related crime committed by those referred for drug treatment through the criminal justice system has reduced by 20 per cent since 2003. The data also shows that there has been a stop in the sharp increases in drug-related deaths identified in the 1990s.

**2.63** Staying in treatment for 12 weeks has a lasting positive impact in reducing the harms associated with addiction and is therefore a key measure of effective treatment. In 2006-07, 80 per cent of drug misusers either successfully completed treatment or remained in treatment for at least 12 weeks. Waiting times are also at an all-time low, with 96 per cent of drug misusers now receiving treatment within three weeks of being assessed.

**2.64** In 2007, the Government announced £54.3 million of new funding to expand in-patient detox and residential rehabilitation services. This funding will mean that a comprehensive range of services are available, enabling drug misusers to access the service assessed as being most appropriate for their needs.

**2.65** This Integrated Drug Treatment System is bringing considerable improvements to the quality of prison treatment. In 2007-08, £18.7 million has been invested in the treatment system by the Government and the National Offender Management Service. This is an increase in funding of 30 per cent since 2005-06. In 2007-08, 23,700 prisoners received clinical treatments of comparable standards to those provided in the community. This is an increase from 22,200 in 2006-07.

**2.66** The Department continues to provide data on the UK drugs situation to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This data is used to compile EMCDDA's *Annual Report*. The UK has implemented all five of the key epidemiological indicators identified by the EMCDDA and provided recent data which meets its reporting standards. The Government continues to work closely with the National Treatment Agency, the special health authority created by the Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

## Progress on health inequalities

**2.67** The most comprehensive programme ever in this country is in place to address health inequalities. A key element is the 2010 PSA target:

- to reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.

**2.68** The Government has made health inequalities a top priority and has aligned incentives at local level. They are a key priority for the NHS for 2008-09, and for part of the national indicator set underpinning LAAs for local government. The Secretary of State for Health has also announced his intention to publish a comprehensive strategy for reducing health inequalities later this year. This will address unjustified gaps in health status, fair access to NHS services for everyone and good outcomes of care for all.

**2.69** Infant mortality and life expectancy data for the period 2004 to 2006 shows that, while there has been some progress, a great deal remains to be done. It will be challenging to meet all aspects of the PSA target (see annex B for details).

**2.70** Infant mortality rates are falling in all socioeconomic groups. The mortality gap between the routine and manual group (the target group) and the rest of the population may have stopped widening, although it remains wider than at baseline.

**2.71** Life expectancy has increased in all areas for both men and women, but more slowly in the spearhead areas (the 70 local authority areas with the worst health and deprivation indicators, and the 62 PCTs mapping to them), which are a focus for the life expectancy element of the 2010 target. The gap for men has remained steady for the last two years, but the gap for women continues to widen.

**2.72** However, some 40 per cent of spearhead areas are on track to narrow their population's life expectancy with England by 10 per cent by 2010, compared with the baseline for either men or

women, or both. The spearhead group has also exceeded national reductions in under-75-year-old circulatory disease death rates, with a 32 per cent reduction in the gap since the 1995 to 1997 baseline. For cancer, the corresponding reduction is 11 per cent from the same baseline.

**2.73** The *2007 Status Report on the Programme for Action* (DH, March 2008) provides a comprehensive assessment of developments against the PSA target, against the 12 cross-government headline indicators covering the social determinants of health, and against the 82 departmental commitments contained in the *Programme for Action*.

**2.74** Building on the key interventions in last year's review of the infant mortality element of the 2010 target, the *Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide* (DH, December 2007) shows how to narrow the health inequalities gap in infant mortality, by looking at current examples of good practice. The actions in this plan will contribute to meeting this element of the PSA target, and to improving infant and child health for all disadvantaged groups.

**2.75** The Department's focus now is to provide support to those areas that need it. For example, the Health Inequalities Intervention Tool (developed jointly between the Department and the Association of Public Health Observatories (APHO) and available via the APHO website) provides local commissioners in spearhead areas with an analysis of their local life expectancy gap, and identifies the interventions most likely to contribute to meeting the life expectancy target locally. In addition, the Improvement and Development Agency for local government is supporting local authorities in working alongside PCTs and leading local action on tackling health inequalities. Also, the Improvement Foundation is using healthy community collaborative methodology to improve early

presentation for cancer and cardiovascular disease in poorly performing spearhead areas.

## The Communities for Health Programme

**2.76** Communities for Health is a new approach to unlocking the energy for health improvement that lies within communities themselves. The programme is designed to promote action across local organisations – voluntary sector, NHS, local authorities, business and industry – on a locally chosen priority for health, to celebrate achievements and build momentum for future change. Following a successful pilot phase in 25 areas, the programme was rolled out to over 50 new areas in 2007. *Communities for Health: Learning from the Pilots* (DH, February 2007), describes over 100 local activities from the pilot stage, to engage local communities in improving their physical and mental health.

## Health and work

### Health, Work and Well-being Strategy

**2.77** Evidence has shown that engaged, healthy employees are less likely to be absent, and are likely to be more fulfilled at work and more productive. The cross-government strategy *Health, Work and Well-being – Caring for our Future* (DWP, DH, HSE, 2007) is a recognition that if government is to achieve its aspiration of an 80 per cent employment rate, it needs to help prevent people from falling out of work and needing to claim benefits in the first place. Main achievements of the Health, Work and Well-being Strategy this year have been: the launch of Professor Dame Carol Black's (National Director for Health and Work) review of the health of the working age population; the subsequent Call for Evidence (October to November 2007); and the final report, published in March 2008.

### Well@Work

**2.78** A £1.6 million applied research programme (led by the British Heart Foundation and funded by the Department of Health, Sport England and the Big Lottery Fund) published its final report on

20 February 2008 at a national conference attended by Secretary of State for Health Alan Johnson.

### Sickness absence and well-being in the Civil Service

**2.79** The Cabinet Office is continuing to work with departments and agencies to reduce sickness absence as part of the public sector leading by example on healthy workplaces. The Healthy Schools Programme (see paragraph 2.34) is an exemplar. Healthy Organisations – a project to improve the health and well-being of NHS staff – is being piloted within three strategic health authorities (SHAs).

### Occupational health: NHS Plus

**2.80** A *Latex Allergy* evidence-based guideline was published in February 2008 by the Royal College of Physicians. Three further guidelines – *Food Handlers, Alcohol* and *New and Expectant Mothers in the Workplace* – will be published later in 2008. Following the publication of the National Director of Health and Work's review of the health of the working age population on 17 March 2008, an £11 million capital fund is being established to set up a further six new NHS Plus demonstration sites to look at innovative ways of supporting small and medium-sized enterprises with occupational health services, adding to the five demonstration sites established in 2007-08.

### Investors in People (IiP) UK: Health and Well-being at Work Project

**2.81** Subject to the current review of IiP UK itself, now run by the Department for Innovation, Universities and Skills, the Health and Well-being at Work Project is still on track to be included in the review of the IiP Standard in 2009. This project will also form part of the Government's response to Dame Carol Black's review of the health of the working age population.

### Pathways to Work: Condition Management Programme

**2.82** From October 2007, Pathways to Work – including the Condition Management Programme – has been rolled out to the remaining 60 per cent of the Incapacity Benefit population in two final stages, via provider-led services.

### Mental health and employment – meeting the challenge

**2.83** On 27 November 2007, the Department for Work and Pensions and the Department of Health jointly announced a package of measures to improve the support available to people with mental health conditions, helping more to find or remain in work.

### Business in the Community (BITC) Healthy Workplace Awards 2007

**2.84** The Department of Health once again supported BITC's Big Tick healthy workplaces award and will do so again in 2008. It also supported BITC's current Business Action on Health Campaign.

### Vocational rehabilitation

**2.85** The Health, Work and Well-being National Stakeholder Council has delegated the work on vocational rehabilitation to a task group established by Lord McKenzie, Minister for Work at the Department for Work and Pensions. An evidence review on vocational rehabilitation was commissioned by the group and is expected to report back in summer 2008.

### Public Health National Support Teams

**2.86** The Public Health National Support Teams work on behalf of and in partnership with Health Improvement Policy and Recovery and Support colleagues, Government Offices and SHAs to identify and support those local health economies across England that are facing the greatest challenge in achieving their local public health priorities.

**2.87** The Department has teams dedicated to each national public health priority on health inequalities, obesity, tobacco control, teenage pregnancy and sexual health. A further team focusing on alcohol harm reduction will start work in 2008. Each team provides intensive tailored support to individual local health partnerships. The Department does this through a programme of structured visits and follow-up support to identify barriers to delivery and opportunities for improvement and makes recommendations for improved outcomes, identifying where the National Support Team may be able to help further.

**2.88** By March 2008, in the first 18 months of operation, the National Support Team will have undertaken almost 120 structured visits across all nine English regions. They will have provided ongoing follow-up support to a large proportion of those areas through visioning events; social marketing training and support; advice and support on action plans and specific recommendations; and the resourcing of additional short-term start-up projects to implement recommendations made.

**2.89** The Department has also provided support nationally to local areas through the publication of *10 High Impact Changes for Genitourinary Medicine 48-hour Access*, and it is due to publish a further high-impact changes document on tobacco control. The Department hosted a national forum on key themes, recommendations and best practice emerging from visits on health inequalities and is planning a sexual health best practice publication.

**2.90** In 2008, as well as the creation of a new team on alcohol harm, the scope and remit of the sexual health team will broaden to work in partnership with the Health Protection Agency to improve delivery of the National Chlamydia Screening Programme.

## Information for health

### Information for the public

#### Social marketing for health

**2.91** Health-related social marketing is the systematic application of marketing alongside other concepts and techniques to achieve personalised behavioural goals. The Department is working to ensure that social marketing is utilised by public health practitioners to support improvements in people's health. A strategic partnership between the National Consumer Council and the Department supports a delivery partner – the National Social Marketing Centre. Key milestones have included a range of practical planning tools such as the *Social Marketing Benchmark Criteria* and the *Big Pocket Guide to Social Marketing for Public Health Professionals*.

**2.92** The Department has also developed an innovative cross-issue-based segmentation model using insight into consumers' lives to inform and shape all local and national health improvement activities. The Healthy Foundations life-stage segmentation model is a core part of the Department's action plan to embed social marketing into public health development. It is one of four programmes in the action plan specifically focusing on the generation and use of effective knowledge and understanding of consumers' lives – known as health insight. This is a core feature of the adoption of a social marketing approach. The new segmentation model will provide a three-dimensional analysis of people's behaviour. It should enable the development of better-targeted and designed interventions to address those most at risk of adopting behaviours that influence poor health outcomes. The model will be supported by a set of practical tools that can be used to underpin the development of behavioural interventions.

#### NHS health trainers

**2.93** *Choosing Health*, the public health White Paper, set out the Government's commitment for

NHS health trainers to deliver advice, motivation and practical support to individuals in their local communities. Since the start of the project in 2005, the following key deliverables have been achieved:

- Some 1,200 health trainers have now been trained and are in post.
- Competences have been developed and signed off and national occupational standards are in place.
- A National Implementation Team has been put in place and now provides full regional coverage.
- National evaluation – expressions of interest have been invited with a view to appointment in spring 2008.
- Two national qualifications based on health trainer competences have been developed – City & Guilds (Level 3) and the Royal Institute of Public Health (Level 2).
- There has been considerable enthusiasm for the project among third party organisations. The Department owns the competences while allowing these organisations to tailor the job descriptions to their specific requirements.

### NHS LifeCheck

**2.94** The NHS LifeCheck Programme is based on a commitment in the 2006 *Our Health, Our Care, Our Say* White Paper to initially develop three NHS LifeChecks for early years, adolescence and mid-life. During 2007, the NHS Teen LifeCheck was successfully piloted, with over 16,000 people entering the pilot website. Following a positive independent evaluation, the NHS Teen LifeCheck is being redesigned to take account of the findings and is currently being built onto the NHS Choices platform. The NHS Teen LifeCheck is expected to be launched initially in the spearhead and Community for Health local authority areas in autumn 2008, with a roll-out to all other areas in England following about three months later. The NHS Early Years LifeCheck has been designed and built onto NHS Choices, and initial piloting in four PCT areas commenced in February 2008. Development plans for the new NHS Mid-life

LifeCheck are currently being assessed in order to complement the Prime Minister's vision for the NHS. This includes interfacing with and adding value to the new preventative health check-ups. Further plans will be announced in due course.

### Health literacy and Skilled for Health

**2.95** Understanding health literacy, and setting out the Department's policy in this area, is key to developing a strategic context for personalising health. The Department will be taking an active role in research, such as the European Health Literacy Survey, and has a number of research projects under way. It is supporting the key networks for health literacy and is putting in place other projects and relationships. These will support and complement the Skilled for Health Programme, which is a partnership between the Department of Health, the Department for Innovation, Universities and Skills, and the health and education charity ContinYou.

**2.96** Launched in 2003, the programme is designing, testing and marketing health literacy resources and packages under the national Skills for Life umbrella. The second phase, which is a *Choosing Health* commitment, began in late 2006, and is working with partners in specific sectors, designing and testing packages to meet their corporate needs and those of their learners. These include employees in business (Royal Mail) and local government (Nottingham City Council), people in prison (Care Services Improvement Partnership), users of libraries (the London Libraries and Museum Agency), the NHS workforce (Gateshead NHS Trust) and, most recently, the Army Families Federation. These sectors offer the prospect of tens of thousands of learners. In addition, a 'community adopter' approach is being used for developing regional and local projects with hubs for wider dissemination and learning in communities.

### NHS Choices and health and well-being

**2.97** NHS Choices (see [www.nhs.uk](http://www.nhs.uk)) is a comprehensive health information service launched

in June 2007 that meets the public's demand for accredited multi-media content about conditions, treatments, news and health services. A 'front door' to the NHS, the new service lies at the heart of the Department's public communication strategy. By harnessing the power of information technology, the new service will help people become better equipped to make informed choices about their health and lifestyle.

**2.98** NHS Choices now exceeds 1.5 million users per month, and the service is developing an increasingly personalised experience for visitors, with new content and features to be added throughout 2008. A series of pathways will help those with long-term conditions such as diabetes and asthma. Information ranging from which preventative measures to take through to advice on living with a condition will assist those at risk of, or suffering from, some of the most common illnesses. NHS Choices has an important part to play in supporting healthier lifestyles. Specifically, NHS Choices will be making a key contribution to delivering the Healthy Weight, Healthy Lives Strategy through provision of personalised advice on diet and activity.

### Information for service providers

#### Health Profile of England

**2.99** The Department published the second *Health Profile of England* (DH, October 2007) as part of the Public Health Information and Intelligence Strategy. It is a collation of national and regional data and provides a baseline against which to compare national data with that in the local authority health profiles. The 2007 report updates tables showing regional comparisons and national trends for indicators presented in local authority health profiles. It contains a wide-ranging snapshot of indicators of public health and well-being and their determinants in England, and this year includes a section on international comparisons.

#### Local authority health profiles

**2.100** The second year's local authority health profiles were launched in June 2007. They had been improved in format since last year and once again were very well received. The media coverage was considerable and there has been a large number of hits to the website. The website is being improved and updated, and now allows fuller interrogation and access to the underlying data (see [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)).

**2.101** The principal audiences for these health profiles are local authority members and officers, as well as healthcare managers and public health professionals in PCTs and SHAs. The profiles describe the health of the local population and enable comparison locally, regionally and nationally as well as over time. Health profiles have been used at a local level for a wide-ranging number of areas to improve health. Examples include tobacco control, alcohol and young people's health. The profiles for 2008 are now being produced and will have more indicators and incorporate further improvements.

#### Informing Healthier Choices

**2.102** Informing Healthier Choices is the Department's information and intelligence strategy for improving public health. A *Choosing Health* commitment, the strategy was published in June 2007 following an extensive consultation exercise. It provides a framework for supporting action to improve the availability and use of information and knowledge to inform public health. A range of organisations, including the APHO and the Information Centre for Health and Social Care, are supporting components of the strategy, but the Department is also directly commissioning projects such as the Public Health and Commissioning Desktop.

**2.103** Key outputs so far include:

- a career framework for information staff;
- improved data management and reporting for the national child height and weight monitoring exercise;

- prevalence models of coronary heart disease and hypertension for use by PCTs;
- detailed guidance on data sources for use in joint strategic needs assessments;
- a prototype version of the National Library for Public Health;
- re-procurement of the Public Health Compendium;
- the *Health Profile of England 2007*; and
- a second set of local authority health profiles.

## Health protection

### Pandemic influenza

**2.104** *Pandemic Flu: A National Framework for Responding to an Influenza Pandemic* was issued jointly by the Department of Health and the Cabinet Office in November 2007 to assist and support all public and private organisations in planning and preparing for an influenza pandemic. In addition, a range of supporting guidance was published alongside it, specifically to support planning in hospitals, ambulance services, social care and community healthcare settings, as well as an ethical framework for policy and planning.

**2.105** The national framework incorporated lessons learned from the Winter Willow exercise earlier in the year. The *Exercise Winter Willow: Lessons Identified* report was published in August 2007.

**2.106** Self-assessment audit tools were issued to the NHS in 2007 to help them strengthen their pandemic influenza plans. NHS organisations will use the tools to self-assess their state of preparedness and then use the results to target the areas that need additional development.

**2.107** In July 2007, the Department signed supply agreements with GlaxoSmithKline and Baxter (worth £155.4 million over four years) to deliver enough 'pandemic-specific' vaccine to cover the entire population in the event of a pandemic. In November, the Department announced plans to double the current stockpile of antiviral medication

to enable treatment during a pandemic of 50 per cent of the population (the reasonable 'worst-case scenario' of how many people could be expected to require treatment).

**2.108** The Department also plans to procure 14.7 million treatment courses of antibiotics to treat and prevent the complications arising from pandemic influenza. The procurement of both antivirals and antibiotics will be subject to emerging scientific evidence and to normal commercial procurement procedures, to ensure that products are purchased at the best price and achieve value for money for the taxpayer. Plans were also announced to purchase about 34 million disposable respirators and about 350 million surgical face masks for the use of health and social care workers. The Department continues to work closely with the devolved administrations on these and other planning issues to ensure consistency of approach.

**2.109** In autumn 2007, the Department launched the Catch It, Bin It, Kill It respiratory hygiene campaign to help reduce the spread of cold, influenza and other viruses and to embed the good hygiene practices that would also help protect people during a pandemic. A public engagement research programme has also been initiated that aims to learn more about public attitudes and behaviour with regard to pandemic influenza.

**2.110** A review of the Scientific Advisory Group took place in 2007 in order to ensure that a wider range of scientific disciplines were included and that the group was more flexible and independent. A series of scientific papers comprising a review of the scientific evidence base underpinning clinical countermeasures and the risk from H5N1 received final endorsement from the Scientific Advisory Group as reflecting a comprehensive and state-of-the-art summary and were published on the Department's website in August 2007.

**2.111** The Department also continued to work with WHO and other international partners to

share learning and strengthen global preparations as a whole. In July 2007, the UK held an international seminar bringing together EU and G8 countries to consider common issues for pandemic influenza planning. In November, the UK pledged a further £2 million to support the global pandemic influenza action plan to increase vaccine supply and to help develop capacity to secure vaccine supplies for the developing world.

### The national immunisation programme

**2.112** The national immunisation programme is the key preventative measure in reducing illness and death from vaccine-preventable disease in young children and in other risk groups. Vaccination policy is based on the best available scientific and medical evidence and is constantly reviewed. This ensures that the most appropriate vaccines are offered to the targeted population in this country. As a consequence, vaccination programmes are updated and changed as necessary.

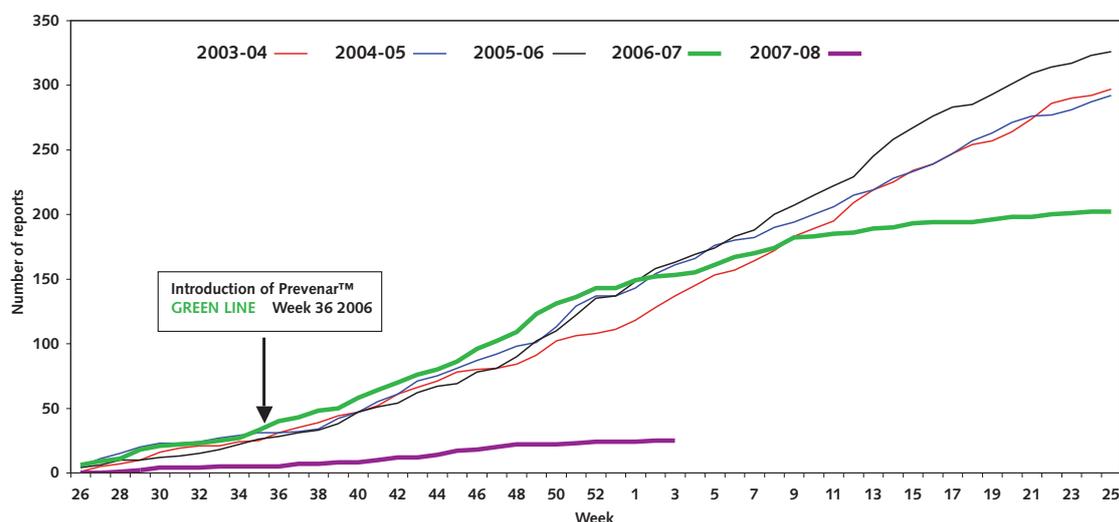
**2.113** In September 2006, pneumococcal conjugate vaccine (PCV) was added to the national childhood immunisation programme. This vaccine protects against the seven most common strains of *Streptococcus pneumoniae*. Estimates show that, by December 2007, PCV had already prevented over

300 cases of meningitis, septicaemia and severe pneumonia in young children. Of these cases, it is estimated that 17 children would have died, and a further 30 would have been left permanently disabled. The Health Minister, Ben Bradshaw, noted that: “These figures are a stark reminder of the importance and benefits of immunisation as we shift the focus of the NHS from a sickness service to a well-being service.”

**2.114** The 7-valent conjugate vaccine was introduced into the childhood immunisation schedule on 4 September 2006, which corresponds with week 36 in **figure 2.1**. Since the introduction of Prevenar, the number of cases of invasive pneumococcal disease caused by any one of the serotypes in the vaccine has fallen dramatically.

**2.115** The Department expects to see the rates of pneumococcal disease covered by the PCV vaccine to continue to fall in young children as the full impact of this vaccination programme emerges. It is also analysing disease surveillance data to determine whether the rates of pneumococcal disease in older people are also falling. The Department expects this to happen due to ‘herd immunity’: by protecting young children, they are unable to spread the

**Figure 2.1: Cumulative weekly number of reports of Invasive Pneumococcal Disease due to any of the seven serotypes in Prevenar™ – children aged < 2 years in England and Wales by epidemiological year, July-June (2003 – to date)**



disease to older people, thus increasing protection for the community.

### Human papilloma virus vaccination

**2.116** Cervical cancer, the second most common cancer in women worldwide, is caused by the human papilloma virus. In developed countries, routine screening programmes have reduced the number of cervical cancer deaths. In England, the number of deaths is about 60 per cent lower than 30 years ago. However, there were still 2,221 deaths from cervical cancer in 2004. In October 2007, ministers announced that human papilloma virus vaccines would be offered to girls aged 12 to 13 years old from autumn 2008. Girls up to the age of 18 years will be offered the vaccine during a two-year catch-up programme starting in autumn 2009.

**2.117** By vaccinating young girls with this vaccine, the Department expects to prevent 400 cases of cervical cancer a year. It will also significantly reduce the number of abnormal results from cervical screening each year, and reduce the uncertainty and concern that women have in dealing with such results. It will take many years for the full benefits of this vaccination programme to be seen, as cervical cancer does not usually occur in women until their mid-to-late 30s. However, reducing the rate of cervical cancer in women by up to 70 per cent through this vaccination programme demonstrates a long-term commitment to health protection.

### Tuberculosis

**2.118** The number of new cases of tuberculosis (TB) in England has risen from a low of around 5,000 in 1987 to over 7,500 in 2006. TB remains a serious public health concern worldwide. It is so common in some parts of the world that it will continue to be a health challenge in England, as infected individuals will continue to enter the country, and disease can develop in infected individuals years after they acquired the infection.

**2.119** TB can be effectively treated and cured. Early diagnosis and treatment are vital to prevent

the spread of infection between people. Therefore, in tackling TB, the Department's aim is to assist the NHS to strengthen services across the board in order to raise awareness of TB, and to detect and treat cases as promptly as possible. To achieve this, in 2007 the Department provided tools to help PCTs commission TB services tailored to local population needs, working closely with their clinicians, public health specialists and other agencies.

**2.120** In addition, the Department initiated a project in 2007 to actively look for cases of TB among the homeless and other groups in London, and to promote the use of 'directly observed therapy', which provides supervised medication and support to patients to improve adherence to treatment. Failure to complete the lengthy course of treatment required is a major factor in the emergence of drug resistance. To address this, from September 2007, TB drugs were exempted from prescription charges on public health grounds when supplied by an NHS trust, NHS foundation trust or PCT, or via a patient group direction.

### Viral hepatitis

**2.121** Hepatitis B and C are recognised as infectious diseases of global public health importance. Chronic infection with hepatitis B or C viruses can lead to serious liver disease (cirrhosis and primary liver cancer) and may require liver transplantation. Long-term measures in place to tackle hepatitis B and C include:

- screening of blood donations;
- antenatal screening for hepatitis B;
- immunisation against hepatitis B for individuals at increased risk of infection; and
- drug therapies for chronic hepatitis B and C, as recommended by NICE.

**2.122** Efforts to tackle hepatitis B and C have been stepped up in recent years. For example, the *Hepatitis C Action Plan for England* (DH, June 2004) sets out a framework of actions to improve

the prevention, diagnosis and treatment of hepatitis C, and is supported by a centrally funded awareness campaign, FaCe It.

**2.123** It is estimated that around 200,000 people in England have chronic hepatitis C infection, the majority of whom are probably unaware that they are infected, as it may take many years for symptoms to occur. The FaCe It Campaign was expanded in 2007 to include national press and radio advertising to encourage people to consider whether they may be at risk of infection and to seek medical advice about having a hepatitis C test. Section 64 grant funding is supporting the hepatitis C voluntary sector in complementary awareness-raising activities.

**2.124** Surveillance by the Health Protection Agency indicates that more hepatitis C testing and diagnosis are now taking place. There was a 10 per cent increase in laboratory diagnoses of hepatitis C reported to the Health Protection Agency in 2006 (8,346) – the latest year for which figures are available – compared with 2005 (7,580), and nearly a 30 per cent increase compared with 2003 (6,566), the year before the awareness campaign began.

**2.125** The Joint Committee on Vaccination and Immunisation is currently reviewing the National Hepatitis B Immunisation Programme to assess whether it might need to be altered. The Advisory Group on Hepatitis is considering ways of improving testing and diagnosis of chronic hepatitis B and C in minority ethnic communities originating from countries where these infections are endemic.

## Global and European Union developments

### Health is global

**2.126** Global health is about the effect of globalisation on health and about the Department's responsibility to use globalisation to improve the health of the world, including the health of the UK

population. There are clear links between the health of the UK population and the health and well-being of people elsewhere. Policies and activities in other parts of the world increasingly impact on the health of the UK's population and on domestic policies concerned with health and healthcare.

**2.127** In March 2007, the UK's Chief Medical Adviser published *Health is Global: Proposals for a UK Government-wide Strategy*, which stimulated a wide debate about the importance of global health and what the Government's priorities should be in this area. The Department held extensive consultations during 2007 and is now coordinating the cross-departmental *Global Health Strategy*, to be published in 2008.

### UK engagement in WHO and other global health bodies

**2.128** The Department is responsible for coordinating the Government's engagement with WHO. The Department of Health is working closely with the Department for International Development on a UK–WHO Institutional Strategy, mapping out its strategic engagement. In May 2007, the UK became a member of the WHO Executive Board, one of the organisation's principal decision-making bodies. The Department will serve until 2010.

**2.129** Key UK objectives for the period of office include work to:

- tackle the social determinants of health and the root causes of ill health and health inequalities;
- address the health impacts of climate change and building pandemic influenza preparedness;
- combat the global rise of obesity, diabetes and other non-communicable diseases;
- strengthen health systems and work to attain the Millennium Development Goals; and
- promote better oversight, governance and management of WHO.

**2.130** In September 2007, the Department held the Presidency of the Regional Committee for the WHO European Region. It is also chairing the drafting group for the WHO European Ministerial Conference, in Tallinn in June 2008, which will discuss how to strengthen health systems to cope with challenges such as the rising burden of non-communicable diseases and an ageing population.

**2.131** The Department has also been working regularly with other international organisations, such as the Council of Europe, Commonwealth Secretariat, Global Health Security Initiative and Commonwealth Fund, to improve health and tackle global and regional health risks.

### Health partnerships and overseas trade

**2.132** DH International, the specialist team promoting the NHS and trade partnership opportunities overseas in tandem with the Foreign and Commonwealth Office and UK Trade & Investment, continues to record a range of successful partnerships and business outcomes.

**2.133** The success of the reforms in the NHS has attracted a great deal of international interest. Countries from all over the world want to learn from the UK's world class clinical practice and its effective models of service. DH International has organised and hosted many visits to the NHS, which have demonstrated the progress at first hand. These visits form the bedrock of collaboration, leading to a range of commercial opportunities for the healthcare industry.

### Health in the EU

**2.134** In 2007, EU member states agreed a new European health strategy called *Together for Health: A Strategic Approach for the EU 2008–2013*. This strategy provides a framework and sets a clear direction for Community activities in the field of health for the next seven years in order to further protect the health of citizens within the EU. The strategy identifies three key areas of health policy where value can be added by taking action at EU-level, namely good health in an ageing population; responding to cross-border health

threats; and supporting health systems and innovation in health. The framework sets out a number of areas for future action where more detailed proposals will follow. The strategy adds value to EU-level action through non-legislative collaboration.

### Health services and patient mobility within the EU

**2.135** Following on from European Court judgements such as the Watts case in 2006, the European Commission intends to bring forward proposals clarifying the rules for patients who wish to travel abroad for treatment at the expense of their national health system. The Department will represent the views of the UK when these proposals are discussed by member states in the coming year. It will work to ensure that the proposals will lead to a set of rules that are clear for patients and sustainable for the NHS.

### Emergency preparedness

**2.136** Through its Emergency Preparedness Division (EPD), the Department continues to develop and improve its own capacity and capability, together with that of the NHS, to contribute to cross-government work on responding to and meeting the challenges posed by terrorism and other major emergencies. The role of EPD is to provide effective leadership, guidance and direction to the NHS and other key stakeholders. In particular, work continues on strengthening the NHS's ability to build resilience to manage the consequences of major emergencies. This is especially through issuing guidance, funding relevant training and development, and promoting and taking part in regular exercises to test plans and procedures and familiarise staff with their respective roles and responsibilities.

**2.137** In 2007, work concentrated on:

- the issue of standardised second-generation personal protective equipment to NHS first responders;
- the advancement of the delivery of medical care into the 'hot zone' of an incident by the

development of Hazardous Area Response Teams (HARTs);

- the storage of medical equipment at major rail hubs and underground stations;
- the development of the third National Capabilities Survey, which seeks to assess cross-government and multi-agency resilience; and
- the issue of guidance on the treatment and management of mass casualties, strategic command arrangements for the NHS, the treatment of blast injuries and critical care.

**2.138** In 2008, EPD's work will focus on further developing a number of the projects begun in 2007. Work is already under way on the roll-out of the first four HARTs. Development of guidance on evacuation, sheltering and lockdown, business continuity in the NHS, the provision of scientific and technical advice during major incidents and the longer-term psychosocial impact following disasters, e.g. following flooding, will also be undertaken. The expert Emergency Planning Clinical Leadership Advisory Group will continue to provide specialist advice to the Department on issues relating to the NHS delivery of clinical care during a major incident.

## Scientific development and bioethics

### Stem cells

**2.139** Progress on the UK Stem Cell Initiative's recommendation 1 continues. The recommendation called for the establishment of a public private partnership to develop predictive toxicology tools from stem cell lines. Stem Cells for Safer Medicines, an independent, not-for-profit company, was launched in October 2007. It is a consortium attracting both public and industry investment, and its membership includes three major international pharmaceutical companies – GlaxoSmithKline, AstraZeneca and Roche. Initiated by the Department of Health and led by the Association of the British Pharmaceutical Industry, the company is also supported by the Department for Innovation, Universities and Skills, the Scottish Government, the Medical Research Council and the Biotechnology and Biological Sciences Research Council.

**2.140** The initiative brings together scientific expertise in stem cell research and medicines safety assessment, to provide guidance and funding for academic research. Its aim is to overcome scientific hurdles and establish open standards and techniques for how stem cells may be used for medicines safety testing. The work of the company will be further supported by an Ethical Review Board and a Scientific Advisory Board. There will be a pilot phase, which is expected to last about two years, with a whole-life project time of up to six years (pilot phase plus four years).

### Human fertilisation

**2.141** The *Human Fertilisation and Embryology Bill* was published on 9 November 2007, and at the time of writing has been debated in the House of Lords. The Bill is the outcome of an extensive review of the law undertaken by the Department of Health, which included a full public consultation in 2005 followed by publication of a White Paper outlining the Government's policy proposals, and subsequently by publication of draft legislation for pre-legislative scrutiny. The intention of the Bill is to update and reform the existing law on assisted reproduction and embryo research (the *Human Fertilisation and Embryology Act 1990*). In 2004, the Government decided that a review of the law was necessary in the light of factors such as technological developments in reproductive technologies since the original legislation was passed, and also developments in society. In particular, the Government is seeking to ensure that the UK remains at the forefront of research that may lead to treatments for currently incurable diseases such as Parkinson's, diabetes and heart disease.

**2.142** The Bill provides clarity as to the extent to which human–animal embryos, which scientists believe may be of great benefit in understanding and treating serious diseases, come within the regulatory framework of the 1990 Act. Overall, the Bill ensures that new developments in technology are appropriately regulated within a scheme that allows scope for major benefits to be realised for medical research and therefore for patients.

## Genetics

**2.143** The review of the 2003 genetics White Paper involved consultation with key stakeholders with an interest in genetics in healthcare, and their views and comments are reflected in the review. While the review was progressing, work on the White Paper proposals continued. For example, several contracts were renewed, including those with the National Genetics Reference Laboratories and the National Genetics Education and Development Centre, and continuing commitments were made to the ongoing funding of additional scientific trainer and trainee posts in the NHS.

**2.144** The Gene Therapy Advisory Committee continued to cover the ethical review of novel clinical trials, approving 17 new trials and providing re-approval for three others, as well as providing advice to ministers on developments in gene therapy including EU Advanced Therapies Regulation. The Genetics and Insurance Committee will monitor the insurance industry's compliance with the Concordat and Moratorium on Genetics and Insurance and will contribute, as required, to the Government's operational review of these agreements.

**2.145** The Human Genetics Commission has continued to provide advice on the social, ethical and legal implications of new developments in human genetics. The Commission addressed new developments in genetic tests offered directly to the public and sought to improve the marketing and publicity of such services. They also recommended that the Government pursue improved regulation at the European level when the relevant medical devices directive is reviewed.

## Human tissue and organ donation

**2.146** In January 2008, the Organ Donation Taskforce published its findings. The report contained 14 recommendations, including employing more donor transplant coordinators and a strengthened network of dedicated organ retrieval teams available 24 hours a day and working closely

with the critical care teams in hospital to retrieve safe, high-quality organs for transplant. The Government accepted all the recommendations and work will be rolled out over the coming year.

**2.147** In July 2007, the Chief Medical Officer, Sir Liam Donaldson, published his annual report for 2006, *On the State of Public Health*, in which he called for action to tackle the present shortages of organs for transplantation. His recommendations included the need for legislation to be amended to create an opt-out system for organ donation.

**2.148** In response to the Chief Medical Officer's report, the Secretary of State for Health asked the Organ Donation Taskforce to examine the proposals. The taskforce has been asked to consider the practical, clinical, ethical, legal and societal issues surrounding such a system. It has established expert working groups to provide advice on issues under each of those headings, with a view to the taskforce reporting to ministers in the summer of 2008 with its initial findings.

## Ethics

**2.149** As part of the implementation programme for the *Mental Capacity Act 2005*, the Department introduced provisions to ensure a smooth transition from the previous arrangements to the new ones for people who had made an advance decision refusing treatment. The Act also introduced provisions to support research projects involving people who lack capacity.

**2.150** The Department has participated in a number of international forums on bioethics, including the Council of Europe and the United Nations Educational, Scientific and Cultural Organisation (UNESCO).

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## Introduction

**3.1** This chapter provides an overview of the policies and programmes that are delivering improvements in patients' access to and experience of the care they receive from the NHS. This includes improvements within specific clinical areas.

## Primary care

**3.2** Around 90 per cent of all NHS contacts take place in primary care, with nearly 300 million general practice consultations a year. Improving access to primary medical care is a key part of improving patients' experience of the NHS.

### Our NHS, Our Future: NHS Next Stage Review

**3.3** The interim report *Our NHS, Our Future* was published in October 2007. It announced immediate action to improve access to primary medical care and thereby deliver more personalised care that meets the needs of individuals and communities, especially those in more deprived areas.

#### Extended GP practice opening hours

**3.4** Primary care trusts (PCTs) will work with GP practices in their areas to develop greater flexibility in opening hours. The *NHS Operating Framework for 2008-09* (DH, December 2007) set out the Department of Health's aim that at least half of all GP practices will offer their patients access to appointments at weekends or on one or more evenings each week.

#### Local procurements of new primary care services

**3.5** The Department is committed to creating a fairer NHS and is focusing on improving access to primary care for those living in more disadvantaged or deprived areas. This also means making services more personal and designing them to fit with people's often busy lives.

**3.6** In October 2007, the Secretary of State for Health, Alan Johnson, announced a £250 million

access fund to support PCTs in establishing at least 100 new GP practices in the 25 per cent of PCTs with the greatest needs and a GP-led health centre in every PCT.

**3.7** The new GP practices will increase capacity in the places that need it most. They will all have extended opening hours, wide practice boundaries to encourage greater patient choice, and a particular focus on preventing ill health. The new health centres will provide walk-in services and pre-bookable GP appointments for any patient (regardless of which GP practice they are registered with), from 8am to 8pm, seven days a week. They will also provide an increasingly integrated, co-located set of wider services (e.g. diagnostic services, pharmacy services and social care).

**3.8** The establishment of new GP practices builds on the Fairness in Primary Care Procurement Programme, under which ten PCTs have been working with the Department to attract new providers with innovative solutions to fill gaps in primary care provision in some of the most under-doctored areas in the country. Nottinghamshire County, Hartlepool and County Durham PCTs have already signed contracts for new GP services, and the first services are expected to be open in spring 2008.

**3.9** During 2008-09, PCTs will be running open and transparent tendering processes that will allow the full range of healthcare providers, including existing practices, independent and voluntary sector organisations, to bid for the contracts to provide these new primary care services.

#### Information for patients

**3.10** The White Paper *Our Health, Our Care, Our Say* (DH, January 2006) and interim report *Our NHS, Our Future* (DH, October 2007) included commitments to ensure that the public has up-to-date, reliable information on GP practices to help them choose the practice that best meets their needs. The public is now able to access key

information about all GP practices – including GP patient survey results, practice opening times, the range of services provided and performance against key quality indicators – via the NHS Choices website at: [www.nhs.uk](http://www.nhs.uk).

### Future strategy for primary and community care

**3.11** The NHS Next Stage Review is developing a vision for world class primary and community services that brings together issues of access with the wider challenges facing primary care. The strategy will identify how to develop world class primary and community health services that focus ever more strongly on promoting health, preventing illness and managing long-term conditions.

**3.12** The review will also identify how the commissioning and contractual arrangements for primary medical care can evolve to reflect trends and challenges, including how to provide a stronger focus on continuous quality improvements, how to improve the equitability of GP funding, how to expand patient choice in primary care, and how to involve the fullest possible range of service providers in developing innovative solutions for the delivery of primary care.

### Improving patient satisfaction with GP services

**3.13** Part of the payments made to GP practices are based on levels of patient satisfaction with the following four areas of access:

- the ability to see a GP within 48 hours (two working days);
- responsive telephone access;
- the opportunity to see a preferred GP; and
- the ability to book appointments ahead.

**3.14** These pay incentives are underpinned by the GP patient survey – the principal indicator of access to GP services. This has given patients a direct say in assessing how their practice performs in these areas and influencing the level of rewards to practices.

**3.15** Over 2 million people responded to the first national GP patient survey in 2007, conducted on behalf of the Department by Ipsos MORI. The results, which are available at national, strategic health authority (SHA), PCT and practice level, were published on 24 July 2007. Nationally, the key findings were as follows:

- 86 per cent of people reported that they were satisfied with their ability to get through to their doctor's surgery on the telephone.
- 86 per cent of people who tried to get a quick appointment with a GP said they were able to do so within 48 hours.
- 75 per cent of people who wanted to book ahead for an appointment with a doctor reported that they were able to do so.
- 88 per cent said they were able to see a specific GP when they wanted to do so.
- 84 per cent said they were satisfied with the current opening hours in their practice.

**3.16** These results showed that the majority of patients are satisfied with access to their GP. However, there are some significant pockets of dissatisfaction, which the Department is determined to address, both through the actions announced in the interim NHS Next Stage Review report published in October 2007, and through additional measures announced by the Secretary of State for Health in July 2007.

**3.17** These additional measures included the establishment of a national improvement team led by the National Director for Primary Care, Dr David Colin-Thomé, to assist PCTs in improving access for patients. The Department also invited Professor Mayur Lakhani, Chairman of the Royal College of General Practitioners, to carry out a review into the reasons why people from black and minority ethnic (BME) communities on average report lower satisfaction with access to GP services and to make recommendations.

## Quality and Outcomes Framework

**3.18** The Quality and Outcomes Framework (QOF), which is part of the new general medical services contract introduced in 2004, rewards GPs for how well they care for patients rather than simply for how many patients they treat. Practices have responded positively, with almost universal participation in the QOF.

**3.19** Independent research shows that achieving the quality targets in the QOF can achieve significant health gains. The QOF was made more challenging from 2006-07. Achievement data published by the Information Centre for Health and Social Care shows that GP practices maintained high achievement levels against this more challenging framework.

## Access to free primary care for foreign nationals

**3.20** The rules on eligibility for free primary medical services for foreign nationals are unclear and much is left to the discretion of individual GPs and practices. The Department is undertaking a joint review with the Home Office of access to the NHS by foreign nationals. Once completed, a public consultation on any new proposals will be undertaken.

## Urgent care and NHS Direct

### Urgent care

**3.21** The *Urgent Care Update* (DH, November 2007) contains the response to the consultation carried out in 2006-07 on a direction of travel for urgent care, and includes a range of supporting information. The ideas emerging from this work will be considered as part of the NHS Next Stage Review led by Lord Darzi to ensure coherency and integration, particularly with the Primary and Community Care Strategy.

**3.22** The possibility of improving and simplifying access to high-quality urgent care through a single point of access and three-digit telephone number, as

announced in the NHS Next Stage Review interim report in October 2007, is currently being explored.

**3.23** To support PCTs in providing or securing the provision of a high-quality, sustainable GP out-of-hours service that meets the needs of their local population, the Department has put in place a set of national quality requirements to set the standards for the delivery of these services. The Public Accounts Committee report *Provision of Out-of-Hours Care in England* (PAC, March 2007), though critical of the preparation for the introduction of the new arrangements, said that out-of-hours services are now “undoubtedly starting to improve”. In order to support PCTs in the commissioning of GP out-of-hours services, the Department has worked with the Audit Commission to develop an effective interactive benchmarking tool that commissioners and providers will be able to use regularly to benchmark their services, and has let a contract to promote and embed the use of this tool in the NHS.

### NHS Direct

**3.24** The Department acts as the lead commissioner for the telephone, on-line and digital television services provided by NHS Direct and has worked closely with NHS Direct to bring about significant performance improvements throughout the year. This has led to an increase in the number of calls answered within 60 seconds from 60 per cent to 95 per cent and a corresponding reduction in abandoned calls from 11 per cent to 1 per cent. Almost 50 per cent of issues raised by callers are now resolved by NHS Direct alone without the need for a referral to other parts of the NHS. This has increased from 34 per cent at the start of the year. The total number of on-line visits is now approaching 3 million a month. NHS Direct has a patient satisfaction rate of 97 per cent and the number of actual complaints remains low.

**3.25** NHS Direct changed its status from a special health authority to an NHS trust on 1 April 2007.

## Emergency care

**3.26** In recent years, numerous improvements have been made to deliver fast, responsive and effective emergency care services, which continue to be maintained effectively for the benefit of NHS staff and patients.

### Accident and emergency services

**3.27** It continues to be a priority for the Department to ensure that patients have timely access to high-quality emergency care services. For accident and emergency (A&E) services, this means that 98 per cent of patients should be seen, diagnosed and treated within four hours of their arrival at A&E. This operational standard is now a permanent feature of the NHS.

**3.28** Since 2005, performance against the operational standard has been maintained – 98.2 per cent of patients were seen, diagnosed and treated within four hours of their arrival at A&E in both 2005-06 and 2006-07. Early published information for the 2007-08 financial year has shown continued commitment by the NHS to delivering the standard – 98.0 per cent of patients have been seen, diagnosed and treated within four hours of arrival across the first three quarters of this financial year (98.2 per cent in quarter 1 (April to June), 98.3 per cent in quarter 2 (July to September) and 97.3 per cent in quarter 3 (October to December)). NHS organisations will continue to work hard to ensure that they maintain performance.

**3.29** Quarterly statistics on A&E performance are available at: [www.performance.doh.gov.uk/hospitalactivity/data\\_requests](http://www.performance.doh.gov.uk/hospitalactivity/data_requests).

### Ambulance services

**3.30** This year ambulance trusts have continued to make progress on the implementation of *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* (DH, June 2005). In particular, those trusts that were created by mergers during

2006 have been working to realise the benefits of their new, larger organisations and to build relationships with local partners. Trusts have also undertaken a range of work collaboratively across England to improve elements of service and capability and capacity, for example in emergency preparedness, procurement, leadership and clinical governance, quality and research.

**3.31** They have also needed to respond to the recommendations from the review for changing the way in which performance against response times is measured. Some of these changes have already come into effect – for example removing the distinction between urban and rural areas, and changing the performance requirements for responding to GP urgent calls to be the same as those for other 999 calls. However, there are further changes that need to be implemented. The most significant of these is the change to the clock start position for response times, so that the clock will start from the moment when calls are transferred to the control room. Trusts will begin to be measured against this new clock start, often known as ‘call connect’, from 2008-09. It requires telephones to be answered more quickly, and means that advice and reassurance will be given earlier, ambulances dispatched faster and the patient reached sooner.

**3.32** Demand for ambulances has continued to increase (6.3 per cent higher in 2006-07 than in 2005-06). However, despite this, ambulance trusts reached more category A (immediately life-threatening) patients within eight minutes in 2006-07 (over 1.3 million compared with 1.2 million in 2005-06).

**3.33** During 2007, the Department has undertaken a range of work to support implementation of the Ambulance Review, including supporting audits of pre-hospital care research and leadership capability within trusts. The Department has also made progress on putting in place arrangements for higher education provision for paramedics, and has supported trusts

in workforce planning and broadening the ambulance workforce skill mix, helping to send the right emergency response in the right setting. The Department is working with ambulance trusts to support them in future applications to become NHS foundation trusts, and is also working with key interested parties on a standard contract for ambulance services, based on one due to be implemented from April 2008 for acute services. The Department also continued to work with trusts to implement a new digital radio service.

### Adult critical care

**3.34** Critical care services (intensive and high-dependence care) have continued to perform well, responding to continuing increased investment. SHAs, provider trusts, commissioners and critical care networks work together to assess the need for, and plan appropriate provision of, critical care services in their local areas. The number of adult critical care beds in January 2008 increased to 3,473 – the highest ever recorded in England and 3.4 per cent more than in January 2007. Overall, a high quality of care has been provided to critically ill patients but there have been some challenges – for example, high levels of respiratory illness have increased demand for critical care beds. However, effective contingency planning by local health communities and critical care networks have ensured that these pressures have been managed.

### Secondary care

#### Elective care waiting times

**3.35** *The NHS Improvement Plan – Putting People at the Heart of Public Services* (DH, June 2004) set out an ambitious new aim that “by the end of 2008 no one will have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation”.

**3.36** The 18-week target is the most ambitious waiting time target ever set. Previous targets focused on reducing waits for particular stages of assessment or treatment (the wait for a first outpatient appointment, or the wait for hospital admission following a decision by a consultant that admission is required). The 18-week target spans all the stages of care (including waits for diagnostic tests and outpatient appointments after the first consultation from referral) through to the start of first definitive treatment (e.g. an operation), properly matching the total wait experienced by individual patients. It also covers all medical and surgical consultant-led treatment, whereas previous elective care stage of treatment targets have focused on surgery. Delivery of the 18-week target will result in substantially shorter waits for around 12 million patients who are referred onto an 18-week pathway every year.

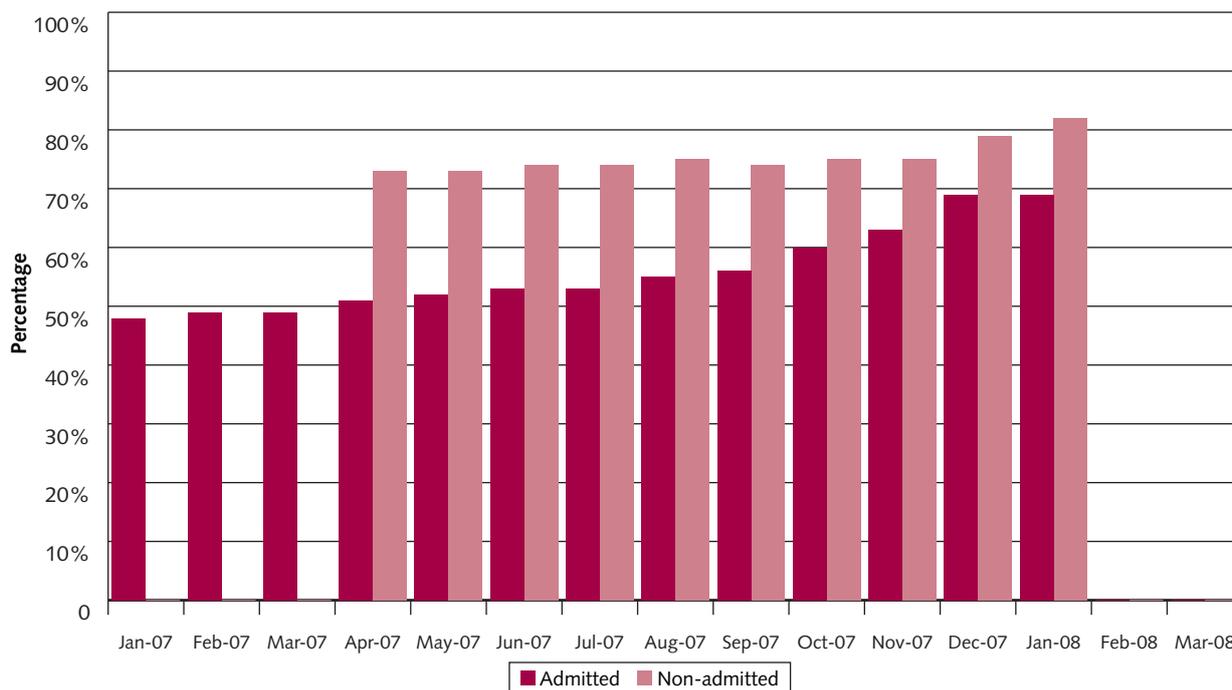
**3.37** In 2007, a new data collection was introduced to enable the NHS to measure the time each patient waits for treatment from the point of referral. This enables the NHS for the first time to track and manage patients through their care pathway without unnecessary delay.

**3.38** The NHS has made good progress. Latest referral-to-treatment (RTT) data (see **figure 3.1**) shows that:

- 69 per cent of admitted patients waited 18 weeks or less in January 2008 compared with 47 per cent in January 2007; and
- 82 per cent of non-admitted patients waited 18 weeks or less in January 2008 compared with 73 per cent in April 2007.

**3.39** These figures are based on patients for whom the NHS has reported complete RTT data in January 2008. A data completeness indicator is used to assess the coverage and completeness of RTT data. The indicator compares the volume of RTT data reported against an existing data source. The Department is working with the NHS to continue to improve data completeness.

**Figure 3.1: Percentage of patients waiting less than 18 weeks for treatment**



**3.40** By the end of March 2008, the NHS is aiming to have achieved milestones of 85 per cent of patients admitted for hospital treatment, and 90 per cent of patients who are not admitted, receiving their treatment within a maximum of 18 weeks.

**3.41** A number of trusts reported achievement of 18 weeks a year early in December 2007. This is an outstanding achievement. The success of these organisations shows that 18 weeks is achievable, and the Department continues to work with the NHS to spread the learning and good practice from these organisations.

**3.42** Access to services at the time and place that people want remains a key litmus test of the public’s views of the NHS. Ultimately, patient experience will be the true measure of success in delivering further improvements in access. The Department will only know if it has succeeded when patients report that they are no longer concerned about waits and that their actual experience of the service is a good one. The Department is testing an 18-week patient survey, which focuses on patients’ satisfaction with the RTT service they have received.

Subject to the outcome of testing, it is planned to roll this out nationally in 2008-09.

**3.43** In December 2007, the Department published operational standards of delivery of 18 weeks for the NHS by December 2008. After adjustments to allow for patient choice along the admitted part of admitted pathways, these standards are:

- 90 per cent of pathways where patients are admitted for hospital treatment should be completed within a maximum of 18 weeks; and
- 95 per cent of pathways that do not result in an admission should be completed within a maximum of 18 weeks.

**3.44** These operational standards allow for patient choice and cooperation along the non-admitted parts of the pathway, and for clinical complexity. These standards are also reflected in the requirements of the NHS contract.

**3.45** The Department continues to support the NHS to deliver the 18-week target through:

- publication of good practice commissioning pathways for 33 key specialty pathways (e.g. hip replacement) developed in conjunction with Royal Colleges and other key stakeholders;
- provision of intensive support to local health communities who request it, for example to help with measurement;
- an extensive programme of engagement with NHS staff;
- working closely with the National Programme for IT to secure the necessary 18-week-related IT changes to support delivery of 18 weeks; and
- publishing an extensive range of information and good practice materials on achieving and sustaining 18 weeks on the 18 weeks website ([www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)).

**3.46** Improving access to services by delivering the 18-week target will reduce unnecessary delays, improve patients' experience of the whole journey and deliver real improvements in health outcomes.

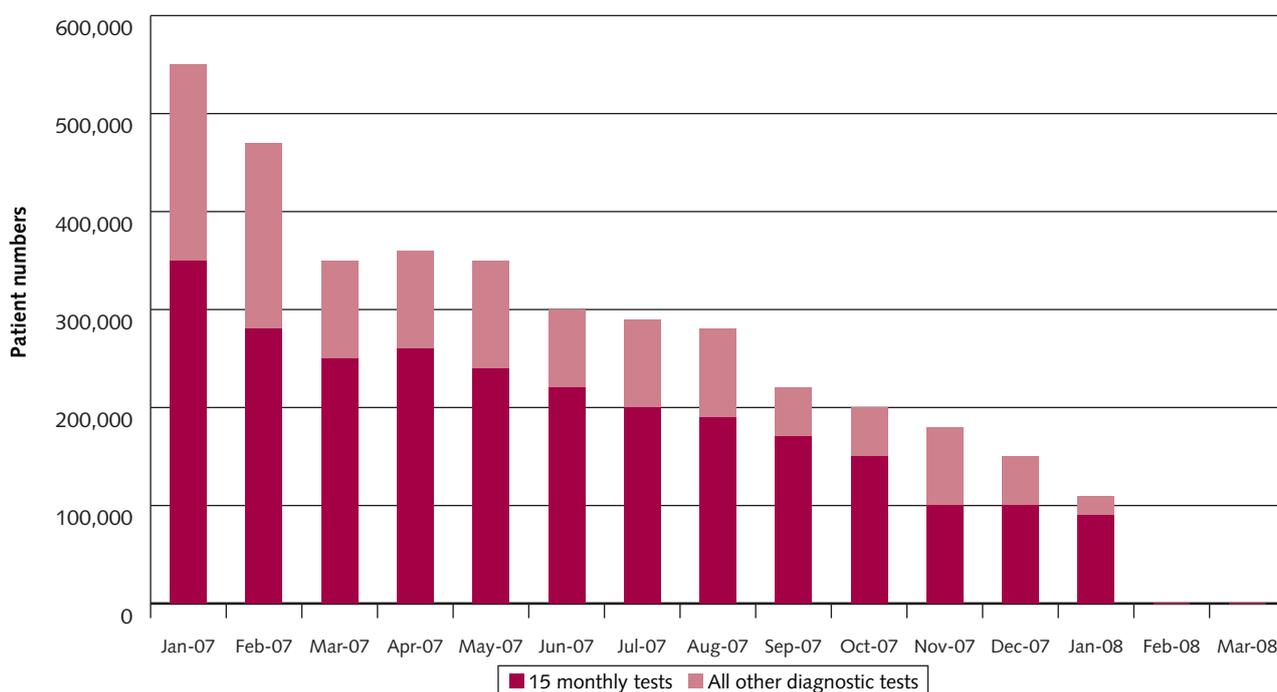
### Diagnostic waiting times

**3.47** The 18-week RTT can only be delivered if the NHS can reduce waits for all diagnostic tests, and in particular the 15 key monthly tests. Access to the 15 key diagnostic tests continues to improve:

- The number of waits of over 13 weeks fell by 150,969 (90 per cent) from 167,826 at the end of January 2007 to 16,857 at the end of January 2008.
- The number of waits of over six weeks fell by 283,349 (80.8 per cent) from 350,822 to 67,473 over the same period.
- The median waiting time now stands at two weeks, compared with 6.1 weeks in April 2006. The number of waits of over six weeks continues to fall, as shown in **figure 3.2**.

**3.48** Audiology waits continue to dominate the numbers of long waits, but are also continuing to fall. In March 2007, the Department published *Improving Access to Audiology Services in England*, setting out how the local NHS can improve access to audiology services.

**Figure 3.2: Diagnostic over 6-week waiters**



**3.49** By the end of March 2008, patients should expect to have to wait no longer than six weeks for a diagnostic test.

### Independent Sector Treatment Centre Programme

**3.50** Since the Independent Sector Treatment Centre Programme started in 2003, 1 million people have benefited from faster access to elective surgery, diagnostic procedures and episodes of

primary care delivered through: 24 operational fixed-site independent sector treatment centres in Wave 1; a mobile ophthalmology service; a mobile MRI scanning service; six walk-in centres with a commuter focus; and five operational independent sector treatment centre schemes in Phase 2.

### Activity trends

**3.51** Figure 3.3 gives details of hospital activity levels for each of the main sectors. 2006-07 saw an

**Figure 3.3: Hospital activity trends, 1997-98 to 2006-07**

	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	Annual average % change 1997-98 to 2006-07	% change 2005-06 to 2006-07
<b>General and acute (thousands of episodes)</b>												
Elective admissions <sup>(1)</sup>	4,500	4,923	4,988	5,101	5,137	5,367	5,553	5,669	5,795	5,847	3.0%	0.9%
Emergency and other admissions (non-elective admissions) <sup>(1)</sup>	3,761	3,882	3,920	3,976	3,995	4,041	4,311	4,535	4,732	4,739	2.6%	0.1%
Total admissions (first finished consultant episodes) <sup>(1)</sup>	8,261	8,805	8,908	9,077	9,131	9,408	9,864	10,204	10,528	10,586	2.8%	0.6%
<b>Geriatrics (thousands of episodes)</b>												
Total admissions (first finished consultant episodes) <sup>(2)</sup>	401	399	383	359	347	357	357	368	361	358	-1.3%	-0.8%
<b>Maternity (thousands of episodes)</b>												
Total admissions (first finished consultant episodes) <sup>(2)</sup>	827	880	884	896	877	924	970	1,000	1,038	1,039	2.6%	0.1%
<b>New outpatients (first attendances) (thousands)</b>												
General and acute <sup>(3)</sup>	10,643	10,919	11,294	11,637	11,838	12,080	12,650	12,617	13,094	12,898	2.2%	-1.5%
– of which, Geriatrics <sup>(3)</sup>	107	108	113	114	115	115	125	122	131	137	2.8%	4.6%
Maternity <sup>(3) (5)</sup>	590	565	554	537	504	522	505	482	465	510	-1.6%	9.7%
Mental illness <sup>(3)</sup>	290	287	282	285	263	271	267	264	239	201	-4.0%	-15.9%
Learning disabilities <sup>(3)</sup>	6	6	7	7	8	7	8	8	7	8	3.2%	14.3%
All specialties <sup>(3) (5)</sup>	11,529	11,778	12,136	12,466	12,613	12,879	13,431	13,370	13,805	13,617	1.9%	-1.4%
<b>New A&amp;E (first attenders) (thousands) <sup>(4)</sup></b>												
	12,794	12,811	13,167	12,953	12,853	12,945	15,313	16,712	17,775	18,011	3.9%	1.3%
<b>Average length of spell (ordinary admissions) (days)</b>												
General and acute <sup>(2)</sup>	7.0	6.8	6.7	6.9	7.1	7.0	6.8	6.3	5.9	5.5	-2.6%	-6.8%
– of which, Geriatrics <sup>(2)</sup>	22.7	22.2	21.8	23.3	23.4	23.1	21.7	20.1	19.0	17.3	-3.0%	-8.9%

Source: NHS Finance, Performance and Operations Directorate, DH

Notes:

(1) SaFR quarterly monitoring and current monthly monitoring. Figures are for admissions purchased by the NHS. Figures prior to 2005-06 have been re-based to allow direct comparison. General and acute specialties do not include mental health, learning disabilities or maternity. From 30 June 1998, activity is calculated on the basis of first finished consultant episodes. Elective activity includes waiting list, booked and planned admissions. Some unknown cases may be elective cases. Figures prior to 2001-02 are from health authorities. With the abolition of health authorities, figures for 2001-02 are based on returns from NHS trusts. Data are presented for financial years and are not adjusted for the differing number of working days per year. There were three less working days (252) in 2006-07 compared with 2005-06 (255).

(2) Hospital Episode Statistics. Figures are for admissions to NHS hospitals in England. Figures are grossed for coverage, except for 2002-03, 2003-04, 2004-05, 2005-06 and 2006-07 which are not yet adjusted for shortfalls. Length of stay is calculated as the difference in days between the admission date and the discharge date, where both are given, and is based on hospital spells and only applies to ordinary admissions i.e. day cases are excluded (unless otherwise stated).

(3) KH09 and QMOP. Figures for 2001-02 and onwards are sourced from QMOP.

(4) QMAE and KH09.

(5) Quarter 1 2005-06 data for maternity has been estimated to obtain the 2005-06 total as it was not collected as an individual specialty.

increase of 0.9 per cent since 2005-06 for general and acute elective hospital admissions and a decrease of 1.5 per cent since 2005-06 for first outpatient attendances.

## Dental services

### Reform of primary dental care services

**3.52** PCTs and dental practices have responded well to the challenge of implementing the revised framework for primary dental services from April 2006. PCTs have commissioned a greater volume of dental services than was delivered in 2005-06 (the final year of the old system).

**3.53** In 2006-07, PCTs committed nearly £1.75 billion in net funding for primary dental care services, an increase of 30 per cent compared with net expenditure in 2003-04. Gross expenditure, taking into account income from patient charges, stood at over £2.2 billion, some £400 million or over 20 per cent higher than in 2003-04.

**3.54** Some areas of the country still have some way to go to address the access difficulties that built up over many years under the old system. The *NHS Operating Framework for 2008-09* sets all PCTs the objective of ensuring year-on-year improvement in the number of patients accessing NHS dental services. To support this objective, the Department has increased PCT funding for commissioning primary dental services to £2,081 million (net of patient charge income) in 2008-09, an increase of 11 per cent on the 2007-08 budget. To provide extra reassurance to patients and dentists that investment in primary dental care will be maintained, the Government also announced on 5 March 2008 that the commitment to ring-fence NHS dental funding allocations up to 2009 will be extended for a further two years to March 2011.

### General and personal dental services

**3.55** **Figure 3.4** provides some principal indicators of activity within primary dental care services in England. The table has been restructured

from the versions published in previous reports to reflect the new service framework now in place. The distinction under the old system between practitioners working in general dental services and in personal dental services is less relevant now that PCTs are responsible for commissioning all elements of primary dental care.

**3.56** Data on the number of dental practitioners has been recalibrated to record the position as at 31 March in each year. The number of dentists providing NHS services is a less valuable indicator than the volume of services they provide for the NHS. It is nonetheless encouraging that numbers of dentists are broadly similar to those in March 2006 (a 0.3 per cent reduction compared with the total just before the reforms) and significantly higher than three to four years ago.

**3.57** Other data shows similar or slightly less activity in 2006-07 compared with 2005-06. This reflects the changeover to the new commissioning framework, with PCTs having to commission new services to replace the 4 per cent of activity associated with dentists who did not take up new contracts from April 2006. PCTs' success in commissioning these new services has allowed for a relatively stable transition.

**3.58** There is no contractual system of patient registrations under the new dental contract. Registration data has therefore been replaced (since 2006-07) with a new measure of access, namely the number of patients accessing primary dental services at least once within the previous 24 months.

## Eye care services

### Review of general ophthalmic services

**3.59** Last year's report noted the completion of the Department's review of general ophthalmic services and the release of a commissioning toolkit to help PCTs develop a wider range of community-based eye care services where this could be appropriate. The Department has subsequently

**Figure 3.4: Family health services – key statistics on primary dental care services, England**

	1996-97	2002-03	2003-04	2004-05	2005-06	2006-07	% change 1996-97 to 2006-07	% change 2005-06 to 2006-07
<b>Primary dental care services</b>								
Number of general and personal dental practitioners <sup>(1)</sup>	16,470	18,801	19,026	19,797	21,111	21,041	27.8%	-0.3%
Number of adults registered (thousands) <sup>(2)</sup>	19,798	17,064	17,374	17,237	17,670	n/a		
Number of children registered (thousands) <sup>(2)</sup>	6,617	6,841	6,964	6,891	7,044	n/a		
<b>Patients seen</b>								
Number of adults seen in previous 24 months (thousands) <sup>(3)</sup>					20,348	20,285		-0.3%
Number of children seen in previous 24 months (thousands) <sup>(3)</sup>					7,797	7,813		0.2%
<b>Courses of treatment</b>								
Adult courses of treatment (thousands) <sup>(4)</sup>	24,580	26,726	27,031	26,488	25,844	25,121	2.2%	-2.8%

Source: Dental and Eye Care Services Division, DH

Notes:

(1) Numbers as at 31 March. Figures for 1996-97 to 2005-06 relate to dentists working within general dental services (GDS) including salaried dentists, or personal dental services (PDS) pilots. Figure for 2006-07 relates to dentists on open contracts in GDS, PDS and trust-led dental services (TDS) and includes some TDS dentists who did not previously work under a PDS or GDS contract in 2005-06.

(2) 1996-97 figures covered adults registered in the previous 24 months and children in the previous 15 months. 2002-03 and later years are numbers of patients registered in the GDS and PDS as at 31 March. GDS registrations lasted for 15 months. PDS schemes had varying registration periods. To ensure comparability with corresponding GDS data, PDS registrations are estimated using 'proxy registrations', namely the number of patients seen by PDS practices in the previous 15 months. PDS proxy registrations were not estimated for periods before September 2003 – actual registrations were used before this date.

(3) Numbers as at 31 March. The figures for 31 March 2007 contain an additional group of patients who were seen by TDS dentists who did not previously work under a PDS or GDS contract in 2005-06. This is thought to have a minimal impact on the figures.

(4) Data on courses of treatment until 2005-06 represent completed treatment claims processed by the Dental Practice Board (Dental Services Division of NHS Business Services Authority from April 2006) within the relevant year. For 2006-07, the figures are for courses of treatment conducted within the year.

consulted on regulations under the *Health Act 2006*, which will remove restrictions on who may contract with the NHS for the provision of NHS sight tests and will create a more coherent framework for commissioning community-based eye care services, which could give patients greater choice and easier access to services.

### General ophthalmic services

**3.60** Activity levels are mainly affected by two factors: variations in the size of the population groups eligible for NHS sight tests and optical vouchers; and variations in the take-up rates for sight tests and vouchers. **Figure 3.5** provides key information on general ophthalmic services in England. The main points are set out below:

- The number of NHS sight tests has risen substantially by some 54 per cent over the ten years from 1996-97 to 2006-07, driven mainly by the Government's decision to extend eligibility for free NHS sight tests to everyone aged 60 and over from 1 April 1999. Since April 1999, the underlying trend has been for an average annual increase of about 1.6 per cent in the volume of tests.

- The volume of NHS optical vouchers has shown a decrease of 5 per cent over the past ten years, averaging out as a fall of 0.5 per cent per year. However, the trend can fluctuate year on year, reflecting changes in demographic factors or factors such as the number of adults claiming Income Support and Jobseeker's Allowance (the main category of people who qualify for vouchers). In fact, the number of vouchers fell by 12.5 per cent between 1996-97 and 2002-03 but rose by 8.4 per cent between 2002-03 and 2006-07. The 2 per cent increase in the volume of vouchers in 2006-07 compared with 2005-06 has been typical of this most recent trend.
- The number of opticians in 2006-07 increased by 4 per cent over the previous year, and at 8,946 represented an increase of 29 per cent over the numbers in 1996-97.

### Pharmacy

**3.61** *A Vision for Pharmacy in the New NHS* (DH, July 2003) paved the way for pharmacy services to deliver greater choice, better access and higher

**Figure 3.5: Family health services – key statistics on general ophthalmic services, England**

	1996-97	2002-03	2003-04	2004-05	2005-06	2006-07	% change 1996-97 to 2006-07	% change 2005-06 to 2006-07
<b>General ophthalmic services:</b>								
NHS sight tests (thousands) <sup>(1)</sup>	6,808	9,662	9,845	10,149	10,355	10,485	54.0%	1.3%
Optical vouchers (thousands) <sup>(2)</sup>	3,967	3,472	3,520	3,624	3,678	3,765	-5.1%	2.4%
Number of opticians <sup>(3)</sup>	6,939	8,096	8,331	8,472	8,639	8,946	28.9%	3.6%

Source: Dental and Eye Care Services Division, DH

Notes:

(1) From 1 April 1999, the eligibility criteria for NHS sight tests was extended to include all patients aged 60 and over. Figures are based on the number of sight test claims where the date of payment fell within the financial year, rather than the date the sight test was conducted.

(2) The voucher scheme was introduced on 1 July 1986 to help certain priority groups with the provision of spectacles. Figures are based on the number of vouchers reimbursed to practitioners in the year, including payments for complex appliances, rather than the date when the vouchers were exchanged by patients for glasses.

(3) Optometrists and Ophthalmic Medical Practitioners at 31 December.

quality for all patients. Since then, pharmacists have developed new clinical roles working alongside other NHS healthcare professionals and made a real contribution to the nation's health and well-being.

## Pharmacy White Paper

**3.62** The pharmacy White Paper *Pharmacy in England – Building on Strengths, Delivering the Future*, was published in April 2008. It sets out a comprehensive development programme, using pharmacy's capacity and capability to deliver further improvements in pharmaceutical services over the coming years. In addition to offering support to enable people to make the best use of their medicines, community pharmacies will become healthy living centres, promoting self-care and enabling people to take better care of themselves. Many will provide help for a range of minor ailments, offer screening services such as for vascular disease and provide support for people newly prescribed medicines for a long-term condition. Two new clinical directors for hospital and community pharmaceutical services will be appointed to support implementation and the delivery of integrated care. This is part of an overall strategy to ensure safe, effective, fairer and more personalised patient care; and recognising that pharmacy is well placed to provide services closer to people's homes as outlined in *Our Health, Our Care, Our Say*.

**3.63** This has been developed to align closely with the NHS Next Stage Review and the development of a new Primary and Community Care Strategy.

**3.64** The White Paper also provides the Government's response to the *Review of Contractual Arrangements for Pharmacy* commissioned in 2007 and conducted by Anne Galbraith, former Chair of the Prescription Pricing Authority. In addition, it takes account of the recommendations of the All-Party Pharmacy Group's report *The Future of Pharmacy* (APPG, June 2007).

## Community Pharmacy Contractual Framework

**3.65** The contractual framework for community pharmacy – now in place for three years – allows pharmacies to offer an ever-expanding range of clinical services rather than simply being outlets to dispense and supply medicines. It also provides a good platform for pharmacy to help people improve their health and reduce health inequalities.

**3.66** Under the contract:

- there continues to be a gradual increase in repeat dispensing. Over 5.6 million items (1.45 per cent of all items dispensed) were dispensed via repeat dispensing in the first half of 2007-08. This is up from 0.86 per cent in 2006-07);
- by the end of January 2008, over 1.2 million medicines use reviews had been conducted by pharmacists; and

- the number of local enhanced services, commissioned by PCTs and provided by community pharmacists in England, such as minor ailment services, stop smoking services, supervised methadone administration and needle and syringe exchange schemes, increased to 20,996 in 2006-07 (from 16,920 in 2005-06), with a 31 per cent increase in stop smoking services.

### Hospital pharmacy

**3.67** The hospital pharmacy team takes a leading role in promoting the safe and effective use of medicines during a patient's stay in hospital and at the transition between primary care and hospital care. The Department is working with hospital pharmacists to develop further their clinical and patient safety roles. For example, consultant pharmacist posts are being established by the NHS to address particular medicines-related priorities, including those in clinical specialties such as cancer, critical care, paediatrics or older people, and those taking forward a wider agenda in the hospital and health community, for example in medication safety and antimicrobials.

**3.68** A programme of work has been commissioned from the National Institute for Mental Health in England, to foster leadership on medicines management in mental health settings, to develop a self-assessment toolkit on medicines management services in mental health trusts, to provide guidance on pharmacy service level agreements, and to extend the contribution of pharmacy technicians to medicines management in mental health trusts.

**3.69** The Department continues to promote good practice in relation to the management of controlled drugs in the NHS and published *Safer Management of Controlled Drugs: A Guide to Good Practice in Secondary Care (England)* (DH, October 2007).

### Pharmacy and public health

**3.70** *Choosing Health Through Pharmacy – A Programme for Pharmaceutical Public Health 2005-2015* (DH, April 2005) aimed to maximise community pharmacy's contribution to improving health and reducing health inequalities over a ten-year period.

**3.71** Pharmacy's increasing engagement in the public health agenda is already being demonstrated. For example:

- many pharmacists have been trained to provide one-to-one NHS Stop Smoking Services and new evidence suggests that the resulting abstinence rates are similar to those of services provided by nurses. In some PCT areas, pharmacies are mostly responsible for delivering the successful quit rates;
- more sexual health services are being provided. In particular, pharmacy is now one of the main ways to access emergency hormonal contraception and such services are highly rated by women;
- involvement in chlamydia screening is growing. Following a national procurement programme in London, pharmacies account for around 15 per cent of chlamydia screens carried out in England; and
- substance misuse services, including needle and syringe exchange schemes and supervised administration of methadone, are well established and accepted by clients.

**3.72** A Public Health Leadership Forum for Pharmacy, drawn from both the pharmacy and public health sectors, has also been established to accelerate pharmacy's positive impact on public health and identify ways in which it can contribute to tackling the wider social causes of ill health. The forum will promote the community leadership role for community pharmacy and engage it in the sustainable development agenda.

## Pharmacy workforce

**3.73** England has a highly trained and experienced pharmacy workforce. Pharmacists and pharmacy staff have greatly expanded their clinical knowledge and expertise in recent years and continue to do so.

**3.74** The Department published guidance on the accreditation of GPs and pharmacists with special interests in April 2007, and is supporting work to take forward the development of specialist accreditation frameworks.

**3.75** In collaboration with Skills for Health and pharmacy stakeholders, the Department has contributed to a revision of national occupational standards in pharmacy. The next stage involves the development of new qualifications for pharmacy support staff from these standards.

**3.76** The *Health Act 2006* enables pharmacists and pharmacy owners to make better and more flexible use of all staff working in pharmacies to support delivery of a wider range of services to the NHS, patients and the public.

**3.77** The Department is taking a phased approach to the introduction of the *Health Act 2006* changes relating to the sale and supply of medicines from pharmacies. In October 2007, the Department issued a public consultation paper on the proposed content of the first set of regulations introducing these changes – those concerning the requirement that each pharmacy is to be in the charge of a responsible pharmacist who has a legal duty to secure the safe and effective running of the pharmacy. A summary of the responses received was published in April 2008.

**3.78** The Department will be consulting on the proposed regulations relating to pharmacist supervision of dispensing activities in due course.

## Utilising IT

**3.79** Progress continues to be made in utilising IT in community pharmacy as announced in *Delivering 21st Century IT Support for the NHS: National Strategic Programme* (DH, June 2002).

**3.80** Further information on both the national Electronic Prescription Service and the NHS Care Record Service is included in chapter 8.

## Prescription charges and exemptions

**3.81** In October 2006, the Government announced that it would undertake a review of prescription charges and exemptions in response to the Health Select Committee's report *NHS Charges* (HSC, July 2006).

**3.82** The Department conducted an internal review and identified some possibilities for change to ensure, as far as possible, that the system is fair and that paying for prescription charges does not prevent people getting the medication they need. It has also decided that any changes should be cost neutral and not reduce the money available to deliver other NHS priorities.

**3.83** The Department will publish a consultation paper later in 2008 seeking people's views on how this might be done.

## Pharmaceutical services

**3.84** **Figure 3.6** provides key information on pharmaceutical services in England. In particular:

- both the volume of prescriptions and the average number of prescriptions dispensed by pharmacy and appliance contractors continue to increase, but less rapidly. The year-on-year growth in the number of prescriptions per pharmacy in 2006 was 1 per cent; in comparison, there was growth of 5.4 per cent in 2005;
- the number of pharmacies, having been nearly constant for several years, rose by 261 from 9,872 to 10,133 between 31 March 2006 and 31 March 2007 following the changes in the control of entry

**Figure 3.6: Family health services – key statistics on pharmaceutical services, England**

	1996-97	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	% change 1996-97 to 2006-07	% change 2005-06 to 2006-07
<b>Pharmaceutical services<sup>(1)</sup></b>									
Prescription fees (millions) <sup>(2)</sup>	452.4	549.7	580.3	611.8	641.5	679.3	711.0	57.2%	4.7%
Number of contracting pharmacies <sup>(3)(4)</sup>	9,775	9,756	9,748	9,759	9,736	9,782	10,133	3.7%	3.6%
Average number of prescription fees per pharmacy dispensed by pharmacy and appliance contractors	46,281	56,345	59,530	62,691	65,889	69,444	70,167	51.6%	1.0%
Average net ingredient cost per fee (£) <sup>(2)</sup>	8.07	10.27	10.87	11.23	11.29	10.50	10.35	28.3%	-1.4%
Percentage of all prescription items which attracted a charge <sup>(5)</sup>	14.4%	14.6%	14.3 %	13.8%	13.1%	12.4%	12.0%		

Source: Medicines, Pharmacy and Industry Division, DH

Notes:

(1) Pharmaceutical services are mainly the supply of drugs, medicines and appliances prescribed by NHS practitioners.

(2) Includes prescriptions dispensed by community pharmacists and appliance contractors; excludes those dispensed by dispensing doctors.

(3) Includes appliance contractors; excludes dispensing doctors.

(4) Figures refer to 31 March (e.g. 2004-05 is number as at 31 March 2005).

(5) Prescriptions dispensed to patients who pay prescription charges or hold prescription pre-payment certificates. The analysis is based on a 1 in 20 sample of all prescriptions submitted to the Prescription Pricing Division of the NHS Business Services Authority in the calendar year. The analysis is based on prescriptions submitted by community pharmacists, appliance contractors and from 2001 onwards it also includes dispensing doctors.

rules; this is the first time the number has exceeded 10,000; and

- the percentage of prescriptions that attract a charge has shown a consistent downward trend over recent years, from 14.6 per cent in 2001 to 12.0 per cent in 2006.

### Non-medical prescribing by nurses, pharmacists and other health professionals

**3.85** Non-medical prescribing has expanded prescribing by trained nurse and pharmacist prescribers. This helps give patients improved and quicker access to the medicines they need:

- Well over 11,000 nurse independent prescribers have qualified to prescribe independently – up by over 2,000 in the last year. They may prescribe any licensed medicine, including some controlled drugs, for any medical condition within their competence.
- There are also over 900 pharmacist supplementary prescribers who can prescribe in partnership with a doctor; 300 of these have qualified as pharmacist independent prescribers.

- In addition, numbers of allied health profession supplementary prescribers (physiotherapists, chiropodists/podiatrists, radiographers and optometrists) are growing steadily, while optometrist independent prescribing is on the horizon and due to begin later in 2008.

**3.86** These expanded prescribing powers are improving NHS services and choice for patients, as well as enabling more flexible NHS working patterns by maximising professional skills and encouraging multidisciplinary working.

### Modernising pathology services

**3.87** In the last year, the Department has taken forward national initiatives to support the NHS in modernising pathology services. It has:

- worked with NHS Connecting for Health on a national project to allow GPs to order pathology tests electronically (as well as receiving test results in this way) and to develop decision support;
- funded the development of a national clinical benchmarking system for pathology in primary care;

- provided national programmes using service improvement and action learning techniques to support NHS pathology services to deliver change locally;
- completed Phase 1 of the Pathology Workforce Re-profiling Project (part of the wider programme of workforce reform in healthcare science). The learning set from this project will be published in early summer 2008; and
- worked with national accreditation bodies to support modernising the pathology accreditation system, including developing a pilot approach to accrediting point-of-care testing in the community and in primary care.

**3.88** In September 2005, as part of the Modernising Pathology Programme, the Department announced an independent review of NHS pathology services, chaired by Lord Carter of Coles, to determine the feasibility of and benefits from wide-scale service reconfiguration and modernisation.

**3.89** The Department accepted the recommendation in Lord Carter's report of the *Review of NHS Pathology Services in England* (DH, August 2006) to test and refine the review's findings through a series of pilots. Twelve pilot sites collected data on activity and costs from January to September 2007 to provide an evidence base for recommendations on service reconfiguration.

**3.90** The report of this second phase of the review is expected in spring 2008. The Department will consider the recommendations when it receives the report and will publish its response in 2008.

## Healthcare-associated infections

**3.91** Over the past year, tackling healthcare-associated infections (HCAIs) has remained a key priority.

**3.92** The *NHS Operating Framework for 2008-09* re-emphasises that improving cleanliness and

reducing HCAIs is one of the NHS's top priorities. Significant investment was made in 2007-08 to support the NHS – an additional £50 million was allocated to SHA directors of nursing to support local improvements. On top of this, SHAs agreed to spend £57 million on deep cleaning all hospitals by the end of 2007-08.

**3.93** In addition, the 2007 Comprehensive Spending Review (CSR) set a new Public Service Agreement (PSA) target to maintain the current improvements in infection rates of methicillin-resistant *Staphylococcus aureus* (MRSA) and, building on the local targets for *Clostridium difficile* (*C. difficile*) in 2007-08, a new national target to reduce the number of *C. difficile* infections by 30 per cent in 2010-11 over the 2007-08 baseline. The CSR also included an additional £270 million per annum by 2010-11 to tackle HCAIs.

## Progress

**3.94** 2007-08 demonstrated how far the NHS has already come in tackling infections. The Health Protection Agency published the latest figures covering October to December 2007 for MRSA and *C. difficile* infections on 24 April 2008. These figures show a drop of 30 per cent, to 1,087, in the number of MRSA bacteraemia infections recorded compared with the same period in 2006, and a drop of 23 per cent, to 9,872, in the number of *C. difficile* infections in the most vulnerable 65 years and over age group compared with the same period in 2006.

**3.95** In addition, a project is under way to investigate the prevalence of new community-acquired strains of MRSA, which are genetically distinct from the strains normally found in hospitals.

**3.96** Turning to cleaning standards, in the hospital Patient Environment Action Team scores for 2007, which assess hospital cleanliness and environment, 98 per cent of hospitals were rated acceptable, good or excellent.

## Activity to tackle HCAs

**3.97** *Clean, Safe Care: Reducing Infections and Saving Lives* (DH, January 2008) is a comprehensive strategy to tackle HCAs and improve cleanliness.

**3.98** To effectively tackle HCAs, NHS staff must understand and be accountable for their role in providing clean and safe care, and this strategy sets out for all staff their responsibilities and obligations in achieving this. NHS staff are responsible for their trust's performance in reducing HCAs – from board to ward.

**3.99** *Clean, Safe Care* sets out where there are national expectations and requirements – such as the new national target for *C. difficile* or the requirement to increase the number of hospital matrons to 5,000 by May 2008. It also guides NHS organisations and staff as to the actions and investment that will be most effective in continuing to tackle infection and improve cleanliness in their local area.

**3.100** It also reconfirms the commitment in the NHS Next Stage Review to introduce MRSA screening to all elective patients by March 2009 and to all emergency admissions as soon as possible within the next three years. This preventative measure is supported by uniform guidance for hospitals and a new 'bare below the elbows' dress code, which will support good hand hygiene.

**3.101** The Clean Your Hands Campaign has been extended to include pilots in non-acute health and social care settings, to raise both public and staff awareness of the importance of good hand hygiene. The Department is also raising awareness through a new antibiotics campaign launched in February 2008 to remind the public that antibiotics do not work on most coughs, colds and sore throats and unnecessary use of antibiotics should be avoided as it can lead to increased microbial resistance.

## Workforce activity to tackle HCAs

**3.102** A number of measures have therefore been put in place to support current members of NHS staff and to increase the numbers and powers of staff who have a particular specialist role in this area, such as:

- additional funding to support PCTs and providers in recruiting additional staff such as infection control nurses, pharmacists and isolation nurses;
- an increase to 5,000 hospital matrons by May 2008;
- guidance on human resources procedures to be developed in conjunction with trade unions – including the importance of induction and training on infection prevention and control for staff; and
- a revised code of practice, which was published in January 2008. The code now also emphasises the chief executive's responsibility for reporting MRSA and *C. difficile* surveillance data and a new mandatory requirement of quarterly reporting to trust boards by matrons and clinical directors on cleanliness and infection control.

## Activity to improve cleanliness

**3.103** Attention to cleanliness plays an important part in creating a culture that allows everyone in a healthcare facility to focus on infection control. Without the backdrop of a very clean environment, measures such as consistent hand cleaning between patients can feel futile. Maintaining high standards of hygiene is also crucial in preventing the spread of *C. difficile* and reducing rates of infection. The Department has taken a number of actions over the last year to improve cleanliness across the NHS or to look at how it can be taken further. These include the following:

- Of the 328 trusts in England that have undertaken a local Deep Clean Programme, 94 per cent had completed their programmes either on or before 31 March 2008. The rest will have completed by May 2008. This has meant that the NHS is reinvigorated, with thoroughly clean

buildings across the estate and a raised awareness of the importance of a properly clean environment.

- A cleaning summit was held by the NHS Chief Executive, and marked the start of a focused programme of joint working with organisations to look at national issues relating to, and affecting, hospital cleaning.
- The National Patient Safety Agency published *The National Specifications for Cleanliness in the NHS* for hospitals in 2007. This will be extended to include specifications for other healthcare settings such as GP surgeries and ambulances.

**3.104** The Department also strengthened the support it offered to the NHS, by:

- doubling the size of the Department of Health's Improvement Team. By the end of 2007, the Improvement Team had visited 154 trusts;
- promoting innovations – introducing a range of programmes designed to accelerate the development and uptake of new technologies;
- re-launching *Saving Lives*, in June 2007, to take account of feedback from the NHS and stakeholders. It now includes additional guidance for taking blood cultures, isolation of patients with HCAs, antimicrobial prescribing and the management of chronic wounds;
- revising and re-launching *Essential Steps to Safe, Clean Care* in June 2007. This programme mirrors *Saving Lives* but provides similar tools for the non-acute health setting. These tools also include the latest learning and guidance on areas such as the movement of patients between organisations and managing MRSA in the non-acute setting;
- publishing *Epic2: National Evidence-Based Guidelines for Preventing Healthcare-associated Infections in NHS Hospitals in England* and maintaining the National Resource for Infection Control; and
- publishing *Board to Ward* guidance (DH, January 2008), setting out the learning from the

Department of Health's Improvement Team to enable staff at every level of an organisation to be clear on their role and know how to make their contribution to tackling HCAs.

**3.105** In order to ensure that the NHS continues to improve, the Department has put in place a number of measures:

- specialist inspectors to undertake annual infection control inspections of all acute trusts every year from April 2008;
- stringent requirements on NHS foundation trust applicants – only top performers on HCAs will be considered for NHS foundation trust status; and
- a new national contract – allowing PCTs to fine trusts that are not hitting local targets on *C. difficile* improvement. The new national contract for 2008-09 also includes the requirement for monthly clinical quality review meetings between providers and commissioners, covering performance on both MRSA and *C. difficile*.

**3.106** 2007 also saw the publication of two Healthcare Commission reports on HCAs. In October, the Healthcare Commission published a report of their investigation into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust. This report showed serious failures in the management of infections, and a detailed action plan has been put in place. The Healthcare Commission is continuing to work closely with the organisation. In November, the Healthcare Commission also published a report on progress made at Buckinghamshire Hospitals NHS Trust since its investigation in 2006. The Department acknowledges that both these events are unacceptable and the range of measures introduced since these outbreaks will mean that such failings in patient care should not be repeated.

## Support for people with long-term conditions

**3.107** Strong general practice, social services, community nursing and hospital outreach services are at the heart of providing care to people with long-term conditions. The wide use of evidence-based good practice through implementation of the national service frameworks (NSFs) and the *NHS and Social Care Long Term Conditions Model* (DH, January 2005) have helped bring about improvements.

**3.108** Nevertheless good care is not happening everywhere, and this is certainly reflected in the views of individuals with long-term conditions. Recent national surveys show that the Department still needs to do more to empower people with long-term health and social care needs through greater choice and more control over their care. Participants in the *Your Health, Your Care, Your Say* consultation said that they have seen significant improvement in services but remain concerned about poor coordination between health and social care services and want more support for independent living.

## PSA target

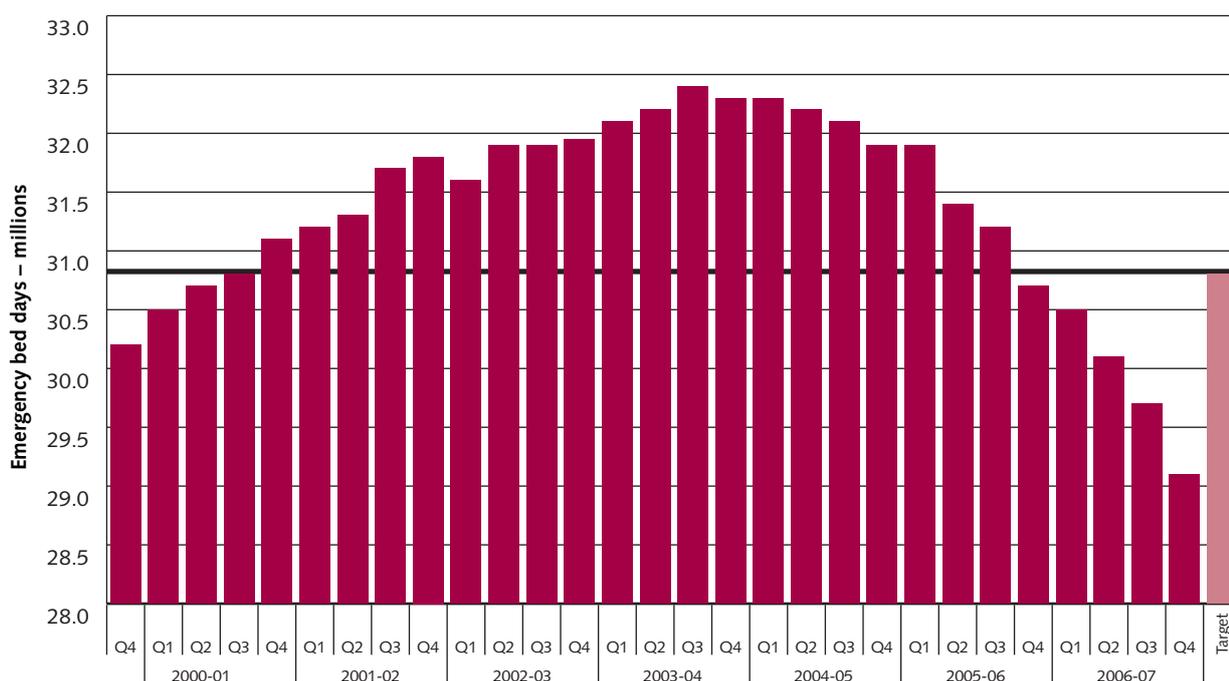
**3.109** The long-term conditions PSA target focuses on improving health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk and reducing emergency bed days by 5 per cent by 2008, through improved care in primary and community settings. The emergency bed day element has now been met – between 2003-04 and 2006-07 the number of emergency bed days decreased by 10.1 per cent. The focus will be on sustaining these bed day reductions in 2008-09. See **figure 3.7** for numbers of emergency bed day reductions.

## Supporting people with long-term conditions to self-care

**3.110** Self-care lies at the heart of putting people in control and plays a key role in improving the management of long-term conditions.

**3.111** The *Our Health, Our Care, Our Say* White Paper included a number of commitments to improve support to self-care, promoting well-being and community engagement and focusing more on prevention and early intervention with services

**Figure 3.7: Numbers of emergency bed-day reductions**



designed around the patient/service user, rather than the needs of individuals being forced to fit around the service.

**3.112** The White Paper specifically committed the Department to work in partnership with Skills for Health and Skills for Care, to develop a competence framework to describe the skills and knowledge required of the workforce to support self-care. A set of *Common Core Principles to Support Self-care* – particularly highlighting four areas of self-care support around skills and training, information, tools and devices and support networks – have been developed in collaboration with the Sector Skills Councils and will be published with accompanying guidance in 2008.

**3.113** These common core principles will then need to be embedded in the workforce. Work with the medical Royal Colleges is under way and self-care competences have been incorporated in some postgraduate medical curricula. This will be built upon and extended to other professions.

**3.114** The Department has run a study carried out through the Ipsos MORI national omnibus and face-to-face interviews in people's homes with a representative sample of the population. The report *Self Care: A National View in 2007 Compared to 2004-05* will be published in spring 2008. The summary concludes that few specific changes have occurred, indicating that it will take longer for the full impact of recent policies and programmes supporting self-care to deliver the desired improvements.

### Men's Health Week 2007

**3.115** Men's Health Week in June 2007 had a focus on men and long-term conditions. The Department worked in partnership with the Men's Health Forum (MHF) during 2007 to publish Haynes men's health mini manuals on *Self-care for Minor Ailments* and *Using Healthcare Facilities*. The MHF mini manuals contain easily accessible and uniquely presented information covering a wide

range of subjects relating to men's health. They have been distributed to major employers such as BT, Royal Mail and Ladbrokes and also to Lloyds Pharmacy.

**3.116** Close partnership working with the MHF is continuing, with a document focusing on men and self-care within the context of the gender duty due for publication shortly. It is intended that this document will explore gender-specific concerns relating to self-care, while also outlining some practical suggestions on the successful implementation of the gender duty.

### Patients' prospectus

**3.117** The Prime Minister committed to bringing forward a patients' prospectus during 2008 that sets out how the Department will extend to everyone with a long-term condition access to a choice of 'active patient' or 'care at home' options clinically appropriate to them and supported by the NHS.

### Care planning

**3.118** *Our Health, Our Care, Our Say* commits the Department to offering personalised care plans to those with both long-term health and care needs by 2008 and to everyone with a long-term condition by 2010. The Department will publish a framework for commissioners on personalised and integrated care planning in the spring of 2008, which will describe an overarching framework for care planning that can be adopted by health and social care organisations locally.

### Choice for long-term conditions

**3.119** People, especially those with long-term conditions, whose health and care needs mean that they use the NHS and social care the most, expect and want greater control over their care and personalised services. Extending choice beyond elective care to people with long-term conditions was identified in the NHS Next Stage Review interim report as a significant next step in providing the more personalised services people want.

*A Generic Choice Model for Long-term Conditions* (DH, December 2007) includes case studies for commissioning services for those with long-term conditions to support choice and personalisation of care.

### Disease-management Information Toolkit

**3.120** The *Disease-management Information Toolkit* was launched in May 2007 and is a free web-based tool, designed to help PCTs and other commissioners of health and social care services strengthen their management of key long-term conditions. The toolkit provides data at PCT level on conditions contributing to high numbers of secondary care bed days in a PCT area. PCTs can benchmark their data against other PCTs, groups of similar PCTs and national averages.

### Raising the profile of long-term conditions care

**3.121** The Department published *Raising the Profile of Long-term Conditions Care – A Compendium of Information* in January 2008, updating the first compendium of information, which was published in May 2004. It includes data about the numbers of people with long-term conditions and information about their high use of NHS and social care services and the associated costs to reinforce the strategic importance of improving care for this group of people.

### White Paper – whole-system LTC demonstrator programme

**3.122** The Department also published proposals in *Our Health, Our Care, Our Say* to establish demonstrators that will test the benefits of integrated care supported by advanced assistive technology. The three successful sites taking this work forward are PCT/local authority partnerships in Cornwall, Kent and Newham, which collectively serve a resident population of at least 1 million from a variety of demographic and geographical contexts. The demonstrators will run for a minimum of two years and will be subject to a rigorous real-time

evaluation process. They will be on a scale significantly greater than anything undertaken before in England, with over 7,000 telecare/telehealth installations over the two-year period across the three sites.

**3.123** The focus of the demonstrators will be on three patient/user groups:

- people of any age who are at risk of current or future hospital admission due to at least one of the following long-term conditions (telehealth eligible): heart failure, diabetes and chronic obstructive pulmonary disease;
- individuals with social care needs (telecare eligible) who are at risk of current or future hospital admission and who have complex health and social care needs (they may have one or more of the above conditions); and
- individuals with both health and social care needs as defined above.

### Cancer

**3.124** The *NHS Cancer Plan* (DH, September 2000) was the first comprehensive strategy to tackle cancer. It set out a programme of investment and reform to improve cancer services.

**3.125** In December 2006, the Department commenced work on the *Cancer Reform Strategy* to build on the progress made since the publication of the *NHS Cancer Plan* and to take account of new challenges and opportunities, including the predicted rise in the incidence of cancer and the likely availability of new technologies.

**3.126** The strategy was published on 3 December 2007 and sets out a programme of action for the next five years, across ten areas, to improve cancer outcomes and to ensure delivery.

### Awareness

**3.127** Early diagnosis greatly increases a patient's chance of survival. The Department is currently investing in a campaign to raise awareness of the

signs and symptoms of breast, lung and bowel cancer to encourage people with symptoms to seek help earlier than they do currently. These campaigns are being run by the Healthy Communities Collaborative in 20 spearhead areas over two years, concluding in March 2009.

**3.128** Coming out of the Cancer Reform Strategy, a new National Awareness and Early Diagnosis Initiative will coordinate a programme of activity to support local interventions to raise public awareness. Initial efforts will focus on providing a tool to allow the level of awareness to be measured and tracked at both local and national level to guide future interventions.

### Breast cancer screening

**3.129** From April 2008, work will start to extend the existing age range for breast screening to include women aged 47 to 73, with a guarantee that women will be offered their first screening before the age of 50. As with previous extensions, this will take several years to implement fully, as more staff will need to be recruited and trained and more equipment purchased. Full roll-out is planned by the end of 2012.

**3.130** Digital mammography can deliver benefits for patients, clinicians and PCT commissioners. Work to commence implementation of this technology will start this year, with the aim that all breast screening units have at least one full-field digital mammography set by 2010.

### Cervical screening

**3.131** Liquid-based cytology (LBC) will speed up the reporting of results and provide a more reliable test. The national roll-out of LBC has continued, and by the end of November 2007, 88 per cent of laboratories had converted to LBC. All laboratories are expected to complete implementation during 2008. The benefits of LBC have already become apparent with the number of inadequate tests falling from 9 per cent in 2004-05 to 4.7 per cent in 2006-07.

**3.132** Action is being taken to minimise the time it takes to get cervical screening results back to women, with the aim of informing women of their result within two weeks of their test. Advice to the NHS on how this can be achieved was published in April 2008.

### NHS Bowel Cancer Screening Programme

**3.133** Roll-out of the NHS Bowel Cancer Screening Programme began in April 2006, with full national coverage in England expected by 2009.

**3.134** By March 2007, the programme had established the five hubs to provide call/recall services and 15 screening centres to provide endoscopy. During 2007-08, 18 centres were added to the programme and around 20 centres will be added during 2008-09.

**3.135** Work will start to prepare for the extension of the programme to those aged 70 to 75 from 2010.

### NHS Prostate Cancer Programme

**3.136** The public awareness pilot programme for prostate cancer, announced in 2004, was completed in mid-2007. The programme has been evaluated and its findings will be fed into the National Awareness and Early Diagnosis Initiative.

**3.137** The Prostate Cancer Risk-management Programme, which is designed to help men make an informed choice about being tested for prostate cancer, has been evaluated by the Cancer Research UK Primary Care Education Research Group at the University of Oxford, and is being reviewed with a view to re-launch in 2008.

**3.138** The *Making Progress on Prostate Cancer* report (DH, November 2004) announced plans to develop master classes in surgical procedures for the treatment of prostate cancer. This has been expanded to cover the whole of the multidisciplinary team.

**3.139** The Prostate Cancer Multidisciplinary Team Training Programme was started in February 2007 with the appointment of Leeds Teaching Hospitals NHS Trust to deliver the 18-month pilot programme. The trust has been recruiting the necessary staff to develop and evaluate the research elements of the programme, with the first training courses due to be delivered in spring 2008. The evaluation report is to be delivered at the end of the 18-month training programme.

### Cancer waiting times

**3.140** Waiting for a specialist assessment, diagnostic tests and treatment can be a major anxiety for patients with suspected cancer and their families. The *NHS Cancer Plan* set out key targets for the maximum time cancer patients should wait for assessment and treatment, which were achieved in 2007.

**3.141** The *Cancer Reform Strategy* builds on this excellent progress and work is being taken forward to extend the benefits of the existing waiting time standards to a wider range of patients and to ensure faster treatment. By 2008, the 31-day target will be extended to cover all treatments, excluding radiotherapy, not just the first, and by 2010 the 31-day standard wait will cover all treatments, including radiotherapy. The two-week wait target will also be extended to include all patients with breast symptoms, even if cancer is not suspected. In addition, hospital specialists will be able to place patients not urgently referred on the 62-day pathway, if they consider it appropriate.

### Cancer treatment

**3.142** The series of National Institute for Health and Clinical Excellence (NICE) *Improving Outcomes* guidance is now complete. Guidance is now available on 12 tumour groups (breast, colorectal, lung, gynaecological, upper gastrointestinal, urological, haematological, head and neck cancers, skin cancers, sarcomas, brain and central nervous system cancers and cancers in children and young

people) as well as guidance on improving supportive and palliative care for adults with cancer.

**3.143** Over the past seven years, NICE has undertaken around 43 appraisals of cancer drugs; 38 of these appraisals have partly, or fully, recommended the use of the treatment in the NHS. The 43 appraisals relate to 22 different cancer drugs, some of which have been appraised for more than one indication (use).

**3.144** It is important that NICE-guidance on new technologies is available as soon as possible, therefore the default position for all new cancer drugs and significant new licensed indications will be that they will be referred to NICE, provided that there is not a more appropriate alternative mechanism for appraisal.

**3.145** Equitable access to NICE-approved cancer drugs is a concern. The National Cancer Director will repeat his review of prescribing patterns of NICE-approved cancer drug usage during 2008.

### Cancer equality

**3.146** There are major inequalities in cancer incidence, access to services and outcomes. A major challenge in reducing these inequalities is the lack of evidence about the extent to which different forms of inequalities exist, what causes them and what interventions will be most effective in addressing them.

**3.147** In recognition of this challenge, the Department will begin a National Cancer Equality Initiative, bringing together key stakeholders from the professions, the voluntary sector, academia and equality groups to develop research proposals on cancer inequalities, test interventions and advise on the development of wider policy.

### Survivorship

**3.148** The *Cancer Reform Strategy* noted that further consideration needs to be given to the services needed by survivors of cancer. The National

Cancer Director will lead a new National Cancer Survivorship Initiative to take this work forward in partnership with Macmillan Cancer Support and other cancer charities, considering a range of approaches to survivorship care and how these can best be tailored to meet individual patients' needs.

**3.149** This initiative will require collaboration between clinicians working in primary and secondary care, social care services, service users and patients and the voluntary sector. It will also link closely to ongoing work for patients with other long-term conditions.

### **End-of-life care – providing high-quality care at the end of life for all patients, irrespective of diagnosis**

**3.150** The Government is committed to improving care and people's choices at the end of life, regardless of their condition or their location.

**3.151** Recent progress includes:

- investing £12 million over the three years to 2007 in an End-of-Life Care Programme, which has proved very successful in rolling out several tools to support the training of generalist health and social care staff in providing end-of-life care;
- providing a £40 million capital fund, from which 146 adult hospices, with 191 projects, have received funding to improve their physical environments; and
- making available a fund of up to £10 million to support Marie Curie's major capital modernisation programme.

**3.152** Key to delivering this commitment is the development of a national End-of-Life Care Strategy for adults, this country's first. The strategy will deliver increased choice to all adult patients, regardless of their condition, about where they live and die. It will help to take forward the commitments in the White Paper *Our Health, Our Care, Our Say*.

**3.153** The Department laid the foundation to support implementation of the strategy in the *NHS Operating Framework for 2007-08*. This asked PCTs, working with local authorities, to conduct a baseline review of local end-of-life care services, which would inform local commissioning plans. This was strengthened in the *NHS Operating Framework for 2008-09*, which specifically refers to improving access to high-quality, coordinated services close to home, a key theme emerging from the development of the strategy.

**3.154** End-of-life care is also one of the eight pathways SHAs will examine as they produce the reports that will help shape the NHS Next Stage Review. To support and complement the development of the review, the Department has deferred publication of the strategy until summer 2008. The Department has shared the emerging findings from the strategy with SHAs to inform the review, and it will then take account of this important local work in the development of the national strategy.

### **Cancer workforce and training**

**3.155** The pilot training programme for laparoscopic colorectal cancer is currently being set up. Following a tender exercise, carried out by the National Cancer Action Team, nine training centres have been selected and were appointed in January 2008. The pilot is due to run for a period of 18 months. An evaluation will be carried out towards the end of the pilot: among the success criteria will be patient outcomes and satisfaction, the competency of surgical training, assessment and accreditation, and value for money.

**3.156** Competency frameworks have been developed by Skills for Health for multidisciplinary team coordinators, staff working in endoscopy, chemotherapy, supportive and palliative care, cystoscopy, breast assessment, cervical cytology sample taking, and new roles relating to flexible sigmoidoscopy and to scope the competences relating to urological assessment and the integrated

cancer care tracker. These competency frameworks ensure that skills are recognised and are transferable across the UK, and are being used to underpin a range of national qualifications and training programmes to support new and extended roles.

**3.157** A project to introduce virtual skills training for student therapeutic radiographers was started in the summer of 2007. The aim is to reduce attrition from training programmes and relieve pressures in clinical departments supporting student placements. To date, ten universities providing therapeutic radiographer training have been given a grant to procure the equipment and software, with all installations planned for completion by June 2008. Up to 40 clinical radiotherapy departments have also received funding to introduce a smaller version to support training. The next stage will be an extensive training programme for lecturers and those supporting students. A full evaluation on the impact of the facilities will be undertaken over an 18-month period.

**3.158** The National Advanced Communication Skills Training Programme, initially developed for specialist and palliative care services, has been further modified this year into one unified model of delivery. Pilots were successfully run in 2007 for staff working with children and young people with cancer. It is envisaged that the programme will now be developed further to meet the needs of staff working in end-of-life care.

### Cancer equipment

**3.159** All funds for the Cancer Equipment Programme have been allocated and the Department is now monitoring delivery of the equipment.

### Cancer information

**3.160** Better information on cancer services and outcomes will enhance patient choice, drive up service quality and underpin stronger commissioning.

**3.161** During 2008-09, the Department will establish the National Cancer Intelligence Network to coordinate the collection, analysis and publication of useful information for cancer patients, commissioners, service providers and other interested parties.

**3.162** The National Cancer Intelligence Network will be tasked with ensuring that optimal use is made of all bodies of data currently collected and to identify and eliminate duplication of effort. It will also bring together all the relevant stakeholders in cancer information.

### Proton therapy

**3.163** Proton therapy is a very precise form of radiotherapy that can avoid damage to critical tissues near the tumour, and evidence is growing that proton therapy can be effective in treating a number of cancers.

**3.164** Currently, there is only one proton therapy facility in the UK, limited by its design to treatment of eye cancers. From April 2008, proton therapy for suitable cancers other than eye cancers will be nationally commissioned from overseas by the National Commissioning Group. The Department of Health will now consider options for providing modern proton therapy services in this country.

## Vascular disease

### Tackling vascular disease

**3.165** Vascular disease includes coronary heart disease (heart attacks and angina), stroke, diabetes and kidney disease. In 2006, the Department of Health brought together national clinical directors and their policy plans for these areas, to support implementation for the NSFs for diabetes, coronary heart disease and renal disease, and the development of a new national strategy for stroke.

**3.166** The Department has already achieved a 40.3 per cent reduction in mortality in people under 75 from cardiovascular diseases five years

ahead of the 2010 target date, and it is also on track to meet the 2010 target to reduce the absolute gap in inequalities. This has now reduced by 32.2 per cent against its 40 per cent target.

## Stroke

**3.167** The *National Stroke Strategy* was published on 5 December 2007 and is the culmination of 18 months' work, with six independent, expert working groups looking at different aspects of the stroke care pathway. A 14-week consultation was held over the summer of 2007, and there were over 1,000 responses, 80 per cent of which came from people who had had a stroke and their families and carers.

**3.168** By following the recommendations in the strategy, up to 1,600 strokes could be prevented each year, with outcomes improved for another 6,800 people. Based around four key areas, the strategy looks to raise awareness of stroke, improve acute care, improve after-hospital care and support, and develop the workforce responsible for delivering stroke services.

**3.169** The Department has committed £105 million over the next three years in central funding to support training of stroke professionals, to fund demonstration sites in both acute care and community services, and to raise awareness. Stroke networks are a leading force for change in implementation of the strategy. The Stroke Improvement Programme will provide national support to encourage the development of local stroke care networks, which will bring together key stakeholders and providers to review, organise and improve the delivery of services across the care pathway.

## Diabetes

**3.170** The Diabetes Year of Care Project, a partnership between the Department of Health and Diabetes UK, is at the forefront of developments in choice in long-term conditions. A Year of Care describes the ongoing care a person with a long-

term condition should expect to receive in a year, and involves shared decision-making between patients and clinicians to design a package that meets patients' needs. Three pilot sites have now begun work to deliver this and understand how this might translate into commissioning a range of services for the local diabetes population.

**3.171** The QOF, part of the GP contract, has led to the diagnosis of 200,000 extra people with diabetes in the last two years. This means that these people can now access the support and treatment to help them manage their diabetes. The QOF also shows that more and more people with diabetes are having their key tests and measurements – such as blood pressure and cholesterol – carried out, reducing the risk of complications later on.

**3.172** The report *Making Every Young Person with Diabetes Matter* (DH, April 2007) highlighted the specific challenges of caring for children and young people with diabetes. The recommendations of this report are now being taken forward by an implementation group led by the National Clinical Director for Children, Young People and Maternity Services Dr Sheila Shribman.

**3.173** In the last twelve months, 85.7 per cent of people with diabetes have been offered screening for diabetic retinopathy. This shows that great progress has been made, with more people screened than ever before. Although the target for the NHS to offer screening to all people with diabetes in the twelve months to the end of 2007 has not been met by all PCTs, 1.67 million people offered screening exceeds the number of people recorded with diabetes, 1.3 million, in 2003 when the target was set. By December 2007, 2.06 million people with diabetes were recorded in England. The Department's focus continues to be on prioritising quality and safety, and it is working closely with PCTs to improve the standards and quality of screening programmes across the country.

## Kidney disease

**3.174** Chronic kidney disease (CKD) is the gradual and usually permanent loss of some kidney function over time, as opposed to total kidney failure. Although CKD often displays no perceivable symptoms, it adds significantly to the burden of cardiovascular death. It has also been a condition that has been under-diagnosed.

**3.175** In May 2007, the NSF for Renal Services second progress report was published. The report celebrates improvements resulting from the renal NSF, published in two parts in 2004 and 2005, most notably in prevention and early detection, new facilities and improving standards.

**3.176** The NHS is now a world leader in early CKD detection and management. Since April 2006, CKD has been included in the QOF. This has helped to support GPs to identify CKD patients earlier and ensure that they are well managed and get high-quality advice and support in modifying the lifestyle factors that exacerbate the effect of their disease.

**3.177** Early figures indicate that in the first year (to March 2007) about 1.5 million people were diagnosed with CKD, creating an opportunity to provide potentially life-saving advice and treatment. This significantly supports the implementation of the renal NSF quality requirements that aim to minimise the impact of CKD in its early stages.

**3.178** During 2006-07, and Phase 2 of the Renal Action Learning Programme, six action learning sets were held, with two groups per topic, addressing:

- acute renal failure;
- the pre-dialysis year; and
- the transition from child to adult services.

**3.179** The final report on the programme and examples of good practice were published in the spring of 2008.

## Heart disease

**3.180** Treatment of heart attack is an area of considerable service change. Primary angioplasty services (angioplasty given as an emergency treatment) have continued to develop and now 22 per cent of those having reperfusion treatment (treatment to restore blood flow to blocked arteries, which cause heart attack) receive a primary angioplasty. Thrombolysis (use of clot-busting drugs) continues to be the main treatment for heart attack and is also an area of change and improvement, with more pre-hospital thrombolysis by paramedics delivering faster treatment.

**3.181** The goal of the *National Service Framework for Coronary Heart Disease* (DH, March 2004) is that eligible heart attack patients should receive thrombolysis within 60 minutes of calling for professional help. The proportion of people treated within 60 minutes has now risen to 68 per cent, compared with 24 per cent in 2000 when the framework was published.

**3.182** The Department has been working with the British Cardiovascular Society to test the feasibility of offering primary angioplasty countrywide and the *National Infarct Angioplasty Project* interim report was published on 18 February 2008. An independent evaluation of patients' experience, workforce implications and costings will be completed in spring 2008 and a final departmental report later in 2008.

## Heart failure

**3.183** In July 2007, the Healthcare Commission published a service review of heart failure. It found that heart failure services had improved markedly since its 2005 report on the framework, but that there was still much room for improvement. The Commission committed itself to continuing to work with those health communities that were scored as 'weak'.

**3.184** The various levers and incentives that the Department has put in place have been driving

progress. The 18-week target has impacted on the speed of access to echocardiography for the diagnosis of heart failure. The QOF incentivises the prescription of ACE inhibitors but not beta-blockers: prescribing of the former has gone up markedly, while the latter lags behind.

**3.185** The new heart failure audit, developed by the British Society for Heart Failure, is beginning to collect data that will help with future work to benchmark services and to improve quality. The audit was launched at the end of July 2007. Currently, 33 per cent of trusts have registered or are submitting data. This is an improvement from 2005-06, when the Healthcare Commission found that fewer than 20 per cent of trusts could meet the framework milestone on audit criteria.

### Heart surgery

**3.186** In 2006-07, the NHS performed over 78,000 coronary revascularisations – a collective term for coronary bypass operations (21,000) and angioplasty procedures (57,000) – 4,000 more than in the previous year. The NHS has sustained its progress on waiting times for heart surgery and no one waits over three months. Heart patients are in the vanguard of choice and are being offered a choice of hospital for their treatment at the time of diagnosis.

### Capital programme

**3.187** The Department's £725 million capital programme – which includes £125 million from the Big Lottery Fund – is nearing completion, providing much-needed investment to secure world class and state-of-the-art facilities for treating patients with coronary heart disease. It has provided two new cardiothoracic centres as well as a host of other capital improvements – new and refurbished buildings, equipment and technology, including 90 catheter laboratories. This capital investment has been targeted at areas of greatest need, where capital stock was poor or did not exist, and is playing a major role in helping to deliver reductions in mortality.

**3.188** In 2007, the £600 million cardiac capital programme saw six major schemes, with a combined cost of £129 million, reach completion. These were:

- a new cardiothoracic centre at Basildon and Thurrock costing £59.3 million;
- a replacement centre costing £42 million at Derriford Hospital in Plymouth;
- the final stage of an £11.6 million development providing a new cardiac theatre and critical care facilities at the Manchester Royal Infirmary;
- a £6.6 million investment to bring all of the cardiac facilities together in new and improved facilities, including catheter laboratories and one-stop outpatient and testing facilities, at Musgrove Park Hospital in Taunton;
- new catheter laboratories and developments to bring cardiac facilities together in one building, costing £5 million, at the Freeman Hospital in Newcastle; and
- the £4.2 million Darent Valley Hospital Heart Centre with a new catheter laboratory in Kent, enabling patients to receive more of their diagnosis and treatment locally rather than having to travel into London.

### Rehabilitation

**3.189** Cardiac rehabilitation is a vital part of caring for patients with heart disease. It is an evidence-based and cost-effective intervention, which reduces future mortality and morbidity. The Department of Health is working with the Heart Improvement Programme and the cardiac networks to spread good practice and help to increase the quantity and quality of cardiac rehabilitation services across the country.

**3.190** The need to collect better information about patterns of service and uptake by patients is being addressed by a new National Audit of Cardiac Rehabilitation, funded by the British Heart Foundation. This is being developed across England to provide stronger evidence on quality and effectiveness and to encourage local areas to appraise

and improve their provision of cardiac rehabilitation. The audit's *Annual Statistical Report 2007* shows that, so far, 157 of the 360 UK cardiac rehabilitation programmes have contributed to the audit, with more having agreed to join. However, there is still room for improvement.

**3.191** For 2008, the Department of Health, the British Heart Foundation and the British Association of Cardiac Rehabilitation have established a multi-site project to look at costs and reimbursement through the payment by results system for cardiac rehabilitation. This project is being sponsored by the Department of Health and is part of the Department's payment by results Development Sites Project.

### Arrhythmias and sudden cardiac death

**3.192** An additional chapter of the coronary heart disease NSF was launched in March 2005, covering arrhythmia and sudden cardiac death. Nationally, the focus areas are: improving access to heart rhythm management devices such as pacemakers and implantable cardioverter defibrillators; and improving information, support and care for families who have experienced a sudden cardiac death. A key emerging challenge is identifying people with atrial fibrillation, and ensuring that those people get the information, advice, treatment and care that they need. Atrial fibrillation affects up to 1 per cent of the population (rising to 4 per cent in the over-65s). The overall incidence of stroke is about 5 per cent per year in people with atrial fibrillation, so it is a significant cause of mortality in England.

### Vascular risk assessment

**3.193** The Prime Minister announced in January 2008 that the Department would bring forward proposals for a vascular checks programme within the NHS to assess the population for the risk of heart disease, stroke, kidney disease and diabetes. *Putting Prevention First* sets out the Department's evidence for such a programme for everyone between the ages of 40 and 74.

**3.194** The checks will be based on straightforward questions and measurements such as age, sex, family history, height, weight and blood pressure. They would also include a simple blood test to measure cholesterol. Everyone will receive a personal assessment setting out their level of risk, and what they can do to reduce it. For those at low risk, this might be no more than general advice on how best to stay healthy. Others may be supported to join a weight management programme or a stop smoking service. Those at the highest risk might also require preventative medication with statins or blood pressure treatment.

**3.195** The next steps will be to work with our key partners across the NHS, the medical profession and the voluntary and private sectors in drawing up a national system that works for them and for the population.

## Mental health services

### Access to care

**3.196** Since the publication of the *National Service Framework for Mental Health* (DH, September 1999), setting out a vision for mental health care, mental health services in the community continue to be strengthened. There are now 760 new specialised mental health teams in place to ensure that people with serious mental health problems get the right treatment, at the right time.

**3.197** As at the end of March 2007, there were around 343 crisis resolution, 251 assertive outreach and 166 early intervention teams established in England (see Lisa's story as an example of this work). In the first two quarters of the financial year 2007-08, crisis resolution teams provided 50,250 home treatment episodes and, by September 2007, 18,840 people had been seen by assertive outreach teams.

**3.198** In 2006-07, the Department made available an extra £130 million of capital for improvements in the environment, including safety, on psychiatric

intensive care units and adult acute mental health wards. This included the development of health-based assessment facilities and was also to ensure that each mental health trust had access to an appropriate place of safety for making assessments under the *Mental Health Act 1983*. Allocation of this money has been phased over 2006-07 to 2008-09.

#### *Lisa's story*

*Lisa has a severe mental illness and when it flares up she needs additional care, which in the past has meant admission to hospital. Recently she was given the choice between hospital care and treatment at home for the first time in her life, and this is what she said about it:*

*"I wasn't feeling very good. I kept crying a lot and I was very sad and miserable. My daughter said to me: 'Mummy, do you know all I want for my birthday? I want you to be happy.' I couldn't go to the doctor, I just sobbed. I said: 'They're going to put me in hospital and I'm not going to see Ellese on her birthday.' That's what I wanted. I wanted Ellese to see me smiling on her birthday. I said to the doctor: 'Please don't put me in hospital.' He said: 'I would have asked you to come into hospital. However, there are home treatments available and because I can see how you're feeling I'm going to suggest that they come and assess you.' That's how I came to have the home treatment and it's benefited me more than any time I've had on a ward."*

### **Suicide rate**

**3.199** The 2000 PSA agreement is to reduce the mortality rate from suicide and undetermined injury by at least 20 per cent by 2010 (PSA SR 2004, target 1). The suicide rate for 2006, the most recent data available, is the lowest recorded level ever and among the lowest in Europe. The latest suicide monitoring data for the three-year period from 2004 to 2006 shows a reduction of 10 per cent from the baseline to 8.3 deaths per 100,000.

**3.200** Significant progress continues to be made in reducing the rates of suicide by mental health in-patients and young men. The Department has commissioned the development of a toolkit for acute in-patient staff to use to reduce the incidence of in-patients dying by suicide while off the ward without permission, in line with the recommendations of the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, established in 1992.

**3.201** In June 2007, the Department published *Sensitive Coverage Saves Lives*, a report that highlighted ways to improve the media portrayal of suicidal behaviour. As a follow-up to this work, the Department commissioned, in conjunction with the SHiFT programme, a handbook and web resource designed to help journalists report mental health and suicide stories in a more responsible way. Following publication of a literature review of the suicide risk among lesbian, gay and bisexual (LGB) people, the Department has included LGB people as a group that has special needs under goal 2 of the National Suicide Prevention Strategy, and will promote the findings and conclusions of the review.

### **Delivering race equality**

**3.202** *Delivering Race Equality in Mental Health Care: An Action Plan for Reform* is a five-year plan launched by the Department in January 2005 to tackle the inequalities in access to services that people from some BME communities experience. Delivering race equality is now a well-established priority for mental health services, supported by significant new resources – including, by December 2007, over 350 community development workers, with more to come. Community development workers help to build bridges between services and their local BME communities, and support those communities in helping to plan and provide mental health care.

**3.203** Delivering race equality is identifying new models for commissioning and provision that better meet individual needs, engage communities, and

make more effective use of resources. For example, the Sheffield Crisis Assessment and Home Treatment Team worked with its local Pakistani Muslim centre to develop more appropriate care pathways for the Pakistani community. The results included: higher satisfaction with services; reduced length of stay in hospital for some service users; earlier contact with services by people experiencing a relapse; and a constructive and lasting relationship between the community and the trust board.

**3.204** The challenge for delivering race equality over the next year is to transplant that sort of experience and learning from the confines of the programme into mainstream local commissioning, so that the NHS can offer equal access to a full range of effective services that are appropriate to the ethnicity or culture of service users. Delivering race equality will remain a top-tier priority until then.

### Older people

**3.205** Policy on older people's mental health has been consistently developing since publication of the *National Service Framework for Older People* (DH, May 2001). This framework contains a standard on older people's mental health care and a service model for dementia. The start of a wider Older People's Mental Health Programme was marked by publication of *Securing Better Mental Health for Older Adults* in 2005 and *Everybody's Business*, the Department's service development guide, in 2006. This was followed by the *Let's Respect* toolkit and campaign led by the Care Services Improvement Partnership.

**3.206** Work is beginning now to determine what should follow on from the mental health NSF when it reaches the end of its lifespan in 2009. The Department is committed to developing policy and practice that are robustly assessed for their potential impact on older people, so that services meet everyone's needs equally well, whatever their age.

**3.207** The Department introduced a new Healthcare Commission indicator for the 2006-07

Healthcare Commission Annual Health Check. This indicator assesses PCTs on the existence and content of the latest local assessments of older people's mental health needs. Results published at the end of 2007 showed that 65 per cent of PCTs achieved the criteria set for this indicator.

**3.208** It is expected that implementation of the National Dementia Strategy, which is currently in development, will be a lever for driving further improvements. More detail on this strategy can be found in chapter 5.

### Strengthening the workforce

**3.209** Since 1997, there have been significant increases in the numbers of consultant psychiatrists (55 per cent), mental health nurses (20 per cent), clinical psychologists (69 per cent), non-medical psychotherapists (141 per cent), and art/music/drama therapists (31 per cent) working in the NHS.

**3.210** Work is continuing in partnership with stakeholders such as the Royal College of Psychiatrists, the NHS Confederation and the National Mental Health Partnership to help local services improve recruitment and retention in line with the needs of their local populations.

**3.211** Work is continuing to support the New Ways of Working (NWW) Programme across all professional groups to promote flexible working, based on competences and capabilities, to meet the needs of service users and carers. This work has been carried out in partnership with stakeholder professional and regulatory bodies representing psychiatrists, psychologists, nurses, social workers, pharmacists and allied health professionals, as well as the NHS Confederation.

**3.212** Moving on from identifying good practice on NWW for each of the professions, the *Creating Capable Teams Approach* (DH, May 2007) has been published to enable multidisciplinary teams to review their function, the needs of service users and carers, and what skills and competences they need

to meet those needs. This results in a workforce plan that identifies learning and development requirements and the need for changing practice and new roles.

**3.213** The *Mental Health Act 2007*'s new clinical roles offer the flexibility and opportunity for a wider range of mental health professionals to undertake the roles of approved mental health professional and approved clinician. This is being addressed as part of the NWW agenda with trusts, commissioners and others.

**3.214** *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce* (National Institute for Mental Health in England, August 2004) was produced to identify what service users and carers really wanted: behaviour of staff that recognised the significant value of the perspective of the service user and carer. The learning materials have been evaluated and issued. Additional linked work has been developed to build on the ten capabilities: race equality and cultural capabilities, recovery, risk and the Care Programme Approach.

### Reducing stigma and discrimination

**3.215** SHiFT was launched in 2004 as a five-year programme to tackle the stigma and discrimination associated with mental illness. Funding has now been extended until 2011, so that it can work in partnership with Moving People, a new Big Lottery-funded anti-stigma and well-being campaign in the charity sector. SHiFT's future focus is on two key areas where people with mental health problems experience discrimination – employment and the media – which are not being addressed directly by Moving People. Work has been done in other areas, for example with young people and through sport.

**3.216** The work in employment is aimed at improving the recruitment and retention of people with mental health problems. A guide for line managers on handling mental health problems in the workplace has been published and a panel of

experts has been set up at the Sainsbury Centre for Mental Health to quality control guidance being developed for employers. SHiFT has played a central role in linking up cross-government work in this area, including making mental health central to the Department for Work and Pension's Employ Ability Campaign to challenge employers' attitudes to disability.

**3.217** SHiFT's other focus has been on improving media reporting, encouraging more positive representations of people with mental health problems and challenging stigmatising coverage. The SHiFT 'speakers' bureau – a bank of people willing to talk about their real-life experiences of mental illness to the media – has become an essential resource for journalists and a way of ensuring that service users' voices are heard. A handbook on best practice for reporting mental health, tackling particularly the coverage of violence and suicide, has been distributed to thousands of journalists. Training for trainee journalists is also being rolled out. Future work will include encouraging psychiatrists to speak out publicly about how rare violent crime linked to mental illness is and thus improve media reporting on a local level.

### Tackling social exclusion

**3.218** The National Social Inclusion (NSI) Programme was initially established to coordinate the implementation of the Social Exclusion Unit's report *Mental Health and Social Exclusion*. The majority of the actions have been completed nationally, although continuing action will be necessary to ensure implementation at a regional and local level. This will be done in partnership with social inclusion leads in each Care Service Improvement Partnership development centre and a range of other stakeholders.

**3.219** In response to *Reaching Out: An Action Plan on Social Exclusion* (Cabinet Office, September 2006) the NSI working group has been tasked with coordinating and setting up nine regional

employment partnerships (linked to regional education networks) and continuing to provide leadership and support for developing regional action to address the vocational and learning needs of people with severe mental health problems.

**3.220** NSI published its third *Annual Review* in December 2007, which highlighted key progress to date and a range of resources produced to support and steer socially inclusive services and practices.

**3.221** Over the next year, NSI's key challenge is to sustain action on inclusion while ensuring that progress is understood and embedded locally in the commissioning and delivery of services in (and with) communities, and ensuring that lessons learned are reflected in future policy and strategy.

**3.222** This will be helped by the new PSA (16), covering four groups of socially excluded adults including those in touch with secondary mental health services. As a performance management tool, over three years it will incentivise working between agencies with a view to making a home and a job more accessible to this vulnerable group of people. However, tackling stigma will remain crucial to making this work in practice for people with mental health problems.

**3.223** On 27 November 2007, the Department for Work and Pensions and the Department of Health jointly announced a package of measures to improve the support available to people with mental health conditions, helping more to find or remain in work.

### Providing choice and improving mental health and well-being

**3.224** The Department is committed to giving people with mental health problems choice and a more personalised service, including making more information available about mental illness to help people manage their own care. In the last year, work has been ongoing, both locally and nationally, to increase the level of choice offered to people with mental health problems.

**3.225** *Our Choices in Mental Health*, written in consultation with service users and carers, sets out a framework that will make choice available locally to people who use mental health services in England. The task group involved reported that "choice and responsiveness have been important ideas for people using mental health services for many years, and frequently come high up as priorities in user surveys". Users and carers tell us that information is essential to support choice. There are many innovative local solutions, including providing a carer's pack on in-patient admission and providing all users with a crisis card detailing who to contact and where to get help in a crisis. Additionally, there are a number of national programmes, including information prescription pilots.

**3.226** Direct payments offer a mechanism for empowering people to make their own decisions about the social care they receive. Programmes to increase the uptake of direct payments by people with mental health problems are ongoing. Individual budgets offer a similar level of control and have been piloted in 13 authorities, some of which have looked at involving mental health service users.

**3.227** Choice is also important in secure settings, and the *Mental Capacity Act 2005* clearly states that the least restrictive option should be employed wherever possible, giving people the maximum opportunity to make their own choices, for example about food and activities.

**3.228** The Department is currently developing a public mental health framework for creating well-being. It recognises the important contribution that mental well-being makes to promoting physical well-being and addressing inequalities in health. Further work will be done over the next year to ensure that an integrated approach to physical and mental well-being is developed. This will involve working across workstreams within the Department of Health and with colleagues from other government departments. Additionally, cross-

government work will take place on addressing wider determinants that affect well-being. These include addressing risk factors, for example substance misuse and violence prevention, and promoting protective factors, including improvements in parenting.

### Improving access to psychological therapies

**3.229** Work on choices in mental health care identified that people who use mental health services consistently identify better access to a choice of talking therapies as a key way to improve the way services are provided.

**3.230** Demonstration sites in Newham and Doncaster achieved remarkable results, treating thousands of people and bringing half of them to recovery, consistent with NICE evidence (see Rita's story for an example of the good work being done with psychological therapies). Crucially, they routinely monitored the outcomes for those treated, showing for the first time that such high-quality data can be collected by mental health services.

**3.231** In October 2007, the Secretary of State announced new funding over the next three years – rising to £173 million in 2010-11 – to build new local psychological therapy services around the country. To enable PCTs to comply with NICE guidance on treating the common mental health problems of depression and anxiety, the Improving Access to Psychological Therapies Programme is preparing a huge training programme for therapists. This will be led by the ten SHAs, which will each choose between two and four PCTs to take part in the first year of training.

**3.232** Nearly three-quarters of PCTs expressed an interest in taking part in the programme during the year, when 11 pathfinder areas were needed to explore the specific therapy needs of particular vulnerable groups. These included children and young people, new mothers, older people, people from BME groups, offenders, people with long-term

conditions and those with medically unexplained symptoms.

**3.233** The programme also captured the imagination of a wide range of therapists' professional bodies, which all signed the New Savoy Declaration in November 2007, and the We Need to Talk Coalition of leading mental health charities, representing people who use the services and their families and friends.

#### *Rita's story*

*"I grew up in a very dysfunctional house, suffering years of child abuse, convinced it was all my fault. I moved to another continent to start a new life but had a series of relationships with abusers, including a 20-year marriage to a specialist in verbal and emotional abuse. I left with nothing but my freedom and life was bleak for a long time. I became increasingly depressed and cripplingly anxious.*

*"One day my GP showed me a leaflet on CBT [cognitive behavioural therapy]. I needed to recover without pills and knew I needed help. I read the books the psychologist gave me and, seeing myself in the text, began to understand my condition. The homework was crucial. As I completed the charts, I could see clearly the patterns I had repeated throughout my life.*

*"What really changed my perspective was my therapist pointing out successes where I had seen none. I realised ideas I had about myself were just plain wrong, drilled into me by people with their own agenda and their own desires for control. I had irrefutable evidence that I was (and am) far more than I ever thought I was. My depression began to lift and I began to heal – a slow, ongoing process. I still get depressed but it doesn't immobilise me thanks to the tools my therapist taught me."*

### Mental Health Act 2007

**3.234** The *Mental Health Bill 2006* introduced into Parliament on 16 November 2006 received Royal Assent on 19 July 2007. The Act extensively amends the *Mental Health Act 1983* to modernise

and improve the legislative framework within which compulsory measures can be taken, when necessary, to ensure that people with mental disorders receive the treatment they require. The changes include greater flexibility about the practitioners who may carry out important statutory roles under the Act and the introduction of supervised community treatment to allow patients to be discharged from detention in hospital and continue their treatment in the community, subject to the possibility of recall to hospital if necessary.

**3.235** The Act also amends the *Mental Capacity Act 2005* to introduce a new regime of safeguards for people who are deprived of their liberty in care homes or hospitals in their best interests and who lack the capacity to make the relevant decisions themselves about the most appropriate arrangements for their care or treatment. In doing so, it addresses the incompatibility with the European Convention on Human Rights identified in the case of *HL v UK* (also known as the Bournemouth case).

**3.236** In the course of 2008-09, the Department will be working with the Care Services Improvement Partnership, the Ministry of Justice, the NHS, local social services authorities and others to implement the majority of changes from October 2008 and to prepare for the implementation of the new *Mental Capacity Act* deprivation of liberty safeguards regime in April 2009. See chapter 5 for further information on the deprivation of liberty safeguards.

### Future direction of mental health services

**3.237** Significant gains in mainstreaming and modernising services for people with severe mental health problems have been made. Many people have been enabled to stay in their own homes while being cared for by community teams, avoiding unnecessary hospital admission and resulting in better access to care, and better outcomes for users. The development of community services is continuing and improvements are being made in the way hospital and community services work

together, especially for those requiring emergency support and treatment.

**3.238** Building on this work, the priority of the Government is to meet the mental health needs of the community as a whole. The Department wants to see service users provided with more information, and given more control over both their care and their choice of treatment. In line with the work on the new National Carers' Strategy, a cross-departmental strategy that aims to raise awareness of carers' needs for support and for a life beyond caring, it will be important to take a critical look at the limited progress made on standard 6 of the *National Service Framework for Mental Health* and seek ways to identify and spread good practice for carers.

**3.239** The Department also intends to:

- develop in partnership with the NHS a tariff or equivalent effective payment system for mental health services so that good practice is incentivised;
- provide stronger primary care for mental health, and ensure that the principles of world class commissioning are applied to the commissioning of mental health services, making integrated health and social care commissioning the key to delivering excellent services; and
- work with stakeholders to establish the best way forward as the *National Service Framework for Mental Health* comes to the end of its life in 2009, to ensure a continuing service that staff can be proud of, and that patients deserve.

### Offender health

**3.240** Since 2006, the NHS has held budgetary and commissioning responsibilities for health services in all publicly run prison establishments in England and Wales. Prison health services should be broadly equivalent in range and quality to those in the wider NHS.

**3.241** *Improving Health, Supporting Justice: A Strategy for Improving Health and Social Care Services for People Subject to the Criminal Justice System* was published in November 2007 for consultation. It aims to examine ways in which health and social services can be better delivered to people who are in contact with the police, courts, prison or probation.

**3.242** Many offenders suffer from social exclusion or poor health, both of which can contribute to offending behaviour. This consultation is looking at the needs of this group, and the contribution that health and social services can make towards the Government's goal of reducing reoffending.

**3.243** People in prison generally have poorer health than the population at large. This is reflected in strong evidence of health inequalities, unhealthy lifestyles and social exclusion – for example, 90 per cent of prisoners have a mental health problem, a substance misuse problem, or both, and 80 per cent of prisoners smoke.

### Prison health services

**3.244** Prisons provide an opportunity to offer health promotion and harm minimisation programmes. Initiatives to improve the health of people in prison have built on earlier successes and include the following:

- Smoking – following the passing of the *Health Act 2006*, smoke-free provisions have been introduced throughout prisons. All indoor areas are now smoke-free, with the exception of cells occupied solely by smokers aged 18 and over. The young persons' prison estate is now entirely smoke-free.
- Drug misuse – the Integrated Drug Treatment System introduced in 2006 has now been implemented in 29 prisons. It is designed to provide:
  - improved clinical management with greater use of maintenance presenting;
  - intensive psycho-social support during the first 28 days of clinical management;

- greater integration of clinical and psycho-social treatment services with renewed emphasis on throughcare;
- disinfectant tablets – these began to be introduced into prisons in October 2007, to help prevent and control the transmission of blood-borne viruses such as HIV, hepatitis C and hepatitis B; and
- hepatitis B vaccination – prisons significantly outperform all other community settings in delivering hepatitis B vaccination to injecting drug misusers, the major risk group for infection in the UK. A Hepatitis B Vaccination Programme was initiated in 2001. In October 2007, the programme involved 128 of 144 prisons (including Wales), providing on average 1,600 vaccination courses completed per month.

### Prison mental health

**3.245** Three hundred and sixty prison in-reach workers now provide mental health services for people with severe mental illness in 102 prisons. A project that aims to reduce waiting times and provide seamless transfers to hospital for those prisoners with a severe mental illness started in April 2005. A new waiting time standard of 14 days for these transfers has been piloted. There has been a reduction in the number of such prisoners waiting over 12 weeks for a transfer to hospital.

**3.246** The number of people transferred from prison to hospital under sections 47 and 48 of the *Mental Health Act 1983* rose from 721 people in 2003 to 926 in 2007.

**3.247** A mental health awareness training package has been developed and produced specifically for HM Prison Service staff. A comprehensive support pack is included and has been sent to all prison mental health leads. It is particularly targeted towards meeting the training needs of prison discipline staff, especially those involved with escort and reception duties.

## Secure mental health services

**3.248** Local commissioning capacity plans are now in place for medium secure services in each region. These capacity plans incorporate the provision of services for different groups, including women and patients with personality disorder. In addition, the new purpose-built building for the National High Secure Healthcare Service for Women at Rampton Hospital opened in November 2006, in order to provide specialist gender-sensitive services for women in high secure care. Broadmoor's and Rampton's dangerous and severe personality disorder pilot units are working towards full capacity and the majority of wards are now open.

**3.249** Commissioning capacity plans are in place for high and medium secure services for all groups of patients in all regions. New arrangements for commissioning high secure services have been agreed, together with a new performance management framework for high secure hospitals. Three women's enhanced medium secure services opened during the year, and women's services in Broadmoor closed. High-level principles and indicators for medium secure services were published, and a programme of health checks in partnership with the Royal College of Psychiatrists is planned to evaluate units' performance against the indicators.

## Children and young people

**3.250** Good health is vital if children and young people are to enjoy their childhood and achieve their full potential. The care provided by families, and the good habits established in the family at the earliest stages, will provide the basis for lifelong health and well-being.

**3.251** The Government is committed to improving the physical, mental and emotional health and well-being of children and young people from conception to adulthood. The Department will prioritise a measurable reduction in inequality of

health outcomes with a focus on prevention and intervention.

### Overview

**3.252** The Government's commitment for child health and maternity over the next spending period (2008 to 2011) is set out in the PSA: to improve the health and well-being of children and young people (PSA 12); to safeguard the young and vulnerable (PSA 13); to increase the number of children and young people on the path of success (PSA 14); and to promote better health and well-being for all (PSA 18). Prevention and early intervention underpins all PSAs.

**3.253** The following performance indicators will be used to measure progress:

- reducing the rate of obesity among children (the Department's work on childhood obesity is reflected in chapter 2);
- increasing levels of breastfeeding;
- improving the emotional health and well-being of children;
- improving the experience of parents with disabled children;
- reducing inequalities in health;
- reducing the prevalence of smoking;
- reducing conception rates in under-18-year-olds;
- reducing the proportion of young people frequently using illicit drugs, alcohol or volatile substances;
- the rate of hospital admissions for unintended and deliberate injuries per 10,000 children aged 0 to 18; and
- the percentage of pregnant women who have seen a midwife or appropriate healthcare professional for a health/social care assessment of their needs and risks by 12 weeks.

**3.254** The importance of child health and maternity is reflected by their positioning as a national priority in the *NHS Operating Framework*

for 2008-09, and the above indicators are reflected in the vital signs and local planning guidance that underpin that framework.

### Child Health and Well-being Board

**3.255** The Department for Children, Schools and Families (DCSF) and the Department of Health are jointly responsible for promoting the health and well-being of all children and young people. A new Child Health and Well-being Board has been set up to oversee delivery of the PSA “to improve the health and well-being of children and young people” and the *National Service Framework for Children, Young People and Maternity Services*. This board is jointly chaired by the Department of Health and the DCSF and is made up of government and external representatives such as chief executives of PCTs and SHAs and directors of children’s services. The board will report at ministerial level.

### National clinical director

**3.256** *Children’s Health, Our Future: A Review of Progress against the National Service Framework for Children, Young People and Maternity Services 2004* was published by Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, in November 2007. It charts the progress made since the *National Service Framework for Children, Young People and Maternity Services* was published in September 2004.

**3.257** Dr Shribman has also established a Child Health Stakeholder Advisory Group made up of external stakeholders who will meet quarterly to support and advise the Child Health and Well-being Board.

### Children’s Plan

**3.258** The cross-government *Children’s Plan*, published in December 2007, set out the Government’s long-term vision. It trailed, among other things, a Child Health Strategy and a child and adolescent mental health services (CAMHS)

review, both of which will be developed during 2008.

### Child Health and Maternal Health (ChiMat) Intelligence Unit

**3.259** This is a new national resource, which provides quick and easy access to information for commissioners and other stakeholders and helps them deliver high-quality, cost-effective services. The range of services comprises a website, on-line tools and a support team. The website is due to be officially launched in April 2008.

### Maternity services

**3.260** The *NHS Operating Framework for 2007-08* cited maternity services as an area for preparatory work by PCTs to support the achievement of the 2009 commitments that: “By 2009, all women will have choice in where and how they have their baby and what pain relief to use. We want every woman to be supported by the same midwife throughout her pregnancy. Support will be linked closely to other services that will be provided in Children’s Centres.” It set out that 2007-08 should be used to assess current services, identify gaps and any barriers to service development, and to set out local strategies for meeting this commitment, including an assessment of workforce capacity.

**3.261** The maternity framework document *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* was published in April 2007. It is the strategy for modernised maternity services, placing safety, quality and improved standards at the very heart of its vision.

**3.262** Central to the framework is an articulation of the choice guarantees for women, which are, by 2009:

- choice of how to access maternity care;
- choice of antenatal care;
- choice of place of birth, e.g. a birth at home, a birth supported by a midwife or a birth supported

by a team of clinicians including a midwife and obstetrician; and

- choice of postnatal care. In addition, support will be linked closely to other services provided in the community, such as in Sure Start children's centres, and every woman will be supported by a midwife she knows and trusts throughout her pregnancy and afterwards for continuity of care.

**3.263** The Department has funded the development of 11 early-adopter sites to encourage local areas to move forward with the implementation of *Maternity Matters*.

**3.264** The *NHS Operating Framework for 2008-09* builds on the 2007-08 requirements by focusing on early access to maternity care. PCTs are required to ensure that sufficient numbers of maternity staff and neonatal teams are in place to meet local needs.

### Neonatal critical care

**3.265** The National Audit Office undertook a value-for-money review of neonatal critical care services in 2007. Its report, *Caring for Vulnerable Babies: The Reorganisation of Neonatal Services in England*, published on 19 December 2007, found that the reorganisation of care into 23 neonatal networks across England has led to a number of improvements. These include a reduction in long-distance transfers of mothers and babies and an increase in intensive care capacity. However, there are still capacity and staffing problems and a lack of clear data on outcomes. The Department of Health has established a Neonatal Taskforce, chaired by Sir Bruce Keogh, to support the NHS to identify and deliver improvements to neonatal services.

### Newborn screening programmes

**3.266** The introduction of newborn screening programmes as part of the Newborn Bloodspot Programme contributes to both saving and improving the quality of lives:

- Screening for sickle cell disorders, which is now offered to all newborn babies in England, is

expected to prevent 15 infant deaths per year and reduce the burden of hospital visits and treatment. In 2004-05, approximately 240 screen-positive affected babies were identified with sickle cell out of 380,000 babies across England.

- The roll-out of screening for cystic fibrosis, completed at the end of 2007, is likely to benefit an estimated 250 babies a year in England through early identification and interventions. This will mean avoiding lengthy diagnostic delays, will minimise frequent hospital admissions and will enable families to make future reproductive choices.
- Screening for medium chain acyl co-enzyme A dehydrogenase deficiency (MCADD) is expected to prevent two to three deaths due to MCADD in under-1-year-olds in England each year.

**3.267** The introduction of the Newborn Hearing Screening Programme, which is now offered in 100 per cent of units, provides the opportunity for children with hearing impairments to keep pace educationally and socially with their peers if appropriate support is in place. Nearly 1,100 babies have been identified and confirmed with a hearing loss before six months of age.

### Family Nurse Partnerships

**3.268** Family Nurse Partnerships (FNPs) look at the effectiveness and practicalities of early parenting intervention tools.

**3.269** The FNP programme is an intensive home-based programme for young, vulnerable, first-time mothers, jointly managed by the Department of Health and the DCSF. A detailed evaluation is under way to assess both practitioners' and families' views about the programme and its impact on pregnancy outcomes, child health and achievement at school, and parents' levels of economic self-sufficiency. Forthcoming activity includes:

- increasing the number of families that can benefit from the FNP programme; and

- research into the impact of the programme in this country.

### The Child Health Promotion Programme

**3.270** The updated Child Health Promotion Programme (CHPP) is looking at how the FNPs might be integrated within a progressive, universal, model CHPP. Additional and future updates to the programme include:

- the production of an updated CHPP schedule and guidance, with national conferences to promote them. These are scheduled for publication in 2008;
- building on the key contact that health professionals have with families to help promote positive parenting and healthy lifestyles;
- maximising the opportunities of access and integration of services through Sure Start children's centres; and
- piloting an NHS Early Years LifeCheck – an on-line tool designed for mothers and families to use to check the health and development of their baby – through Sure Start children's centres through seven NHS Choices Learning Network areas during the first quarter of 2008.

### Working with schools

**3.271** Health and well-being go hand in hand with high educational standards. Children do better at school when they are physically healthy, emotionally resilient and motivated.

- School nursing services play a key role in supporting delivery of the Healthy Schools Programme and Extended Schools Initiative.
- The Extended Schools Initiative commits schools to working in partnership with the public, private and voluntary sectors to provide a range of core services for children, their parents/carers and the wider community by 2010. This should include parenting support and referral to specialist services such as family support, mental health and sexual health advice services. Many of the extended

schools already in existence are also offering access to additional health services.

- The Healthy Schools Programme encourages schools to help pupils make small but significant changes to their lifestyles. As at October 2007, over 90 per cent of schools were involved in the programme and evidence suggests that it is having a positive impact.

### Child and adolescent mental health services

**3.272** The Department has an operating standard to improve the life outcomes of ... children with mental health problems by ensuring that all patients who need them have access to ... comprehensive CAMHS. Its ongoing commitment to this work has been reflected in the PSAs noted earlier.

**3.273** Data for 2007 in *A Profile of Child Health, Child and Adolescent Mental Health and Maternity Services in England 2007* (DH, DCSF and Durham University, December 2007) shows that CAMHS continue to expand. The main measure of CAMHS progress is the annual mapping exercise. The fifth exercise was conducted between November 2006 and March 2007 and showed that:

- spend on CAMHS increased from £322 million in 2003-04 to £461 million in 2005-06;
- the workforce increased by 25 per cent between 2003 and 2006 – the biggest growth being in the number of nurses; and
- the caseload was 86,521 in 2003 and rose to 112,984 in 2005, an increase of 31 per cent.

**3.274** The Department continues to monitor the existence of care pathways for three key aspects of CAMHS:

- 24/7 emergency assessment;
- CAMHS for those with learning disabilities; and
- CAMHS for 16- and 17-year-olds.

**3.275** Returns from PCTs indicate that access to these services is nearly universal (see **figure 3.8** and **figure 3.9**).

**Figure 3.8: CAMHS service availability**

Element of service	2005	2006	2007
24/7 emergency assessment	82.5	96.7	100.0
CAMHS for those with learning disabilities	50.5	87.5	100.0
CAMHS for 16- and 17-year-olds	74.3	90.8	100.0

Source: Partnerships for Children, Families and Maternity, DH

Notes:

(1) The above figures show the position at calendar year end.

**3.276** The issue of under-18s being treated on adult psychiatric wards was highlighted by the *Pushed into the Shadows* report by the Children’s Commissioner for England (January 2007). In September 2007, the Government set out the following commitments to tackle this issue:

- By November 2008, no child under the age of 16 years old will be treated on an adult psychiatric ward.
- The *Mental Health Act 2007* contains a provision (section 31) that ensures that patients aged under 18 are treated in a hospital environment that is suitable for their age and needs. The Government has committed to start this provision in England by April 2010. Capital funding of £31 million has been provided in 2007-08 for 17 projects

specifically designed to help eliminate the inappropriate use of adult psychiatric wards for children and young people.

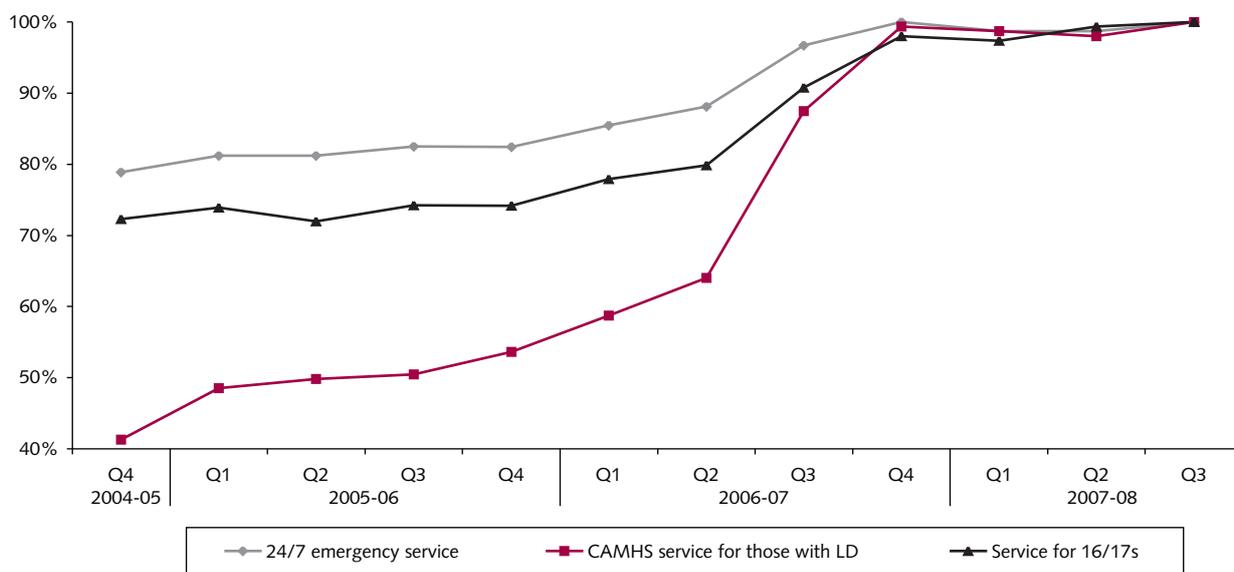
**3.277** As noted earlier, the *Children’s Plan*, published in December 2007, contained a commitment to commission an external review of CAMHS. A final report is to be submitted to the respective Secretaries of State for the Department of Health and the DCSF by summer 2008.

### Vulnerable children

**3.278** An extensive programme of work has continued to support the NHS contribution to safeguard children. This includes:

- the launch of a website and discussion database to share best practice;
- funding the Care Services Improvement Partnership to deliver a range of support for designated and named health professionals; and
- the launch of a new network of named safeguarding health professionals in mental health trusts.

**Figure 3.9: CAMHS progress**



Source: Partnerships for Children, Families and Maternity, DH

**3.279** The Department announced in February 2008 £10 million per annum over the next three years to support health professionals participating in the new statutory child death review processes. Safeguarding children will remain a significant focus for the Department, and there will be further development of the range of support for the NHS to deliver its safeguarding children responsibilities, working with the DCSF and stakeholders to support the delivery of the *Care Matters* White Paper and the Staying Safe Action Plan.

### Disabled children

**3.280** May 2007 saw the publication of *Aiming High for Disabled Children: Better Support for Families* (HM Treasury, May 2007), a cross-government review of services for disabled children and their families.

**3.281** Improving the quality and experience of disabled services has been identified as a priority in the *NHS Operating Framework for 2008-09*. *Aiming High for Disabled Children* has invested over £430 million in local authorities to fund disabled children's services during the CSR period 2008 to 2011, with additional growth funds in the baseline allocation to PCTs to increase the range and number of short breaks and to support the service in responding to the palliative care strategy.

**3.282** The DCSF Secretary of State and the Department of Health's Social Care Minister are due to launch a key stakeholder event in May 2008 to promote what the Government is doing to improve services for disabled children and their families and the investment being made.

### Developing a National Violence and Abuse Prevention Strategy

**3.283** The Department also continues to work with colleagues across government on cross-cutting programmes including the Victims of Violence and Abuse Prevention Programme and the Tackling Violent Crime Programme. *Developing a National Violence and Abuse Prevention Strategy* will be

published in May 2008. The Department has commissioned and funded a voluntary sector organisation to produce the report *Developing Effective Responses for Asian Women Experiencing Domestic Violence*. This is due to be published in summer 2008.

### Palliative care strategy

**3.284** England's first Palliative Care Strategy, *Better Care, Better Lives*, was published in February 2008 (DH, February 2008). The policy puts palliative care at the centre of local children's service provision and sets out expectations for improving choice, access and continuity of care. It focuses on building a sustainable service of palliative care networks and support for community nursing teams, including 'Diana' nurses.

### Provision of short breaks

**3.285** A three-year transformation in short break services for disabled children was announced on 14 January 2008. Twenty-one local authorities, working with PCTs, launched the first wave of a £370 million investment to provide more disabled children with enjoyable and valuable experiences away from their parents and carers, who in turn will benefit from a break in caring. The programme will extend to all of England from 2009.

### Bercow Review into speech, language and communication services

**3.286** The first major review in seven years into services for children with speech, language and communication needs was commissioned by Ed Balls (Secretary of State for Children, Schools and Families) and Alan Johnson (Secretary of State for Health). It is being conducted by John Bercow. An interim report was published in March 2008 and the final report is due in July.

## The third sector and the Department of Health

**3.287** The third sector fulfils a number of roles for the Department, such as service provider, advocate and partner in developing and implementing policy. Together with the NHS and social care, the Department has a long and established history of working with the third sector for the benefit of patients, service users and carers.

**3.288** The Department has taken a strong proactive approach to recognising and embedding the third sector as critical and integral to the delivery of reform to public services in health and social care. A cross-cutting third sector programme was established within the Department in 2007, overseen by a delivery board chaired by the Parliamentary Under Secretary for Care Services. It takes forward the recommendations from the minister-led Third Sector Commissioning Taskforce and its report *No Excuses. Embrace Partnership Now. Step Towards Change!* to promote a sound commercial relationship between commissioners and the third sector. The delivery board is complemented by an external sounding board to provide a further reality-check and ensure that the Department's Third Sector and Social Enterprise Programme is positioned effectively within the wider third sector partnership agenda.

**3.289** The Third Sector Funding and Investment Review will develop a strategic framework for departmental investment in the third sector to transform current piecemeal arrangements into a strategic portfolio that more explicitly supports delivery of the Department's objectives and priorities. The review was subject to a full consultation with third sector organisations and concluded on 20 March 2008. Full delivery and implementation plans are now being developed.

### The Section 64 general scheme of grants

**3.290** This scheme helps to strengthen and further develop the partnership between the Department of

Health and third sector organisations. It is the Department of Health's main funding stream for national voluntary organisations working in the health and social care fields. The current scheme supports innovative proposals of national significance that complement statutory services and help secure and promote high-quality health and social care in England.

**3.291** The total budget for 2007-08 was £17.2 million, including continuing grants agreed in previous years. The Department awarded 125 new grants in the 2007-08 funding round out of a total of over 1,100 applications received. Some 254 grants continued from the previous year. The average grant in 2007-08 is around £50,000 a year.

### The Opportunities for Volunteering Scheme

**3.292** Opportunities for Volunteering (OFV) is a partnership between the Department and the voluntary and community sectors. It uses the expertise of the voluntary and community sectors at a local and national level to enable local people to meet need and create change within their own communities. OFV grants range from £2,000 to £35,000. They are distributed to projects run by local community organisations that involve volunteers in the delivery of health and social care services. The scheme is administered by 16 national organisations known as national agents.

**3.293** The Department's strategic review of funding and investment in the third sector will have an impact on the Section 64 and OFV schemes. Any changes are expected to be implemented from 2009-10.

### Social enterprise

**3.294** The White Paper *Our Health, Our Care, Our Say* set out the aim of improving the choice and responsiveness of health and care services in community settings by promoting the development of social enterprises.

**3.295** Social enterprises are organisations, often partnerships with third sector bodies and community groups, that operate as businesses but that reinvest any surpluses in the community or in further service development and improvement. It is estimated that around 33 per cent of social enterprises in the country are delivering services in health and social care.

**3.296** Social enterprises can have a wide range of benefits, such as improving the quality of care available to people in the communities in which they are based, adapting to the needs of specific client groups and communities, applying expert knowledge and experience to address local priorities, and delivering a wider social dividend, such as contributing to community regeneration and promoting social inclusion.

**3.297** In June 2006, the Department of Health established a Social Enterprise Unit to promote and champion the value of social enterprise in health and social care, to encourage and support new social enterprises, and to open up marketing and commissioning to social enterprises by encouraging commissioners to consider their role in meeting the health and care needs of local communities.

**3.298** The Social Enterprise Unit works closely with the Department's Third Sector Policy Team to ensure that work on social enterprise is aligned with the broader third sector partnership agenda. It also has close links with the wider social enterprise sector and the Office of the Third Sector, based in the Cabinet Office, to ensure that social enterprise in health and social care is consistent with wider efforts to promote and encourage the development of social enterprise across all sectors.

**3.299** In January 2007, the Department announced 26 social enterprise pathfinder projects across England. The pathfinders are leading the way in delivering innovative services using social enterprise business models. The projects are being independently evaluated and learning will be shared

across the health and social care sector, so that others can benefit from the pathfinders' experiences.

**3.300** The Department has also established a Social Enterprise Investment Fund, which is worth £100 million (£73 million capital and £27 million revenue) over four years from April 2008 to March 2011, and which is available to new and existing social enterprises. The *Health and Social Care Bill 2007* includes legislative powers that will allow the fund to be used to support a wide range of organisations to develop sustainable models of service provision in order to improve access to user-centred, responsive, innovative services, which in turn can promote independence and well-being by providing early intervention and preventative services.

# 4 System Reforms in Health and Social Care

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## Introduction

**4.1** This chapter reports on the progress made against the ongoing, comprehensive programme of modernisation in health and social care that aims to deliver better care, better patient experience and better value for money. It also provides an update on the recommendations for service improvements.

## The health reform programme

**4.2** The health reform programme began in 2000 as a series of separate initiatives set out in *The NHS Plan: A Plan for Investment, a Plan for Reform*, (DH, July 2000) concentrating on hospitals and elective care: strengthening providers and introducing patient choice, supported by changes to the payments system. From 2005, a more comprehensive approach to reform was developed with a framework of four main elements: demand, supply, transactions, and system management – with an emphasis on coherence and the interplay between these elements. This approach strengthened health reform and implementation. It has delivered the shortest ever waiting times, including patients having to wait no more than 18 weeks from GP referral to hospital treatment, and improved management of NHS resources through foundation hospitals and a broader diversity of supply to support improved local performance. It also introduced choice at referral for approximately 10 million patients a year from January 2006.

**4.3** The third stage of reform now builds on these successes. The *NHS Operating Framework for 2008-09* (DH, December 2007) sets out the major steps to implementation of the existing reforms – always being clear that it is reform with a purpose to improve patient care. The health reform programme is focusing on:

- making services responsive to patients;
- giving more freedom to the front line;
- encouraging greater clinical engagement;
- improving quality and safety;

- enabling innovation and dynamism; and
- enshrining the values of the NHS for the 21st century in an enduring NHS Constitution or settlement.

**4.4** In October 2007, Lord Darzi's NHS Next Stage Review interim report set the scene for the full report due in summer 2008. The report will set out the vision over the next ten years to ensure that all aspects of the NHS are world class, building on the reform programme to date. His report will set out the enabling mechanisms to take reform forward to deliver an NHS that is fair, personalised, effective and safe.

## Making services responsive to patients

### Choice

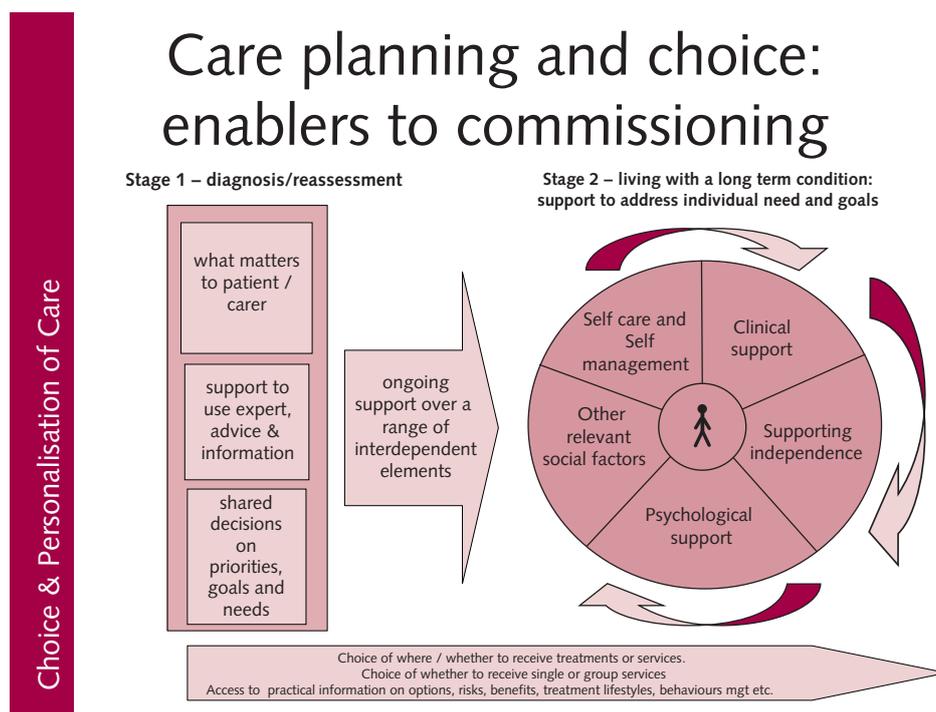
**4.5** Growing expectation about choice, access and convenience of healthcare is a fact of modern life. People want healthcare services that meet their needs and fit in with their busy lifestyles. That is why giving patients choice through reforms to encourage plurality of provision and drive up quality, creating a level playing field between competing local providers and allowing money to follow the patient are very important in building a more responsive and more accessible healthcare service. From 1 April 2008, patients have been able to choose services from any hospital provider in England that meets NHS standards and costs, including foundation hospitals and independent sector providers.

### Personalising care for people with long-term conditions

**4.6** Extending choice beyond elective care to people with long-term conditions (see also chapter 3) was recognised by the interim NHS Next Stage Review as a significant next step in providing the more personalised services people want.

**4.7** PCTs will shortly be implementing this, drawing on the generic choice model in the *NHS Operating Framework for 2008-09* (see **figure 4.1**)

Figure 4.1: Care planning and choice: enablers to commissioning



Choice & Personalisation of Care

for people with long-term conditions. It builds on the Diabetes Year of Care Project, which is exploring ways of offering people with diabetes a truly personalised care plan with a choice of options that are attractive and appropriate for them, while also understanding how this might translate into commissioning a range of services for the local diabetic population.

#### Patient prospectus

**4.8** By the end of 2008, there will be a *Patient Prospectus*. This will signpost access to a range of ‘active patient’ or ‘care at home’ options for the 15 million patients with a chronic or long-term condition, encouraging greater self-care and prevention. The prospectus will inform patients about their condition, steps they can take to improve their health, and the range of services available to them (ranging from participation in virtual or actual ‘expert patient’ groups, information, local exercise, weight reduction or smoking cessation services, to options for telemedicine).

#### Provision of choice in maternity services

**4.9** In 2005, the Government made a commitment that “by 2009 all women will have choice over where and how they have their baby and what pain relief to use. We want every woman to be supported by the same midwife throughout her pregnancy. Support will be linked closely to other services that will be provided in Children’s Centres.”

**4.10** In April 2007, the Department of Health published *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service*. This is the framework to support local implementation of the Government’s maternity commitments. It introduces new national choice guarantees for women, making it easier for them to access maternity services. Accompanying *Maternity Matters* is a self-assessment tool for commissioners to help PCTs and their partners ensure that local maternity services meet population requirements and address health inequalities.

**4.11** A high-level Maternity Matters Implementation Group (MMIG) has been established. The MMIG brings together key

personnel from the North West who are leading implementation on behalf of the NHS in England, with national policy leads from the Department of Health and other government departments (see also chapter 3).

### Provision of choice for people with mental health needs

**4.12** For people with mental health needs, such as depression and anxiety disorders, choice is increasing. Unprecedented investment to increase access to psychological therapy services was announced by the Secretary of State for Health in October 2007. As a three-year programme of improving access to psychological therapies rolls out, people will begin to have the choice of a range of psychological therapies approved by the National Institute for Health and Clinical Excellence as an alternative or addition to medication (see also chapter 3).

### Giving more freedom to the front line

#### Payment by results

##### *Achievements*

**4.13** The Department consulted the NHS and other stakeholders to set the direction for the future development of payment by results (PbR). *The Options for the Future of Payment by Results: 2008/09 – 2010/11* consultation ran between March and June 2007, and almost 300 responses were received. A departmental response to the consultation was published in January 2008.

**4.14** Work is already under way to deliver some of the proposals within the consultation document, including our commitment to improve the technical basis of PbR by implementing a new currency (Healthcare Resource Group 4), and a better-targeted approach to payment for specialised services.

**4.15** The Department met its commitment to early confirmation of the next year's tariff. After a period of road testing with the NHS, the national

tariff for 2008-09 was published in December 2007, alongside the *NHS Operating Framework for 2008-09*.

**4.16** Evaluation of the implementation of PbR continued during the year with the publication of two major studies by the Audit Commission and a consortium of universities led by the University of Aberdeen. Both reports confirm that PbR is now part of the mainstream business of the NHS and that its introduction has been beneficial, especially in terms of improving the management information available to NHS organisations.

#### NHS foundation trusts

**4.17** As part of the reform of NHS service providers it is expected that all NHS acute and mental health trusts will become NHS foundation trusts within the next two to three years. All NHS patients and service users should be able to benefit from their local services being delivered by an NHS foundation trust.

**4.18** All strategic health authorities (SHAs) are required to work with those trusts that have not yet achieved NHS foundation trust status so that they can improve and develop their management structures and strategic outlook in ways that will allow them to bring to their patients and service users the benefits that come with NHS foundation trust status. There are now 96 NHS foundation trusts operating with greater accountability to their service users, staff, and local people, and delivering services in a way that is most appropriate to their own communities. The Department is actively working with SHAs to ensure that all remaining trusts can go through the application process. Monitor (the independent regulator of NHS foundation trusts) have also been allocated additional resources, both to deal with the existing backlog and a higher number of applicants coming through. SHAs will also be working with their ambulance trusts to ensure that they will be in a strong position to apply to become NHS foundation trusts in 2009.

## Strengthening commissioning

### World class commissioning

#### Achievements

**4.19** In May 2007, the Department of Health conducted a review of primary care trust (PCT) commissioning capability with the Prime Minister's Delivery Unit. The review findings and recommendations have informed the development of the World Class Commissioning Programme.

**4.20** Commissioning is the way PCTs secure the best value for patients and taxpayers, giving the best possible health outcomes and healthcare within available resources. World class commissioning is a statement of intent, aimed at delivering outstanding performance in the way that health and care services are commissioned.

**4.21** World class commissioning will allow the NHS to take a strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. Local partners, including PCTs, patients, the public, local authorities, clinicians and providers will need to develop open and innovative partnerships to deliver the best possible health and care services for the local community. Together, they will make informed choices about local priorities and how best to deliver them.

**4.22** The *Vision and Competencies for World Class Commissioning* (DH, December 2007) set out what excellent commissioning in the NHS can achieve, and the organisational competencies that organisations would need in order to become world class commissioners. The 11 competencies require that organisations:

- are recognised as the local leader of the NHS;
- work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities;

- proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health;
- lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation;
- manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements;
- prioritise investment according to local needs, service requirements and the values of the NHS;
- effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes;
- promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration;
- secure procurement skills that ensure robust and viable contracts;
- effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes; and
- make sound financial investments to ensure sustainable development and value for money.

**4.23** The vision and competencies were developed through partnership working with the NHS, social care and local government.

**4.24** The NHS Next Stage Review signals a new vision for the NHS that is fair, personalised, effective and safe. World class commissioning will be one of the ways in which this vision can be realised. World class commissioning sets out how commissioning will have a direct impact on the health and well-being of the population, driving unprecedented improvements in patient outcomes, and ensuring that the NHS remains one of the most progressive and high-performing health systems in the world. World class commissioning will

ultimately deliver better health and well-being for all, better care for all, and better value for all.

**4.25** Commissioning will increasingly become the process by which the NHS is held to account. An assurance system is being developed, which will hold PCTs to account and reward performance and development as they move to become world class commissioners. The assurance system will be one national system, managed by the SHAs. It will provide a common basis for agreeing development by PCTs as they move toward world class performance. The commissioning assurance system is currently being developed, and has been tested by PCTs in the North West SHA. In addition, SHAs will be able to call on the Care Quality Commission's published independent comparative information on the performance of commissioners in performance managing PCTs.

**4.26** Alongside the commissioning assurance system, SHAs will lead on providing PCTs with support and development resources for commissioners to draw upon as they work to improve. The support and development framework will provide a range of tools, and commissioners will draw upon these differentially depending on their local strengths and weaknesses.

**4.27** The *Framework for Procuring External Support for Commissioners* (FESC) is one example of a support resource. FESC was launched in the latter part of 2007. FESC helps PCTs to address gaps in their commissioning capability or capacity, by providing access to independent sector suppliers with pre-assessed skills in different aspects of the commissioning cycle. The use of FESC is optional, and is only one of several tools available to PCTs within the World Class Commissioning Programme. A number of PCTs are considering the use of FESC, with the help of a central support team. PCTs are provided with a standardised procurement route and a full package of resources including tender documentation, business cases, and

FESC-specific contracts with a number of payment models.

### Practice-based commissioning

**4.28** Practice-based commissioning (PBC) is at the heart of world class commissioning. PBC is about engaging clinicians in the commissioning process, enabling them to redesign services to better meet the needs of their patients. PCTs and practice-based commissioners will work in partnership to deliver improvements in health outcomes. The relationship between the PCT, which is legally accountable for ensuring appropriate services are commissioned, and clinicians, who are accountable for the care packages that are provided, is of key importance. World class commissioning will only be achieved when these elements are aligned.

**4.29** Implementation of PBC by practices and PCTs has been supported by key stakeholder organisations. The Improvement Foundation has delivered a development programme on behalf of the Department to provide tailored support to PCTs and practices in helping to establish and develop PBC in their local areas.

**4.30** The Department is jointly funding both the Advanced Commissioning Programme with the National Association of Primary Care and the Improvement Foundation, and the Commissioning Academy in partnership with the NHS Alliance and Humana. The NHS Primary Care Contracting team continue to provide advice and support to PCTs and practices.

**4.31** The Department has commissioned Ipsos MORI to deliver a quarterly practice survey to measure 'practice engagement' in PBC and their experience of the support arrangements provided by their PCT. While the survey shows that PBC is developing locally, PCTs still need to do more to develop their local PBC support arrangements. The Department will continue to work closely with SHAs in supporting PCTs to make further improvements. The excellent range of case studies in

the NHS Alliance's *Early Wins, Early Lessons* (NHS Alliance, September 2007) document show that with the right support, PBC is making a difference.

## Future plans

**4.32** Good progress has been made in 2007-08 in setting out a clear narrative about the role commissioning can play in improving health outcomes. The Department will build on this in 2008-09 by:

- developing a national support programme on PCT board development;
- finalising and building the infrastructure to allow roll-out of the commissioning assurance system; and
- continuing to support the partnership approach to PBC between PCTs and practices within the World Class Commissioning Programme.

**4.33** Following the introduction of the assurance system and development framework in 2008, significant improvements are expected to be seen in commissioning capability, resulting in improvements in health and well-being outcomes.

## Improving quality and safety

### NHS Choices

**4.34** In June 2007, NHS Choices was launched. It contains information on hospitals aimed at helping patients make informed choices about where to go for treatment. The information provided includes overall service quality (as rated by the Healthcare Commission), infection rates, waiting times and readmission rates for a number of common treatments. The website also contains information on GP practices, health conditions and treatments, and healthy living. The range of information on NHS Choices will gradually be extended to provide further support for patient choice.

**4.35** A Clinical Information Advisory Group chaired by the NHS Medical Director, Sir Bruce Keogh, advises the Department on clinical indicators for publication on NHS Choices. Following the recommendations of the group, NHS Choices has published indicators on approximately 40 treatments, including hip and knee replacements, heart bypass and cataract surgery. Over the coming months the group will consider indicators in a range of other treatment areas.

**4.36** NHS Choices also provides the public with an increasing range of digital services, including high-quality information on healthcare providers and healthy living. The on-line service, which incorporates video, mobile and audio channels, brings together information from the NHS, arm's length bodies and national clinical audits, to enable patients to understand where they can access particular services and compare the quality of those providers.

**4.37** Where a choice of provider is offered to a patient by their GP, the information provided by NHS Choices is integrated with the Choose and Book system. This allows patients to review the quality indicators relating to the options they have discussed with their GP, before booking their appointment.

**4.38** Supporting patients' selection of provider is one of three areas in which NHS Choices seeks to inform the health and healthcare decisions that face patients and the public. The 'Live Well' section of the website addresses the lifestyle choices that are major determinants of health, in a manner that is tailored to particular groups of the population and increasingly integrated with the Department's related campaigns. The third aspect of the site helps patients take an informed part in the discussion with professionals of their condition and the treatment choices they may have, via a comprehensive A to Z of health topics and an analysis of the health stories currently in the news.

## The future regulation of health and adult social care in England

### Achievements

**4.39** As part of a broad cross-government strategy to modernise public services inspection, the Chancellor's 2005 Budget report signalled the creation of a single health and adult social care regulator. This will replace three existing regulatory bodies, the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

**4.40** In November 2006, the Department published the report *The Future Regulation of Health and Adult Social Care in England*. This consulted on the future shape of the regulatory framework and sought views on how the new regulator could best work alongside other bodies in the health and social care systems to fulfil the functions set out in the document. Over 100 written responses from a wide variety of stakeholders were received during the three-month consultation. The Department also held a number of workshops and open forums to consider the document.

**4.41** In October 2007, the Government published its response to the November 2006 consultation document. This:

- reaffirmed the Government's vision for regulation;
- summarised the main themes the Department gathered in response to the consultation;
- outlined the organisational roles and responsibilities for each of the seven regulatory functions identified by the consultation document; and
- reinforced the Government's commitment to establish a new integrated health and social care regulator, the Care Quality Commission, by outlining the roles and responsibilities for the new regulator.

**4.42** The document also made clear that the current regulatory system has worked well but has

been held back by artificial barriers between health and social care and a lack of flexibility when trying to deal with new and innovative services. The new Commission would therefore focus on assuring levels of safety and quality of care across health and adult social care services in England.

**4.43** The *Health and Social Care Bill* was introduced on 16 November 2007 and will legislate to establish the new regulator and set out its new regulation and inspection functions.

### Future plans

**4.44** The creation of the Care Quality Commission will build on the excellent work to date of the existing organisations. The new regulatory framework will focus on the needs and expectations of patients and service users and will be flexible enough to adapt as health and adult social care systems evolve over time.

**4.45** Subject to parliamentary approval, the new regulator will:

- register care providers (for the first time including NHS providers as well as social care and independent sector healthcare providers);
- monitor compliance with registration requirements and use enhanced enforcement powers if necessary to ensure that all service providers meet those requirements;
- assess the performance of providers and commissioners and publish comparable information for public accountability and to help people make informed choices of provider (alongside other information sources such as the NHS Choices website);
- keep the operation of the *Mental Health Act* under review, with new enhanced powers to protect patients; and
- take a proportionate approach to regulation and have a role in minimising the overall burden of regulation on health and social care organisations.

**4.46** Subject to the progress of legislation, the new Commission will be established in October 2008 and take over the functions of the three commissions it replaces in April 2009. The new registration system will be phased in from April 2009 with healthcare-associated infection as the first priority.

**4.47** The legislation includes powers to make regulations specifying which services will need to be registered with the new commission and what requirements service providers will be required to meet. The Government is currently consulting on both the scope of registration and the process of registration itself.

**4.48** New regulations will be made in time for the Care Quality Commission to develop and consult on the details of the policies and procedures to underpin its operation of the new regulatory framework, including the criteria it will use to assess compliance with registration requirements.

## Enabling innovation and dynamism

### Choice in elective care

#### *Achievements*

**4.49** Since July 2007, NHS providers of orthopaedic services have had the opportunity to add their services to the national menu of hospitals and clinics across England on the NHS Choices website. Patients being referred to see an orthopaedic specialist have had the opportunity to choose from any provider. Since December 2007, NHS providers of cardiology, gynaecology and general surgery have had the opportunity to add their services to the national menu and patients being referred to see a cardiologist, gynaecologist or general surgeon have also been able to choose from any provider.

**4.50** Over 5,350 services are listed on the national menu. This number is continuing to increase as new NHS foundation trusts are approved, and

independent sector treatment centres and independent sector providers are added to the menu.

**4.51** The results from the ninth patient choice survey, published in February 2008, indicate that 45 per cent of patients recall being offered a choice of hospital for their first outpatient appointment. This is less than the 48 per cent in March 2007 but up from 30 per cent in the first (May/June 2006) survey.

*Les says "I went to see my GP for a list of orthopaedic surgeons because I was going to take out a loan if necessary and pay to get it done. My GP explained there were other options available now and I could choose where and when to get it done on the NHS."*

*(Stockport Recorder, March 2007)*

*Linda says "The doctor told me that I now had a choice about which hospital to go to and he brought four or five of them up on his computer screen. I chose Southend because I've been there before and not had any problems and they could see me in six or seven weeks."*

*(Basildon/Southend Evening Echo, April 2007)*

### Future plans

**4.52** In April 2008, all patients needing planned elective care will be able to choose to be treated by any provider that meets eligibility criteria and NHS clinical and financial standards.

### Choose and Book

**4.53** Choose and Book is a key enabling mechanism for choice. It is a national service that combines electronic booking and a choice of time, date and place for first outpatient appointments. Patients can now choose to book their appointment at their GP surgery, on-line, or by telephone via the Appointments Line run by NHS Direct. Choose and Book is a big step towards giving patients greater involvement in the decisions about their treatment. It is bringing real improvements to patients' experience

of the NHS and real benefits to clinicians and NHS services by delivering a safe and secure method of electronic referral that helps improve the communication between primary and secondary care – ensuring that the patient’s journey through the system is effectively managed from the start. Further details of Choose and Book achievements are given in chapter 8.

*Ashley says “My GP told me I would get a call to confirm an appointment, and when the NHS appointments line called, the woman talked to me about the different hospitals I could choose from. That was very different to the first time round when I just got a letter saying where to go and on what day.”*

#### Choice in primary care

**4.54** The NHS Next Stage Review interim report in October 2007 announced commitments to establish over 100 new GP practices in underserved areas and over 150 GP-led health centres across the country. As well as providing additional primary care services and supporting innovation, these new practices and health centres will help promote greater choice in primary care. PCTs have been asked to complete procurements for these services during 2008-09.

**4.55** Key information about all GP practices, including the results of the first-ever national patient survey, practice opening times and performance against key quality indicators, is now being made available on the NHS Choices website to support patient choice.

**4.56** As part of the NHS Next Stage Review, the Department is developing a wider strategy for primary care and community services. As set out in the interim report, this will include looking at how to expand patient choice further in primary care, including exploring new models that make it easier for patients to register with a different GP practice if they wish.

**4.57** Independent and third sector participation will be mainstreamed by ensuring effective competition and a level playing field with several measures to facilitate this due to be in place by April 2008. Principles and rules, together with locally led procurements, will enable the entry of new providers. For social enterprises, the Department will build capability and support entry through the new Social Enterprise Fund.

#### An NHS Constitution

**4.58** The approaching 60th anniversary of the NHS is an opportunity to put in place an enduring constitution or settlement to reaffirm the core values of the health service as the basis for a modern, forward-looking NHS. Lord Darzi’s NHS Next Stage Review has been asked to consider how an NHS Constitution might embed a stronger focus on rights and responsibilities for patients, the public and staff, and strengthen accountability for decision-making in the NHS.

#### Implementation and impact of reform

**4.59** The health reforms are the means to drive up quality and improve care and health outcomes for patients and the public. But reform is not something the Department can, nor should, do to the NHS. Rather, local NHS organisations will put the components of reform in place and use them together to transform whole care systems.

**4.60** In 2007-08, the Department commissioned a new independent research programme to evaluate the impact of health reform as it is implemented. The evaluation will enable policy-makers, both current and future, to learn what has worked well, and what has not – and to apply those lessons, in keeping with its commitment to evidence-informed policy. The programme complements and builds on existing evaluation, filling the gaps through in-depth studies of individual reform mechanisms and whole-system examination of the combined effect. There is a strong focus on feeding early results into policy

development, to allow reform policy to evolve in the light of feedback from implementation.

## Service improvement

**4.61** Hospital reconfiguration, and access to local maternity and A&E services in particular, remains an issue of great interest to the public.

**4.62** Proposals for the reconfiguration of services remains a matter for the NHS locally, working in conjunction with clinicians, patients and other stakeholders and, while much has been done to improve transparency and engagement of stakeholders, more is still to be done.

**4.63** On 4 July 2007, the Secretary of State for Health announced that he would seek the advice of the Independent Reconfiguration Panel (IRP), on all cases referred to him by local authority Overview and Scrutiny Committees where they believe such changes are not made in the best interests of the local population.

**4.64** In addition, Lord Darzi set out in his interim report a series of additional measures to improve accountability and engagement. The NHS Next Stage Review committed to “ensure that any major change in the pattern of local NHS hospital services is clinically led and locally accountable, by publishing new guidelines to make clear that”:

- change should only be initiated when there is a clear and strong clinical basis for doing so (as there often may well be);
- consultation should proceed only where there is effective and early engagement with the public; and
- resources are made available to open new facilities alongside old ones closing.

**4.65** Based on the principles and recommendations previously set out by Sir Ian Carruthers, these guidelines also set out the intention that proposals for service change should, prior to consultation, be subject to independent clinical and management assessment.

**4.66** This assurance will be provided for all schemes from April 2008 through the Office of Government Commerce’s gateway review process.

## NHS Operating Framework

**4.67** The purpose of the *NHS Operating Framework for 2008-09* is to set out the parameters within which local organisations will operate in 2008-09.

**4.68** 2008-09 is the first year of a three-year planning cycle and therefore the framework sets out in greater detail the truly ambitious programme for the NHS over the next three years. Specifically, it addresses the following key areas:

- **Priorities:** freeing up the front line, by moving towards local stretch targets, while delivering on national priorities.
- **Enablers:** develop world class commissioning to act as the key agent for change on behalf of patients and the public, using the full range of levers and incentives to transform services and improve outcomes.
- **Financial regime:** a framework that fully supports reform goals and incentivises transformational improvements in services within available resources.
- **Business processes:** a business-like and transparent approach to planning.

### Priorities

**4.69** This year, there are five key areas where PCTs are expected (working with providers and their local partners) to pay particular attention. From listening to patients and the public, the Department knows that these are the most important issues, regardless of where people live. These are:

- improving cleanliness and reducing healthcare-associated infection;
- improving patient experience, staff satisfaction and engagement;

- improving access through achievement of the 18-week referral-to-treatment target and better access to GP services;
- keeping adults and children well, improving overall health and reducing health inequalities; and
- preparing to respond in a state of emergency such as an outbreak of pandemic influenza.

**4.70** The focus is not just on national priorities but also on providing the headroom for organisations to focus on locally identified priorities. A list of indicators, known as vital signs, has been developed alongside the framework to encourage and enable partnership working between PCTs and local authorities and between SHAs and Government Offices.

**4.71** The vital signs pull together the commitments made through the 2007 Comprehensive Spending Review (CSR) process by the Department of Health to both HM Treasury and other government departments. To support the alignment of priorities across health and adult social care, indicators have been included within the vital signs that are also in the National Indicator Set for local government. Performance against all of these indicators, along with existing commitments that need to be achieved or maintained, will be published annually to allow the local population to understand how well or poorly their local PCT is performing and be part of the local conversation between PCTs and their populations.

### Enablers

**4.72** Improved services for patients and the public can only be delivered by local delivery and implementation of the enablers. A world class NHS is responsive and accountable to its local population. PCTs will need to concentrate efforts on empowering and engaging patients and local communities in the same way that they will focus on implementing and monitoring contracts to achieve the vision of being a world class

commissioner. Local organisations will need to work with one another and the Department to deliver a healthcare system that meets their local needs and is effective.

### Financial regime

**4.73** The framework sets out the PCT allocations for revenue and capital during 2008-09, which are the financial rules the NHS will work within, and confirms that the principles of transparency, consistency, independence and fairness introduced to the management of NHS finances in 2007-08 are built upon in 2008-09. This requires that:

- the aggregate resource accounting and budgeting (RAB) surplus delivered in 2007-08 will be carried forward to 2008-09;
- a surplus is delivered in 2008-09 at least to the value of that carried forward from 2007-08;
- all organisations plan to deliver in-year balance; and
- all organisations demonstrate the delivery of 3 per cent efficiency savings.

**4.74** The independence given to the NHS in managing its finances means that SHAs have flexibility in determining the level of contingency necessary and where this is best held. In addition, SHAs and PCTs will agree locally the arrangements for the transfer and lodging of resources.

### Business processes

**4.75** As progress is made towards a more devolved system, there is a need for a business-like and transparent approach to planning. Delivery of the goals set out in the framework requires effective business processes throughout the system. This needs to support local accountability in driving change for the benefit of patients. Therefore, plans need to be aligned to Local Area Agreements to encourage strengthened local ownership and accountability and to meet statutory public sector duties towards equality.

**4.76** Guidance entitled *Operational Plans 2008-09 to 2010-11* for the NHS on planning and the future performance management role of SHAs and the Department was published in January 2008. In addition, PCTs are developing plans at an operational and strategic level, while SHAs produce a talent or leadership development plan.

## Local Area Agreements

**4.77** Following the sign-off of the final round in April 2007, every area in England now has its own tailored Local Area Agreement (LAA) in place. An LAA is a three-year agreement that sets out the priority outcomes for area Local Strategic Partnerships. It represents an agreement between central government and a local area represented by the lead local authority and its key partners including PCTs, NHS trusts and NHS foundation trusts.

**4.78** The local government White Paper, *Strong and Prosperous Communities*, published in October 2006 sought to place LAAs in the mainstream of public service delivery. The supporting legislative framework has been strengthened by a number of statutory duties set out in provisions within the *Local Government and Public Involvement in Health Act 2007*. As well as placing duties on local authorities and their partners to have regard to targets agreed in LAAs, the Act also places a duty on PCTs and local authorities to undertake a joint strategic needs assessment of the health and well-being needs of the local population. This new duty meets the Department's commitment in *Strong and Prosperous Communities* to bring forward legislation aimed at strengthening partnership working between the NHS and local government.

**4.79** As part of a wider performance framework for local authorities and their partners, from June 2008 LAAs will be the only place where local authorities can be performance monitored on what they do on their own or in partnership. They will focus on up to 35 targets selected from a set of 198

national indicators that were published following CSR 2007. These priorities will form the central delivery contract between central government and local government and its partners.

**4.80** LAAs have been vital in stimulating stronger local partnerships between the NHS and local government. They now offer an even more significant mechanism for ensuring that, where necessary, the local authorities and PCTs work together to tackle the major health and well-being challenges facing health and social care services. Thirty-one of the 198 indicators are also vital signs set out within the *NHS Operating Framework for 2008-09*. Alongside PCT operational plans, LAAs will therefore play a crucial role in delivering this and other government departments' Public Service Agreement targets, and the Department of Health's Departmental Strategic Objectives.

**4.81** Over the past year, the Department has worked closely with other government departments to understand the implications and potential benefits of LAAs and the wider performance framework. Regional Public Health Groups and the Care Services Improvement Partnership have been key to the work that has been undertaken to date. In order to support this delivery further, the Department is enhancing its regional presence, which will work directly with local authorities and PCTs as well as across other regional partners including Government Offices for the Regions and SHAs.

## System management

**4.82** The consultation on the future of regulation in health and social care (which took place in November 2006, with a response in October 2007) gave a clear steer to the future regulatory environment of the NHS. While there would in future be a single regulator for health and social care, there would be no economic regulator: the setting of 'system rules', pricing and financial allocations would remain with the Department of

Health, while SHAs would function as regional system managers.

**4.83** Thus, the Department began the process of developing a system management framework, and related technical tools, to support itself and SHAs in performing these roles. Two major tools – the new *Standard Contract for Acute Services* and the *Principles and Rules for Cooperation and Competition* – were published alongside the *NHS Operating Framework for 2008-09*.

**4.84** A standard approach to contracting for NHS services was first proposed in *Health Reform in England: Update and Commissioning Framework* (DH, July 2006). It has been introduced as an important part of the arrangements for managing the reformed NHS system. It will improve NHS business processes and support the development of world class commissioning.

**4.85** The range of contracts and service level agreements, which the standard contract replaces, were not fit for purpose in an environment of greater plurality of provision, more autonomous providers and the ability of any willing provider to offer elective treatment in a system without volume constraints. The new contract will support the achievement of key standards and targets and ensure that commissioners and providers do not become financially exposed.

**4.86** The standard contract will create legally binding agreements between PCTs and NHS foundation trusts, and between PCTs and independent and third sector providers. Agreements between PCTs and NHS trusts will be in exactly the same form and be treated with the same degree of rigour and seriousness as if they were legally binding.

**4.87** An interim version of the standard contract was introduced for 2007-08, and applied to NHS trusts and NHS foundation trusts only. Since then, the contract has been further refined, with detailed stakeholder involvement, to learn lessons from the

way in which the interim version was used. The final version was published with the *NHS Operating Framework for 2008-09* and was followed by a comprehensive programme of implementation support for the NHS.

**4.88** In 2008-09, similar approaches will be developed for mental health, ambulance, and community services.

**4.89** The *Principles and Rules for Cooperation and Competition*, released after engagement with a wide range of stakeholders, provide a clear, transparent and robust framework for local organisations' decision-making about the management of the health economy. Covering commissioning, procurement, pricing, competitive and collusive behaviour, integration and the management of failure, the principles and rules are a key tool for empowering local organisations to take forward reform of the NHS that best benefits patients.

**4.90** Several other major pieces of work have been taken forward at the same time. These include the *Code of Practice for the Promotion of NHS-Funded Services* (DH, March 2008), the *PCT Procurement Guide* (DH, April 2008), the *Framework for Managing Choice, Competition and Cooperation*, co-designed with the SHAs (DH, April 2008), and a manual for corporate transactions, scheduled for July 2008. Taken together, these pieces of work represent a significant toolkit for local organisations seeking to implement fundamental reform.

**4.91** A further major piece of work is the implementation of the Cooperation and Competition Panel, first committed to by the Secretary of State in late 2007. The aim of the panel is the provision of advice to providers and NHS bodies where competition disputes cannot be resolved. The panel is scheduled for launch in late 2008.

## Empowering patients and the public

**4.92** During the *Your Health, Your Care, Your Say* consultation the public told the Government that they wanted a greater say over how their money is spent on care services. The Department also believes that services deliver better care if they listen to the people who use them. This is why the Government has put in place a series of initiatives to make services more accountable and responsive, as well as giving citizens more opportunities to influence the care they receive.

**4.93** In 2006, the Department of Health published *A Stronger Local Voice: A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services*. The document set out plans that were introduced via the *Local Government and Public Involvement in Health Act 2007*.

**4.94** On 31 March 2008, the Commission for Patient and Public Involvement in Health was abolished along with the system of Patients' Forums. These have been replaced by Local Involvement Networks (LINKs). The Government has made £84 million available to establish and support LINKs from 2008-09 to 2010-11.

**4.95** As an independently run network of local groups and individuals, a LINK's role is to find out what people want from services, to monitor local delivery and to use its powers to hold health and social care services to account. The Government believes that LINKs will make it easier for more citizens to get involved in shaping services, as well as making dialogue between communities and services easier. In addition to funding, a programme of support has been put in place to help communities get their networks up and running.

**4.96** The Government believes that the voice of patients should lie at the heart of the commissioning process. Under the *Local Government and Public Involvement in Health Act 2007*, the NHS duty to involve citizens has been strengthened and a new

duty of reporting on consultation has been established.

**4.97** The duty of involvement obliges all NHS bodies to involve the patients and the public in planning, service development and decision-making. The new duty of reporting on consultation requires SHAs and PCTs to report back to their communities on how they have involved users and how such involvement has impacted on their commissioning decisions. The Government has put in place a programme of work, including new guidance, to help the NHS get better at involving citizens in a systematic and sustained manner.

**4.98** In addition to new legislation, the Department has committed to reform the complaints process. The Department wants a single system for users of health and social care services in England to make it easier for citizens to share their experiences and for services to listen, respond, learn and improve care.

**4.99** Government proposals have been fully consulted on. An Early Adopter Programme has been established to help develop robust guidance and to ensure that the new complaints arrangements are implemented effectively.

**4.100** In response to a recommendation in *Our Health, Our Care, Our Say* to review the National Patient Survey Programme, the Department of Health has carried out a review of the way that information about people's experience of care services is collected and used. The results of the review will be used to inform plans to fully embed information from patients' experiences in world class commissioning and the delivery of services across health and social care.

### Information for choice

**4.101** People make daily choices about their health, care and services and the Department is introducing a number of new ways for people to get the

information that they need to make choices about their health and care.

**4.102** Information prescriptions were piloted throughout 2007 in 20 sites across England. Information prescriptions are given to people by their health and social care professionals and build on the information already provided by, and discussed with, those professionals. They contain signposts to sources of information on health and social care, such as addresses, telephone numbers and websites. An interim report on the evaluation of the pilots was published in November and detailed the lessons learned so far from the pilot programme. The final report on the evaluation will be published in spring 2008 and will contribute to the development of the national implementation of information prescriptions for people with long-term conditions, which will take place during 2008.

**4.103** During 2007, standards for the development of health and social care information were agreed in collaboration with a range of stakeholders across health, social care and the voluntary sector. Subject to ministerial agreement, these standards will form the basis of an information accreditation scheme that helps information producers to raise quality and helps the public to identify trustworthy information sources. Information producers would be supported to implement the standard and would be awarded a quality mark through independent certification. This quality mark can be used by the public to identify quality information.

**4.104** In response to a recommendation in *Our Health, Our Care, Our Say*, the Department commissioned a report into the ways that people find information about services. This was published by the Picker Institute in April 2007 and its recommendations have been used to inform the development of the new choice website NHS Choices.

**4.105** During 2007, the 'Questions to Ask' materials have been successfully deployed. These leaflets and posters support shared decision-making between patients and professionals by providing a short set of generic questions that people can use in a range of consultations with professionals. The leaflets are available in a range of formats to support hard-to-reach groups. There has been good take-up of the materials from both the statutory and third sectors.

**4.106** Good quality information will be essential to support patients in making informed decisions about providers and in helping to ensure that choice is equitable for all.

### Partnership for Patients

**4.107** The Partnership for Patients Programme pilot is a collaboration to deliver information to support choice and the booking of patients on-line through the libraries network. Library staff have been trained to support patients via websites such as nhs.uk, the Healthcare Commission and Patient Opinion.

**4.108** There will be a six-month pilot through 30 libraries, where patients can obtain more information to help them choose the right hospital for them and have the library staff help them to book or in fact book their appointment for them.

# 5 Transforming Adult Social Care

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## Introduction

**5.1** The Directorate for Social Care is now the Directorate for Social Care, Local Government and Care Partnerships. This has led to a more inclusive and coherent approach to the development of policy where social care has an important role to play not only within the Department of Health, for example in offender health and mental health services, but also across government. In order to deliver the Government's overall commitments and objectives, the Directorate works collaboratively across Whitehall; some examples can be found below.

**5.2** *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care* (HM Government, December 2007) sets out, for the first time, the vision, ambitions and components of the future system in one place. In particular, it recognises the need to empower citizens to shape their own lives and the support they receive.

**5.3** Led by the Department of Health, *Putting People First* established an explicit, collaborative approach between six government departments, local government, the sector's professional leadership, providers and the regulators. The Social Care Reform Grant (see Local Authority Circular (DH) (2008) 1, *Transforming social care*) provides three years of ring-fenced funding to support councils to undertake the necessary reforms to deliver this transformation.

**5.4** The Department has been working closely with the Home Office and the Department for Children, Schools and Families to introduce a new scheme that will require those who work with vulnerable people to be vetted and, if necessary, barred from work that brings them into contact with vulnerable people. The scheme will be administered by a new body, the Independent Safeguarding Authority.

**5.5** The Department also works with the Department for Communities and Local Government on housing issues, particularly where housing is provided with care and support arrangements included. The Department has input to the future arrangements for the Supporting People Programme and the development of a housing strategy for an ageing society. In addition, the Department is funding the development of extra care housing facilities through a grant worth £40 million in 2007-08.

**5.6** The Department is working closely with the Department for Work and Pensions' LinkAge Plus Programme to extract evidence and provide learning and practical guidance that will help councils to invest in early intervention and prevention in the most efficient and effective way. The departments have developed an on-line resource to help local authorities assess their own progress, identify areas for improvement and access a range of guidance based on the experience of the Partnerships for Older People Project (POPP) pilots, LinkAge Plus pilots and a range of related initiatives. For 2008-09, the Department plans to organise learning events in partnership with the Department for Work and Pensions' LinkAge Plus Programme to share the latest findings from the POPP and LinkAge Plus pilots.

**5.7** The Directorate has been responsible for strengthening the profile of social care, both in a number of the Department's key strategies – including planning for pandemic influenza, improving cancer and stroke services – as well as in wider government activity such as performance assessment in local government and the NHS.

**5.8** Social care faces challenging times with the changing demographic of an ageing society and rising expectations both of people currently using services and those who will need support in the future. The Department is responding in a number of ways that are discussed in more detail later in this chapter.

**5.9** In addition, the Directorate has established a Social Care Strategy Unit. That unit's focus at this time is the longer-term reform of the funding system. That process has begun with an extensive consultation and the Department will produce a Green Paper later in the year, in which it will set out the key issues and options for reform.

**5.10** The Social Care, Local Government and Care Partnership has also been taking a long hard look at how it works with its stakeholders. The Directorate Management Board has signed off a Stakeholder Engagement Strategy that sets out the principles of good engagement and sets a standard that all the programmes have to live up to. With our partners at the Central Office of Information, the Directorate refreshed background information on stakeholders to enable a refresh of engagement plans. In addition, for the first time, the Directorate shared its draft business plan with external stakeholders for their comment.

**5.11** The Department has also announced an independent review of local authorities' use of eligibility criteria. It has asked the Commission for Social Care Inspection to report back with recommendations in the autumn. The review will focus on national definitions of need and their application at a local level by councils.

## Strategy

**5.12** The Government's vision for social care was set out in the White Paper *Our Health, Our Care, Our Say* (DH, January 2006).

**5.13** *Putting People First* sets out a unique public service reform programme that aims to be co-produced, co-developed and co-evaluated. It recognises that real change will only ever be achieved through the participation of people using services, and their carers, at every stage.

**5.14** Local government will need to spend some existing resources differently and the Department is providing specific funding to support system-wide

transformation through the Social Care Reform Grant (see chapter 9 for further details).

**5.15** The Department's intention is that every locality will aim to develop a single community-based support system focused on the health and well-being of the local population, including those who fund their own support. The new local performance framework covers the delivery of all services by local government, working alone and in partnership.

**5.16** The transformation of adult social care will harness the requirements of the new local performance framework, such as the duty of local authorities and primary care trusts (PCTs) to undertake a joint strategic needs assessment to drive through reform that really delivers for local people.

**5.17** A personalised adult social care system will ensure that people are supported, irrespective of illness or disability, to:

- live independently;
- stay healthy and recover from illness;
- exercise maximum control over their own life and, where appropriate, the lives of their family members;
- sustain a family unit which avoids children being required to take on inappropriate caring roles;
- participate as active and equal citizens, both economically and socially;
- have the best possible quality of life, irrespective of illness or disability; and
- retain maximum dignity and respect.

**5.18** There are many good examples of innovation in adult social care such as the In Control work with learning disabled people. The Individual Budgets, POPP and LinkAge Plus pilots have all improved the Department's understanding of what works and what barriers it needs to overcome.

**5.19** Adult social care will be transformed through working with our partners in local government, the NHS, other statutory and non-statutory agencies, local communities and individuals giving and receiving support. The Department has already made good progress on its programme of reform.

**5.20** The Department will always fulfil its responsibility to provide care and protection for those who, through their illness or disability, are genuinely unable to express needs and wants or exercise control. Nonetheless, the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse. That is why dignity and respect must be central to everything that is done in social care.

**5.21** The purpose of the work of the Directorate is to improve the quality of people's lives through:

- enabling people to live as independently as possible;
- enabling people to exercise choice and control over the support they receive; and
- the promotion of high-quality, safe services.

**5.22** In 2007-08, the Department has achieved these outcomes in the following ways.

## Enabling people to live as independently as possible

**5.23** By reforming social care services, the Department can do more to help people at earlier stages of their lives or illness or disability. This will give people a greater chance of retaining or improving their independence.

*"It's easier, because I feel like I've got someone helping me to be myself." Kate, 31, is finally living independently in Barnsley with the help of a personal assistant.*

## Prevention and early intervention

### Partnerships for Older People Projects

**5.24** The 2004 Spending Review provided ring-fenced funding of £60 million (£20 million in 2006-07 and £40 million in 2007-08) for councils with social services responsibilities to establish locally innovative pilot projects in partnership with PCTs, the voluntary, community and independent sector.

**5.25** The pilots are focused on demonstrating improvements in the following three key areas, which support delivery of two key Public Service Agreement (PSA) targets, those on long-term conditions and supporting vulnerable older people:

- Providing more low-level care and support in the community to improve the health, well-being and independence of older people, preventing or delaying the need for higher-intensity and more costly care.
- Reducing avoidable emergency admissions and bed-days for older people.
- Supporting more older people to live at home or in supported housing such as sheltered or extra care housing, as opposed to in long-term residential care.

**5.26** Collectively, the pilots will demonstrate 'what works, for whom, where and in what circumstances'. The Department is funding a national evaluation to capture this. An interim report of progress from the national evaluation team in October 2007 highlighted some early findings:

- With some important caveats, there are early indications that POPP pilots are having a significant effect on reducing hospital emergency bed-day use when compared with non-POPP sites.
- The initial findings show reductions in emergency bed days against trend that would produce an average potential cost saving in the order of for every £1 spend on POPP, £1 will be saved on hospital bed-days.

- POPP projects potentially bring benefits by reducing avoidable hospital admissions. Benefits accrue from the savings that could be released from a reduced use of hospital services, and also from the better outcomes people might experience from staying at home.
- Pilot sites are reporting improved access for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
- Partnerships between statutory organisations and the community and voluntary sectors have improved if compared with the reported quality of partnerships prior to the initiation of POPP.
- Pilot sites are reporting that older people's involvement has increased within steering groups, commissioning, recruitment, provision and evaluation.
- There is better integration of older people's health (including mental health) and well-being needs within the wider strategic agenda.

**5.27** A further interim report of progress is due in October 2008 and the Department expects it to explore older people's reported quality of life alongside an analysis of cost-effectiveness.

**5.28** At the other end of the spectrum, there are issues about how the Department supports and cares for those with very complex needs, including those that may be nearing the end of their life.

## National Service Framework for Long-term Conditions

**5.29** The Department published *The National Service Framework for Long-term Conditions* (NSF) in March 2005 with a ten-year implementation period. It sets 11 quality requirements to improve treatment, care and support from diagnosis to the end of life for people with neurological conditions.

**5.30** It is estimated that, at full implementation in 2015, the annual cost of providing services will be £511 million, which will be met from general

funding allocations. Evidence shows that this expenditure could lead to cost savings of between £550 million and £970 million through investment in improved and appropriate services leading to better outcomes and a reduced need for ongoing health and social services support.

**5.31** The Department has made significant progress centrally over the last three years in:

- aligning the NSF with key programmes, e.g. *Our Health, Our Care, Our Say*, the personalisation and choice agendas, the 18-week referral-to-treatment time, and the End-of-Life Care Strategy;
- taking forward neurology-specific initiatives and developing underpinning tools and guidance to support local service commissioners and deliverers; and
- working with the Care Services Improvement Partnership (CSIP) to deliver appropriate services.

**5.32** To support local implementation of the NSF, the Department has developed *National Support for Local Implementation*, a resource tool for health and social care practitioners, which provides a resumé of the tools, guidance and resources that have been produced since the NSF was published, and makes the links to broader departmental work programmes that can support local implementation. *National Support for Local Implementation* is being finalised and will be published on the Department's website.

**5.33** The Department has completed the bulk of national work on implementing the NSF. Responsibility for delivery now rests with health and social care locally.

## Independent living for disabled people

**5.34** For the Department of Health, the priority of the Government's report *Improving the Life Chances of Disabled People* (Prime Minister's Strategy Unit, January 2005) is to deliver the recommendation that, by 2010, each locality should

have a user-led organisation modelled on existing centres for independent living. The Department has instigated a range of work in partnership with disabled people, their families and their organisations to map the current position, identify barriers to delivery and develop proposals to deliver this objective.

**5.35** Achieving the life chances recommendation is dependent on the initiative and commitment of disabled people across the country. To support this, the Department has set up the User-led Organisations Development Fund of up to £850,000 in 2007-08, offering user-led organisations the opportunity to become a User-led Action and Learning Site. The emphasis is on user-led organisations themselves developing practical solutions locally, and sharing these with others.

**5.36** It is already known that one way of enabling disabled people to live independently in their own homes is by getting the support right. For most people, this will be a combination of services and facilities pulled together as a 'care package'. For many people, an important component of any package is the right equipment, especially where it reduces unnecessary reliance on a family member or a friend.

### **Preventative Technology Grant**

**5.37** The Department established the Preventative Technology Grant (PTG) to enable councils to support people to remain in their own home. The purpose of the grant is to bring about change in the way that organisations design and deliver services to prevent a loss of independence and maintain the well-being of people in their own homes.

**5.38** The grant totals £80 million over two years (£30 million in 2006-07 and £50 million in 2007-08). Councils can use it for purchasing equipment and services, undertaking service redesign and building the local infrastructure needed to support telecare.

**5.39** The implementation of the PTG over its two-year lifespan (2006-07 to 2007-08) has been good. The funding provided by the PTG has continued to support the mainstreaming and embedding of telecare services as well as delivering significant numbers of additional telecare users.

**5.40** An analysis of the 2006-07 returns by the CSIP showed 83,742 new users. This figure broadly reflects PTG expenditure and exceeds the Department's indicative target of 60,000 new users in the first year of the grant.

**5.41** The number of new users is extremely encouraging in the context of the PTG target of 160,000 over two years.

**5.42** There are many examples of the impact that the PTG has had in supporting the mainstreaming of telecare services. For example, local authorities such as South Gloucestershire, Kent, Cheshire, Lancashire, Newham, Croydon and Southwark have been able to use the new technologies to help carers of people living with dementia.

**5.43** The PTG has enabled Stoke-on-Trent Council and partners to set out a four-year roadmap to take telecare forward. There are currently 20 people with telehealth units. Extra care housing, PCT walk-in centres and some GP surgeries are installing further units. The number of units community matrons use will increase to 50. The service aims to make available some form of telecare over a four-year period to up to 20,000 people.

**5.44** Telecare provision in Sunderland has progressed considerably. It reflects a significant degree of investment and modernisation of a broad range of services. The use of telecare has provided improved levels of responsiveness, reassurance and security for the users of services and their families. The long-term benefits of the systems are proving to be cost-effective and are providing the kinds of service that people want.

## Personalisation – enabling people to exercise choice and control over the support they receive

### Putting People First

**5.45** The concordat *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care* sets out the cross-sector commitment to personalising public services and the need for the state to empower citizens to shape their own lives and the services they receive.

**5.46** Six government departments and a wide range of external stakeholders and agencies signed this, demonstrating the commitment to independent living for all adults. It is unique in establishing a collaborative approach between central and local government, the sector's professional leadership, providers and the regulator.

**5.47** It articulates the common aims and values that will guide all the participants in modernising adult social care. It signals the recognition across the sector of the need to work across shared agendas with users and carers to transform people's experience of local support and services. It shifts the focus of care and support, across the spectrum of need, away from intervention at the point of crisis to a more proactive and preventative model centred on improved well-being, with greater choice and control for individuals. It builds on work the Department had already begun as part of delivering *Our Health, Our Care, Our Say*.

### Individual Budgets Programme pilot

*“By the end of the process, I felt like I was really in control...”* Cindy, a wife and mother of three, has written her own support plan and hired a personal assistant to help her cope with her blindness.

**5.48** The idea behind the individual budget concept is to enable people needing social care and associated services to design that support and to give them the power to decide the nature of the services

they need. The concept builds on the successful features of direct payments and on other initiatives to develop self-directed care, most notably the In Control Project that was jointly developed by Mencap and the Valuing People Support Team.

**5.49** The Department of Health, Department for Communities and Local Government and the Department for Work and Pensions have worked together to develop a starting model for individual budgets. There is a wide range of income streams that could potentially be included in an individual budget, but the local authorities taking part in the pilot projects include at least social care and one, or more, of the following funding streams:

- council-provided social care services;
- Independent Living Funds;
- Supporting People;
- Access to Work;
- Disabled Facilities Grant; and
- Integrated Community Equipment Services.

**5.50** Thirteen local authorities piloted individual budgets: Barking and Dagenham, Barnsley, Bath and North East Somerset, Coventry, Essex, Gateshead, Kensington and Chelsea, Leicester, Lincolnshire, Manchester, Norfolk, Oldham and West Sussex. The pilot programme ended on 31 December 2007.

**5.51** In order to ensure that the pilots were fully testing the evidence, evaluation was built into the process from the outset. The three departments' ministers will have a first draft of the evaluation report later in 2008.

### Personal budgets

**5.52** This is the term used in the concordat *Putting People First* to describe an upfront, transparent allocation of adult social care resources to individuals. The intention is that, in the future, everyone eligible for statutory support in social care will know how much resource is available to meet

their needs, enabling them to exercise more informed choice and greater control of that support.

### Extension of direct payments

**5.53** *The Health and Social Care Bill*, introduced to Parliament in October 2007, contains a clause to extend direct payments to those people who may lack capacity, including some adults with head injuries, some people with dementia and severely disabled children moving into adulthood who, under current legislation, lose their direct payment. This delivers on the commitment given in the 2006 White Paper *Our Health, Our Care, Our Say*. Subject to Parliament, the Department will introduce regulations and amended guidance later in 2008.

### Transforming community equipment services

**5.54** On 22 June 2006, the Prime Minister announced that the Department of Health would undertake a radical review of community equipment and wheelchair services for adults and children – the Transforming Community Equipment and Wheelchair Services Project – helping to make independence a reality.

**5.55** The new retail model aims to change the way in which community equipment is supplied to people in England. The design of the new service puts the individual at its heart with improved accessibility to services, improved dependability and improved choice.

**5.56** The programme is currently working with lead partners (Cheshire and Oldham) to develop the design of the model and tools to enable other services to implement from April 2008.

## The promotion of high-quality, safe services

### Dignity in Care Campaign

**5.57** The Department leads the campaign, launched in 2006, and a wide range of key stakeholders support it. It aims to create a national

debate about dignity and send a strong signal to care services about the importance of dignity in the care of older people and other groups.

**5.58** The Department extended the campaign to mental health services in August 2007. That extension covers the specific areas of tackling stigma, in-patient mental health services and older people's mental health. The next step will be to extend this campaign to all client groups and move from a centrally driven campaign to one that is more decentralised and devolved, driven by local ambition. More information on the campaign is available at: [www.dh.gov.uk/dignityincare](http://www.dh.gov.uk/dignityincare).

**5.59** The campaign followed a series of ministerial listening events, which were held to hear from staff, people who use services and their carers about their experiences of care services. Over 700 people took part in either the listening events or the subsequent on-line survey.

**5.60** As part of the campaign, the Department issued the Dignity Challenge, which sets out the national expectations of services that respect dignity.

**5.61** It also invited local staff and the public to join a network of Dignity Champions, who are forming an army of volunteers willing to take action locally to improve the way older people experience care services. To date, over 1,300 people have signed up as Dignity Champions.

**5.62** The Department held the first live on-line webchat on 14 November 2007 (the first anniversary of the campaign launch) and has proposed that further webchats will follow. The Department has updated its on-line *Dignity in Care Practice Guide* (Social Care Institute for Excellence, Practice Guide 9) aimed at supporting staff to help address areas of concern for older people, and to spread best practice. This includes specific sections on promoting privacy in care settings.

**5.63** The campaign has also highlighted concerns around nutritional care for older people. October 2007 saw the publication of a joint Department of Health and stakeholder *Nutrition Action Plan* (DH et al, October 2007) aimed at addressing the issues that exist in this most fundamental aspect of care.

**5.64** A number of national policy programmes underpin the campaign. These include improving the patient environment, strengthening adult protection arrangements and inspection and regulation regimes as well as measures to ensure the care workforce is registered and better trained to deliver dignity in care. This includes £128 million of capital money being committed to improving the environment for older people in hospices and care homes.

**5.65** The Department has a wider piece of work creating system reform for older people. For some people with complex needs and their families, a major issue is not just who provides what service but who pays for it. The fact that NHS care is free at the point of need and social care is means tested continues to be an issue in the delivery of services. The Department has invested considerable resources in arriving at an equitable solution.

### **Continuing healthcare and NHS-funded nursing care**

**5.66** Continuing care is a complex and highly sensitive area which can affect people at a very vulnerable stage of their lives. To make the system fairer for everyone, the Department has produced new national guidance that sets out a single, national system for determining eligibility for NHS continuing healthcare. This will lead to fair and consistent access to NHS funding across England, irrespective of location, so that people with equal needs should have an equal chance of getting all their care paid for by the NHS.

**5.67** The Department published the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England* on 26 June

2007, following a public consultation. The framework sets out a single, national system for determining eligibility for NHS continuing healthcare and there is now a single band for NHS-funded nursing care. The Department implemented the new framework on 1 October 2007.

**5.68** The Department is also continuing to pursue the agenda set out in the Government's *Improving the Life Chances of Disabled People*.

### **System Reform for Older People Project**

**5.69** The Department has built on the *National Service Framework for Older People* (DH, May 2001) and the National Director for Older People's reconfiguration report on redesigning services for older people with complex needs, *A Recipe for Care – Not a Single Ingredient* (DH, January 2007). The system reform project has sought to develop the evidence base around increased efficiency and improved outcomes in the care of older people to inform ongoing activity within the Department and the service.

**5.70** A particular focus of the work has been redesign of acute and intermediate care pathways for older people with complex needs, focusing in particular on older people with falls. A stakeholder workshop was organised to address some of the key issues and outcomes and will inform the NHS Next Stage Review and the Care Closer to Home Project. The Department also published best practice guidance on urgent care pathways for older people with complex needs.

*"I'm not an old lady in my head. I still want to be in the swing of things and, with the right help, I manage smashing. I've got my life back."* Brenda, 68 and living in Oldham, now has personal assistants to help her manage her health condition.

## National Dementia Strategy and Implementation Plan

**5.71** The Department has responded to public concerns about services for people with dementia by developing a National Dementia Strategy and Implementation Plan.

**5.72** Dementia is one of the main causes of disability later in life, ahead of some cancers, cardiovascular disease and stroke. It is estimated that there are currently some 560,000 people in England with dementia. An ageing population means that numbers of people with dementia are set to rise to over 750,000 in England by 2020.

**5.73** According to National Audit Office (NAO) sources, the direct costs of dementia to the NHS are approximately £3.3 billion per year. Direct costs to social care are also significant. Some 65 per cent of people in long-term residential care and many of the people delayed in hospital have dementia. The overall annual economic burden is estimated to be £14.3 billion per year. Furthermore, the NHS in England spent some £60.9 million on dementia drugs during 2005. All of this indicates the scale of the social and economic cost of dementia, and the extent to which this will rise in the future.

**5.74** The NAO published a report on *Improving Services and Support for People with Dementia* on 4 July 2007. This highlighted a number of areas where the Department can make improvements, focusing on awareness, diagnosis and the quality of care provided. This report, together with the Alzheimer's Society *Dementia UK* report, provided the evidence base for government action. On 6 August 2007, the Department announced the launch of a one-year project to develop a National Dementia Strategy and Implementation Plan.

**5.75** The objectives of the project are to develop a National Dementia Strategy and Implementation Plan that will address the following three main themes:

- improved awareness;
- early diagnosis and intervention; and
- improving the quality of care for dementia.

**5.76** The Department published the first product of the strategy work programme, *Strengthening the Involvement of People with Dementia: A Resource for Implementation*, on 27 November 2007. It designed this toolkit to support practitioners and commissioners to engage with people who have dementia, as well as helping people who have dementia, and their carers, to understand how they can become more involved in the planning and delivery of their care.

## Mental Capacity Act

**5.77** Relevant to people living not only with dementia but also with a wide range of impairments is the implementation of the *Mental Capacity Act*.

**5.78** The aim of the *Mental Capacity Act* (MCA) is to provide a statutory framework to empower and protect people who lack capacity to make decisions, for example some people with dementia, learning disabilities, mental health problems, and stroke or head injuries.

**5.79** The MCA introduced the Independent Mental Capacity Advocacy (IMCA) service, as a statutory service. The Department successfully launched this on 1 April 2007. Its aim is to support and represent people who lack the capacity to make certain important decisions, if they have no one to help them make these decisions.

**5.80** More than 4,000 of the most vulnerable people benefited from the IMCA service during the first nine months of its operation in 2007.

## Mental Capacity Act: Deprivation of Liberty Safeguards Implementation Programme

**5.81** To meet European Court of Human Rights requirements, Section 50 of the *Mental Health Act 2007* has amended the MCA. This amendment adds provisions for the lawful deprivation of liberty of a person with a mental health disorder (in a care home or in-patient setting) who lacks capacity to consent, if it is in that person's best interests. The process by which agencies lawfully deprive someone of their liberty will safeguard those who lack capacity from arbitrary or unlawful deprivation of liberty.

**5.82** The prime objective of the programme is to support the roll-out of safeguards compliant with the European Convention on Human Rights.

**5.83** The Department estimates that 2,000 best interests assessors, 4,000 mental health assessors and 500 independent mental capacity advocates may need to be trained. Discussions continue with key organisations, including the NHS Confederation, Association of Directors of Adult Social Services and the Royal College of Psychiatrists.

**5.84** Central to the Department's policy agenda, as across all of government, is putting citizens at the heart of all that is done and building sustainable communities. The Department's commitment to the greater personalisation of services is crucial to achieving the transformation of adult social care, most recently articulated in the concordat.

## Carers

**5.85** This year, the Government has renewed its commitment to the vast numbers of informal carers, those family members, friends and neighbours that many people rely on.

**5.86** *Our Health, Our Care, Our Say* signalled the New Deal for Carers. On 21 February 2007, the Government formally launched details of the New Deal for Carers. The Government announced

a multi-million pound package of support for carers through a range of measures. It also announced 'the most far-reaching national consultation ever on the future of carers, to encourage the fullest engagement of the very people who would benefit most'. The New Deal for Carers is in four strands: the review of the Prime Minister's 1999 *Strategy on Carers*; an information helpline; an Expert Carers Programme; and money for emergency cover for carers.

**5.87** On 3 September 2007, the Prime Minister, announced a Standing Commission on Carers.

## Strategy review

**5.88** The review of the Prime Minister's 1999 *Strategy on Carers* is a cross-government review involving officials and ministers from the Department of Health, Department for Work and Pensions, Government Equalities Office, Department for Children, Schools and Families, Department for Innovation, Universities and Skills, Department for Business, Enterprise and Regulatory Reform, HM Treasury, Department for Communities and Local Government, Welsh Assembly and Scottish Government.

**5.89** Work on the review of the strategy has taken place in two parallel strands. Firstly, there has been a comprehensive public consultation, which ran from 13 June 2007 until 11 January 2008. Secondly, work has taken place in four taskforces looking at four key issues relating to carers: health and social care; income; employment; and equalities.

**5.90** The strategy will be published in late spring 2008.

**5.91** The web-based consultation was open for just under four months from 13 June until 30 September 2007 with over 13,000 visits made to the site. Some 1,760 ideas were submitted and over 33,000 rankings (of those ideas) were made.

**5.92** The Department held nine regional events, with 50 carers at each one.

**5.93** It held the deliberative events in London and Leeds on 21 and 26 November respectively. In addition to 80 carers, there were 50 members of the public and 20 professionals (those who deliver the services) in attendance. There was, additionally, a deliberative event for children held on 24 November on the HMS Belfast.

**5.94** The final consultative event for the strategy took place on 11 January in Leeds. Approximately 70 carers attended and there was a strong ministerial presence.

### **Information service and helpline**

**5.95** Carers need accessible and reliable information that enables them to access services and support for themselves and the person they care for. Presently, a number of local and national services exist to provide such support to carers. What is lacking is a well-funded, comprehensive, nationally available information service.

**5.96** In recognition of this, the Department is establishing the carers' information service and helpline. The service will provide, via a website and a single national telephone number, access to the information so needed by carers. It is expected that the service will provide carers with assistance directly, or refer onto a more appropriate service.

**5.97** The Department has now developed the specification of the service and the tendering process will start in May with the contract likely to be awarded in autumn 2008. The Department anticipates the service being in place towards the end of 2008, and it is making up to £2.8 million a year available to support this service.

### **Expert Carers Programme**

**5.98** The Department acknowledges the huge contribution carers make to society, but it is a role that people often take on suddenly and without

preparation. In recognition of this, the Department is establishing an Expert Carers Programme.

**5.99** In December 2007, the Department awarded a contract to a consortium comprising the Princess Royal Trust for Carers, Carers UK, Crossroads, Partners in Policy-making and the Expert Patient Programme, to lead the delivery and ongoing development of the Expert Carers Programme. The contract commenced on 1 January 2008.

**5.100** It is expected that the first face-to-face training for carers will be in place by August 2008, and the distance-learning version by December 2008. The Department is making up to £4.65 million per annum available to fund the programme.

### **Emergency cover**

**5.101** From 1 October 2007, the Department made £25 million available to local authorities in England to ensure that each council puts plans in place to provide short-term cover for carers in emergencies.

**5.102** The Department has issued guidance to councils about how they are expected to use these additional funds to set up systems to support carers needing cover in a crisis or emergencies. The Department will add the new grant, from 2008 onwards, to the Carers Grant.

### **Standing Commission on Carers**

**5.103** The Commission had its first meeting on 12 December 2007 and has had three subsequent meetings in January and February, one of which was attended by the Prime Minister. Further meetings are planned in spring 2008.

**5.104** The Department will soon be making longer-term appointments to the Commission in accordance with guidance issued by the Office of the Commissioner for Public Appointments.

It envisages that these appointments will take effect from summer 2008.

## Adult social care resources and funding

**5.105** It is the responsibility of local authorities to allocate resources for adult social care. The Department for Communities and Local Government distributes the majority of resources for adult social care on behalf of government. This contributes to the resources available to local authorities alongside the collection of council tax and fees and charges. In addition, the Department of Health allocates a range of specific grants to meet specific policy objectives.

**5.106** Local authorities have been set efficiency targets of 3 per cent, and adult social care services will support the delivery of this target. The Department of Health funds the Care Services Efficiency and Delivery Team to support local authorities in their work to deliver services in a more efficient way. They have developed a series of products and toolkits to assist authorities.

**5.107** In order to support the delivery of social care performance improvement and transformation, the Department is investing more resource through its regional presence, which will work directly with local authorities and PCTs as well as across other regional partners, including Government Offices for the Regions and strategic health authorities.

**5.108** For a more detailed breakdown of Personal Social Services expenditure and resource provision, see chapter 9.

# 6 Research and Development

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## Introduction

**6.1** This chapter provides an overview of the Government's health research strategy, *Best Research for Best Health*, and the progress the Department has made in implementing this strategy and taking forward the recommendations of the Cooksey report.

## Strategy

**6.2** The Government's aims are to:

- make the UK the best place in the world for health research, development and innovation;
- ensure that the NHS is equipped and able to make a key contribution; and
- realise the potential of the NHS to support research that improves national health and increases national wealth.

**6.3** The Department's research and development (R&D) budget for the NHS for 2007-08 was £733 million – 7.7 per cent higher in real terms than in 2006-07. This pattern of increases in government funding for health research is set to continue across the 2007 Comprehensive Spending Review period. It will lead to a budget of £1.03 billion for the Department of Health and a total government investment in health research, including funding for the Medical Research Council (MRC), of over £1.7 billion per annum by 2010-11.

**6.4** Further, in 2007-08, the NHS R&D programme was allocated a capital budget of £55 million to invest in Biomedical Research Centres and Clinical Research Facilities.

**6.5** The Department is making rapid and substantial progress with implementing the Government's health research strategy, *Best Research for Best Health* (DH, January 2006). This aims to create a health research system in which the NHS supports outstanding individuals working in world class facilities, and in which leading-edge research focused on the needs of patients and the public is conducted.

**6.6** The Department established the National Institute for Health Research (NIHR) in April 2006 to achieve these aims. The NIHR brings together existing NHS research units and programmes with major developments that form the main planks of the strategy. It forged new partnerships with both academia and industry, sharpened the focus on clinical trials and evaluations, and is working to reduce bureaucracy.

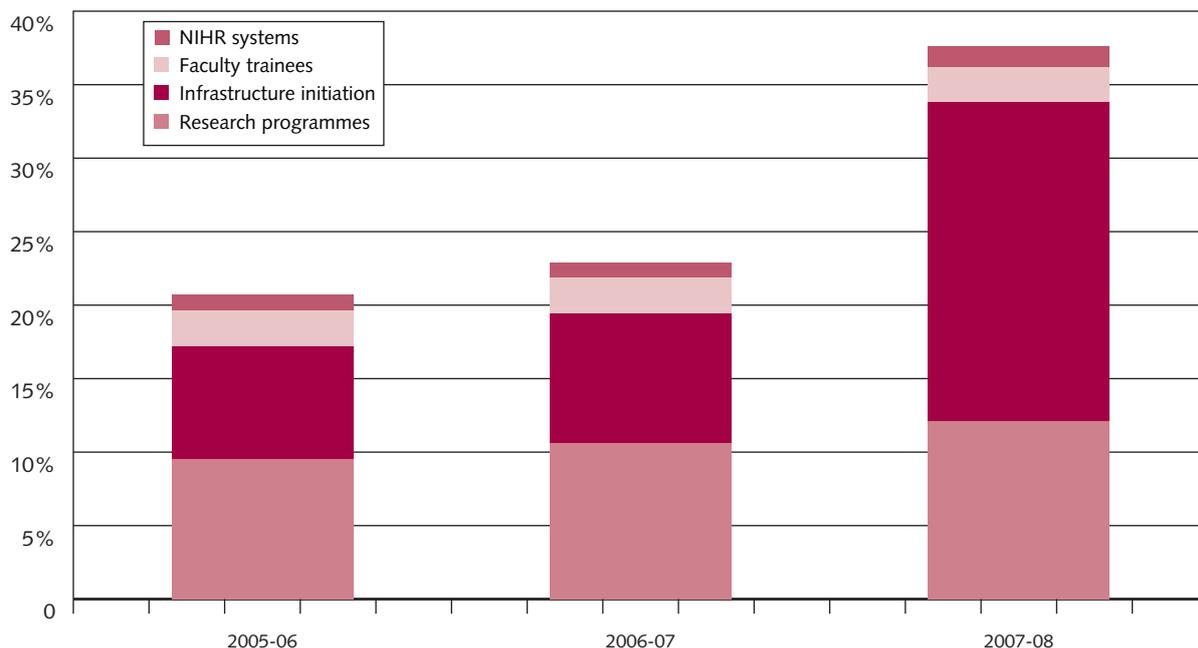
**6.7** A fundamental principle is that government expenditure on R&D should result in the more effective translation of health research, into health and economic benefits for the UK, and that it should deliver quality and value for money awarded contestably and transparently through rigorous competition.

**6.8** NHS R&D funding supports transition toward this new system. The Department has continued to allocate transitional R&D funding to all previous recipients of NHS R&D support funding, but at reducing levels over the three-year transition period from April 2006 to March 2009 to enable the NHS to plan for the effect of transition. At the same time, an increasing amount of NHS research funding has been awarded through new schemes for agreed purposes. The total distributed was divided between the principal funding streams, shown in **figure 6.1**.

**6.9** The transition period will be complete by the end of 2008-09 when NHS research funding will be dedicated to the schemes taken up or introduced through the NIHR.

**6.10** The Office for Strategic Coordination of Health Research (OSCHR), created in response to Sir David Cooksey's review of UK health research funding, was also established in 2007-08, under an agreement and joint funding between the Department of Health and the Department for Innovation, Universities and Skills.

**Figure 6.1: Percentage of NHS R&D budget spent on NIHR programmes**



## Best Research for Best Health – progress with implementation

**6.11** A full account of progress since the publication of *Best Research for Best Health* is given in *Transforming Health Research: The First Two Years* (DH, January 2008).

*“This impressive progress report demonstrates that our vision of transforming health research in this country is starting to be realised.”*

*(The Prime Minister, Gordon Brown)*

### Research

**6.12** To ensure that all NIHR research provides tangible benefits for patients, the Department is expanding existing programmes and introducing new funding streams.

**6.13** NIHR Evaluation and Trials, which includes the Health Technology Assessment (HTA) Programme, works with organisations such as the National Institute for Health and Clinical Excellence (NICE) and the UK National Screening Committee, to ensure that research findings drive

real changes in working practices in the NHS and patients’ lives. The budget will increase to £70 million by 2009-10.

**6.14** The NIHR Service Delivery and Organisation Programme commissions research to underpin improvements in the quality of patient care and the efficiency of NHS health services. The annual budget is planned to grow to £12.5 million by 2009-10, taking into account new areas of work including public health.

**6.15** New funding with a total value of £45 million was awarded to 29 research programmes under the NIHR Programme Grants for Applied Research. Each programme is a series of interlinked projects on conditions that cause significant impact on the NHS. The first funding round awarded grants for research into mental health, medicines for children, diabetes, stroke and dementias, neurodegenerative disease and neurology. When it reaches full capacity, this funding scheme will have an annual budget of £75 million.

**6.16** The NIHR Research for Patient Benefit (RfPB) Programme awards grants designed to promote health, prevent disease, overcome illness and improve patients' everyday experience of the NHS. Funding is building to £25 million per year by 2009-10. Another new programme supplements RfPB: Research for Innovation, Speculation and Creativity (RISC). This is for research proposals that could lead to a step change in the care and management of patients. Seven RISC grants were awarded in September 2007 and spending is planned to increase to £5 million per year.

**6.17** Another new programme, NIHR Invention for Innovation, brings together the work of several smaller programmes to help accelerate the development of new healthcare technologies and devices.

**6.18** The NIHR also provides core funding for the UK Cochrane Centre, one of 12 established worldwide, and contributes to the Cochrane Collaboration, which has an international reputation for its reviews into the effects of healthcare interventions.

## Systems

**6.19** Efficient and robust ethical and governance systems that safeguard patients and the public without unnecessary bureaucracy are essential to meet the challenges of health research in the 21st century. To address this, research management systems have been updated, administrative and regulatory procedures governing trials and studies have been simplified, and research ethics committee structures have been strengthened.

**6.20** The Department launched the National Research Ethics Service in March 2007. As part of the National Patient Safety Agency, it provides UK-wide management support for some 120 research ethics committees.

**6.21** A new Research Passport system was launched in October 2007. Pre-engagement checks

(such as criminal records and occupational health) carried out by non-NHS employers are now shared with NHS organisations, reducing duplication and speeding up the process of getting research under way.

**6.22** In partnership with the UK Clinical Research Collaboration (UKCRC), the Department has established a national Regulatory and Governance Advice Service. Rolled out across the UK in April 2007, it links front-line advisers in the NIHR clinical research networks with national regulatory experts and other resources.

**6.23** The Research Capability Programme, a long-term initiative designed to support secondary use of patients' health records for health research purposes, was launched in September 2007 by the NIHR in partnership with NHS Connecting for Health.

**6.24** Meanwhile, the NIHR Coordinated System for gaining NHS Permission became fully operational from April 2008. It will ensure that clinical research studies are approved quickly through a consistent and streamlined process while addressing all quality assurance and statutory research requirements.

## The National Institute for Health Research Faculty

**6.25** The National Institute for Health Research (NIHR) Faculty brings together, for the first time, the people funded by the Department to support applied, people-focused health and social care research. The goal is to attract, develop and keep the best research leaders, senior researchers and collaborators working in the NHS in England.

**6.26** The first cohort of NIHR Senior Investigators – health researchers with the most substantial research portfolios in the NHS in England – will be appointed from April 2008.

**6.27** NIHR Traineeships are awarded to support the academic training paths of all health and

social care professionals. In 2007-08, the budget for NIHR Trainees was £16.3 million with 186 Academic Clinical Fellows and 70 Clinical Lecturers appointed.

### Health research infrastructure

**6.28** The NIHR clinical research networks were set up to support a portfolio of clinical trials and studies throughout England and promote patient and public involvement in health research. They have significantly increased the number of participants taking part in clinical trials, improved their speed, quality and coordination, and strengthened NHS links with industry. The Department invested £66 million in the networks in 2007-08.

**6.29** The NIHR research networks comprise:

- the Primary Care Research Network (PCRN);
- six topic-specific clinical research networks (cancer, dementias and neurodegenerative diseases, diabetes, medicines for children, mental health, and stroke); and
- the Comprehensive Clinical Research Network (CCRN) which will be fully operational from April 2009.

**6.30** Eighty-five per cent of NHS consultations take place in primary care settings. The PCRN, together with a new NIHR School for Primary Care Research based in the leading academic centres for primary care research in England, are focusing on research to increase the evidence base and improve everyday practice in primary care.

**6.31** Eleven new NIHR Biomedical Research Centres began operating across England in April 2007. They share more than £450 million over five years to transform their scientific breakthroughs into life-saving treatments for patients. A further Biomedical Research Centre was created and 12 new NIHR Biomedical Research Units, researching health areas not covered by the centres, also became operational in April 2008.

**6.32** Two NIHR Research Centres for NHS Patient Safety and Service Quality have been awarded more than £9 million over five years.

**6.33** The Department has invested in technology and cutting-edge research infrastructure in 2007. This includes:

- £6 million in dedicated NHS Clinical Research Facilities for Experimental Medicine;
- running costs of £7.1 million for a small number of NIHR Developmental Clinical Research Facilities established in collaboration with the major health research charities, the MRC and the other UK health departments;
- £14 million over two years to cover the support costs of diagnostic imaging platforms in 25 NHS trusts; and
- £3 million each year for the next five years in 15 Experimental Cancer Medicine Centres.

**6.34** In October 2007, the Department launched Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) to address key recommendations of the *Cooksey Report* and the Chief Medical Officer's high-level review of clinical effectiveness. A total investment of up to £50 million in the pilot phase will lead to each CLAHRC receiving between £5 million and £10 million over five years.

### Working with stakeholders

**6.35** The NIHR Advisory Board, chaired by David Nicholson, Chief Executive of the NHS, includes chief executives of NHS trusts and strategic health authorities as well as leaders of academic organisations. It provides advice and support on the strategic development of *Best Research for Best Health* and of the NIHR.

**6.36** Chaired by the Department, the UKCRC works through partnership to re-engineer the clinical research environment in the UK. This is a key forum for partnership working, particularly with industry and other funders.

**6.37** The Department is committed to involving patients and members of the public in research at every step. The INVOLVE Programme ensures that patients and the public are integrated into all research proposals, from setting research priorities to ensuring that patients benefit from research findings across the whole range of NHS settings. In 2007-08, INVOLVE agreed a new strategic plan to establish long-term priorities and appointed 17 new members to its working groups to take this forward.

**6.38** In October 2007, the first nationally approved tripartite model Clinical Trial Agreement was launched for use between contract research organisations, NHS trusts and pharmaceutical companies to speed up the contracting process for industry-sponsored trials.

### **Policy Research Programme**

**6.39** The Policy Research Programme, with an annual budget of £33 million, continues to provide the evidence base for policy development and evaluation of policy implementation in health and adult social care.

### **Office for Strategic Coordination of Health Research (OSCHR) and the strategic plan for health research**

**6.40** The OSCHR has been created in response to the Cooksey review of UK health research funding. Its mission is to facilitate more efficient translation of health research into health and economic benefits in the UK through better coordination of health research and more coherent funding arrangements to support translation.

**6.41** A key part of its role is to forge agreement between the Department of Health and the Department for Innovation, Universities and Skills on the overall strategic plan for health research, and on the allocation to the MRC and the NIHR of over £1.7 billion of government funding (the single health research fund) to deliver the strategic plan which is planned for publication in 2008.

## 7 Workforce

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## Introduction

**7.1** This chapter includes information on both the health and social care workforce. It looks at the modernisation and development work in the areas of education and training, regulation, and pay and pensions.

**7.2** Over the past six years, there has been significant investment to expand the workforce and embed considerable contractual changes. The Department has played a supporting role to the service to secure the right number of appropriately trained and motivated staff to deliver high-quality care for patients and users. The objective now is to follow through the gains of recent years and facilitate the transition to new models of health and social care built around the needs of the patients, their families and carers. Greater workforce integration between the NHS, independent healthcare sector and social care will form a key theme over the remainder of the decade.

**7.3** The immediate challenge for the Department is to strengthen leadership capability and support the NHS to harness the benefits from pay modernisation and more productive ways of working. The Department will continue to work closely with employers, trade unions, the education sector and patient and user groups, so that future workforce strategies are built on engagement and shared purpose. The benefits achieved through the Social Partnership Forum and the National Stakeholder Forum will be built upon in 2008.

**7.4** Knowing what matters to staff and engaging them in how to deliver the best possible care is vital to achieving better outcomes for patients. The Workforce Directorate has formed the People Matters Executive Group to ensure that a national workforce framework is in place to strengthen local decision-making in this area. It is one of the five conversations redefining the relationship between the Department of Health and the NHS so that

future policies are created in partnership, rather than through central targets.

**7.5** The People Matters Executive Group supports and improves processes to strengthen workforce availability, talent and leadership development, staff involvement and employment conditions. It aims to ensure that staff who deliver NHS services have what they need to improve lives for patients and users. With membership drawn from the strategic health authority (SHA) directors of workforce and the Department, the Executive Group will identify priorities, take decisions on existing policies and make recommendations on new policies to the NHS Management Board. Policy groups are being established which would link with external stakeholders.

## Developing and strengthening leadership in the NHS

**7.6** In consultation with key stakeholders, the Department is defining and developing a model of excellent leadership for implementation within the NHS. It is intended that this model will exist at individual, organisational and system levels. The model will be clear in setting out the vision for NHS services as defined by clinicians, offering a clear improvement method to make the NHS world class, and setting out the agreed and expected behaviours necessary to drive results.

**7.7** In parallel with the development of the leadership model, an investigation into methods through which a talent pool of potential leaders in the NHS can be increased has also been initiated. Strategies to increase the supply of potential leaders from black and minority ethnic backgrounds and non-NHS backgrounds to enrich the talent pool will form part of the investigation.

**7.8** Encouraging more clinicians to take up leadership roles as part of their normal career paths is fundamental to this work and, in order to achieve this, both the incentives and barriers that contribute

to clinicians views' of leadership and management roles in the NHS today will be examined.

**7.9** The emerging view of leadership development is that it should be explicitly linked to this leadership model and values. Funding is currently in place across a range of leadership development initiatives, the content and values of which are often more representative of leadership and management development as a core part of curriculum at all levels of professional education. This means starting leadership development at undergraduate level, continuing throughout postgraduate training and it being embedded in all careers of NHS staff right through to its top leaders.

## What matters to staff

**7.10** In order to understand the things that matter to staff better, a research project was commissioned in spring 2007. This work consisted of qualitative and quantitative research with a wide range of staff across the NHS. As a result of this work, ten things that matter to staff were revealed and these have been grouped into four main themes:

- The resources to deliver quality care for patients.
- The support I need to do a good job.
- A worthwhile job with the chance to develop.
- The opportunity to improve the way we work.

**7.11** This work forms part of a process to understand patients and the public better. It has informed the Next Stage Review and the Department is working with partners to see how the findings can help improve staff engagement at a local level.

## NHS Staff Survey

**7.12** The NHS Staff Survey, while it has a different emphasis to the what matters to staff research, is also a key source of information relating to staff engagement in the NHS.

**7.13** The Department is working closely with the Healthcare Commission, which administers the survey, and with employers, trade unions and others to ensure that the results of the survey are used locally to drive improvement and that the survey develops to meet the changing needs of the service.

**7.14** The results of the survey are used at a national level by the Social Partnership Forum to identify priorities for action as well as by Department of Health policy sections on such areas as violence against staff and healthcare-associated infection. The Department is also improving awareness of the survey and its results within itself to help underpin policy development and delivery.

## Meeting NHS workforce needs

**7.15** Over the last ten years, the NHS in England has benefitted from an expansion in capacity at unprecedented levels. The total budget has trebled to around £90 billion per year and that has helped to increase the number of professionals working in the system delivering care to patients.

**7.16** In April 2007, over 1.3 million people were employed in the NHS, an increase of over 272,000 or 26 per cent since 1997 (headcount). There are now almost 400,000 qualified nurses and 128,000 doctors working in the NHS. This is an increase of almost 80,000 more nurses and over 38,000 more doctors than in 1997.

**7.17** Increased capacity combined with improved retention has led to continuing reductions in vacancy levels, a key indicator of staff shortages. The level of three-month vacancies (i.e. posts that have remained vacant for three months or more) has consistently fallen, with qualified nurses (including midwives) down from 3.4 per cent in March 2001 to 0.5 per cent in March 2007. The overall improvement in staffing levels has helped reduce waiting times, improve access to services and ensure the continued provision of high-quality treatment and care.

**7.18** The Department has moved away from year-on-year rapid growth in the NHS workforce to a more steady state where there is a closer match between demand and supply. The position now is one of growing self-sufficiency with the NHS developing its own workforce and reducing reliance on international recruitment. The challenge is to improve workforce planning capacity and capability to support reform, so that the NHS becomes more patient centred and more productive.

**7.19** This year, the Department has seen continuing emphasis on putting resources into the front line, with fewer managers and fewer primary care trusts (PCTs) and a rebalancing of the workforce. This has resulted in a small number of compulsory redundancies, but only as a last resort. At the end of 2007-08, there had been 2,330 compulsory redundancies, with the vast majority (around 85 per cent) in non-clinical posts. This is in the context of the total NHS workforce of 1.3 million people, which means that compulsory redundancies were less than 0.1 per cent of the total NHS workforce.

**7.20** The NHS is a very large employer, continuing to offer many opportunities and to need new staff to replace those who retire or take career breaks.

### Improving workforce systems

**7.21** Optimum strategic and operational benefits from the Electronic Staff Record (ESR) system can only be fully realised by consistent adoption of the system and full and effective use of its functionality by NHS organisations. The Department will continue to work with stakeholders and employers to identify and overcome any barriers to achieving this goal.

**7.22** The ESR is well on track to completing the implementation phase, on target and within budget. As one of the world's largest information technology implementations, it will have replaced the 29 payroll and at least 38 human resources (HR)

systems used in the NHS, and will be paying 1.3 million employees when roll-out completes in March 2008.

**7.23** Significant attention is now being focused on achieving the benefits from the ESR, including capturing its potential as an HR tool, delivering a high-quality service to users and building confidence and capability in its use.

**7.24** Work has commenced on the benefits realisation phase of the ESR and this will be a key initiative over the next year. The focus will include integration with other systems to improve information quality and completeness and to deliver further efficiencies confirming the ESR as the main source for all workforce information required by the NHS and the Department.

### Improving productivity

**7.25** Productive time is about maximising the time spent by clinical, managerial and administrative staff on activities aimed at improving services for patients – that is, working smarter, not harder. As a result of joint working with the NHS Institute for Innovation and Improvement, Integrated Service Improvement Programme and others, the Department is on course to meet the Gershon efficiency target of £2.7 billion by March 2008. The approach taken has been to encourage service planning that integrates workforce, process and technological changes, as this will maximise the benefits of the change.

**7.26** In the final year of the Productive Time Programme, the emphasis has been on local organisations delivering the service improvements. A joint team comprising the Department of Health, the NHS and HM Treasury undertook a short review of front-line activity to assess the likelihood of delivery of the productive time target in spring 2007. This exercise has given greater confidence that productive time activity is embedded as a concept and is seen as key to keeping within the budgetary, quality and policy constraints faced by

the NHS. Service improvements and reduced costs as a result of productive time activity are sustainable as they are embedded within performance management structures.

**7.27** In addition, the NHS Institute for Innovation and Improvement has continued its work on the *Delivering Quality and Value* series with the production of further products and tools to enable front-line services to improve for the benefit of staff, the organisation and patients, for example *High Volume Care (volume 2) – The Productive Ward and Productive Operating Theatre*.

**7.28** The Department has published *Delivering Quality and Value: Consultant Clinical Activity 2005-06* (DH, October 2007) and *Delivering Quality and Value: Consultant Clinical Activity 2006-07* (DH, February 2008) to enable clinicians and managers to assess the activity rates of consultants across the range of specialties.

**7.29** The Better Care, Better Value indicators have been further developed, and continue to include workforce metrics, including staff turnover, sickness absence and agency costs.

**7.30** These tools have given greater confidence, combined with the latest figures, that the productive time target will be met by the NHS.

## Modernising education and training

**7.31** Education and training programmes that reflect patient need must underpin the transformation set out in *Our NHS, Our Future: NHS Next Stage Review* (DH, October 2007). New ways of working, new treatments and procedures, a greater focus on public health and prevention, and the shift of more services into the community to reflect patient choice require a health workforce that has the right skills for new healthcare environments. The Department has therefore embarked on major reform programmes aimed at producing health professionals who can respond more readily to changing needs.

**7.32** Following the successful launch of Foundation Programmes in 2005 as the first phase of the Modernising Medical Careers (MMC) Programme, serious problems were encountered during the process for recruitment to specialty training for junior doctors in 2007. These problems caused serious distress for some doctors and their families, for which the Department has apologised. A single team for the operational management of the programme was established. Subsequently, an English MMC Programme Board, including representatives from the British Medical Association, the Royal Colleges and NHS, was established, and this board has made recommendations to ministers on the underpinning principles and future management of the MMC programme.

**7.33** The recommendations of the Programme Board, all of which have been agreed by the Department, have led to reforms to the recruitment process in England in 2008. There is to be no national computer system or application form for the 2008 process, and the process of recruitment will be managed at a local level by individual deaneries operating on behalf of SHAs in most cases. The exceptions to the local recruitment arrangements have been scrutinised and agreed by the Programme Board. One of the additional major changes for the 2008 recruitment process has been the removal of any constraint on the number of applications that a candidate can make, subject to the individual meeting the person specification requirements.

**7.34** The MMC team and Programme Board are also beginning the process of establishing the selection and recruitment arrangements for specialty training for future years.

**7.35** There are continuing discussions between the Chief Medical Officers in all four UK countries to ensure, where possible, that arrangements for selection to and the organisation of postgraduate specialty training is common to all.

**7.36** During 2007, the Department commissioned an independent review of the MMC programme, by Professor Sir John Tooke, Dean of the Peninsula Medical School. Sir John's final report was published in January 2008, and will lead to significant future changes in postgraduate medical training for 2009 and beyond. The Department is currently considering its response to the detailed recommendations in Sir John's report.

**7.37** *Modernising Nursing Careers: Setting the Direction* (DH, September 2006) put forward comprehensive plans for a more flexible and competent workforce; new career pathways for nursing; preparing nurses to lead in a changed system; and updating the image of nursing. An extensive UK-wide programme of work has been set up with activity in England closely aligned to the NHS Next Stage Review. Because of this work, the Department has recently undertaken a consultation on a new careers framework for post-registration careers built around patient care pathways, and initiated a consultation on the future of pre-registration education by the Nursing and Midwifery Council. More detailed proposals for implementation will be developed throughout 2008.

**7.38** A further work programme – Modernising Allied Health Professional (AHP) Careers – is under way to develop a competence-based career framework for AHPs and related support staff. The framework is underpinned by learning design principles developed by the Sector Skills Council and Skills for Health.

**7.39** Modernising Scientific Careers is the programme within the Department designed to ensure flexibility, sustainability and modern career pathways fit to address the future workforce needs of the NHS for healthcare scientists as it takes forward *Our NHS, Our Future*. The programme is led by the Chief Scientific Officer, with involvement from the other UK health departments and will build upon the Department's *Healthcare Science Career Framework* (DH, November 2005),

the UK-wide healthcare science national occupational standards and other healthcare science work commissioned from Skills for Health. There are four aims to the programme:

- Developing a competent and flexible scientific workforce.
- Updating career pathways and choices including academic careers.
- Preparing scientists to lead in a changed NHS.
- Modernising the image of healthcare science and scientists.

**7.40** This will provide a fundamental shift in the future education and training of healthcare scientists that will help secure, plan and develop the future workforce. It will also introduce flexibility to both practitioners and future employers across healthcare scientist disciplines and scientific diagnostic services that can respond to the needs of local health systems and to the provision of scientific services closer to patients.

### Financial support for healthcare students

**7.41** At any one time, there are some 90,000 healthcare students training for professional status and, to support this, the Department invests over £450 million a year in the NHS Bursary Scheme. It is important that the student support system is fair and non-discriminatory and reflects the diverse nature of the health workforce. In 2007, the Department continued the review of the NHS Bursary Scheme which included:

- introducing a new adoption award, which mirrors the maternity award where students are entitled to up to 45 weeks' authorised absence;
- making interim arrangements for a new maternity support award, which allows students who are fathers, nominated carers and partners up to four weeks' authorised absence; and
- publishing a student bulletin (2008: Issue 1) to clarify the hardship arrangements.

**7.42** Work will continue with stakeholders to review other parts of the NHS Bursary Scheme during 2008. Elements to be considered are the childcare allowance and the clinical placement travel and accommodation reimbursement system.

**7.43** The service provided by the NHS Student Bursaries Unit (formally the NHS Student Grants Unit) has improved greatly since 2007. This has been reflected in the Customer Satisfaction Survey where high satisfaction is demonstrated in every aspect of performance.

## Modernising the regulation of healthcare workers

**7.44** While the public and patients rightly hold the substantial majority of health professionals in high esteem, the need for reform to sustain confidence in regulation of healthcare professionals has been underlined by the findings of a number of high-profile inquiries into doctors who have harmed their patients, most notably the *Shipman*, *Kerr-Haslam*, *Ayling* and *Neale* Inquiries.

**7.45** Building on the responses to a consultation, the Department published the White Paper *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century* (DH, February 2007) which sets out how it will reform and modernise the system of professional regulation. The White Paper signals a move towards a more robust regulatory system, which earns and sustains the confidence of patients, the public, healthcare professionals and employers. Some of the key changes include:

- measures to make regulators more independent, such as the appointment of council members, professional members no longer forming the majority of these councils and an independent adjudicator for doctors;
- measures to ensure that healthcare professionals are objectively revalidated throughout their career and remain up to date with clinical best practice;

- the creation of General Medical Council Affiliates to help deal with more cases concerning doctors at a local level and to ensure independent oversight of aspects of revalidation;
- changing the standard of proof used in fitness to practise cases from the criminal standard to the civil standard; and
- moving towards a more rehabilitative approach to regulation, with the development of a comprehensive strategy for prevention, treatment and rehabilitation services for all health professionals.

**7.46** Putting those principles into practice effectively requires the advice and participation of a wide range of stakeholders. As part of this wide-ranging programme of work, the Department of Health has set up seven working groups to cover the areas of implementation. These are:

- enhancing confidence in healthcare professional regulators;
- extending professional regulation;
- health for health professionals;
- medical revalidation and education;
- non-medical revalidation;
- tackling concerns nationally; and
- tackling concerns locally.

**7.47** The final recommendations from each of these groups will be available during 2008-09. In addition, a National Advisory Group, with stakeholders from across the professional regulation and patient safety arena, has been established to advise on the overall implementation of the programme. This met for the first time on 5 June 2007 to discuss the proposed membership, terms of reference and work programmes of the working groups. A further meeting to discuss progress is being organised for early 2008.

## Health and Social Care Bill

**7.48** Part 2 of the *Health and Social Care Bill* (November 2007) contains provisions that

implement those recommendations in the White Paper, and the Government's response to the Shipman Inquiry 5th report and the recommendations of the *Ayling, Neale and Kerr-Haslam* Inquiries – *Safeguarding Patients*, which require primary legislation. Some of the key changes include:

- the creation of a new body to be called the Office of the Health Professions Adjudicator which will have adjudication functions in relation to the professions regulated by the *Medical Act 1983* and the *Opticians Act 1989*;
- amendments to Part 3 of the *Health Act 1999*, extending the powers under section 60 of that Act (including, in relation to pharmacy, measures to facilitate the establishment of a General Pharmaceutical Council, and the removal of the restriction that currently prevents there being a lay majority on the councils of the regulatory bodies), and imposing the use of the civil standard of proof by healthcare professions regulators in proceedings relating to fitness to practise;
- amendments to the constitution and functions of the Council for Healthcare Regulatory Excellence and the way members are appointed;
- regulations to require designated bodies in the UK to nominate or appoint 'responsible officers' who will have responsibilities relating to the regulation of doctors. Designated bodies will be bodies that provide, or arrange for the provision of, healthcare or employ, or contract with, doctors; and
- the creation of a general responsibility on healthcare organisations, and other specified bodies in England and Wales, to share information regarding concerns about the conduct and performance of healthcare workers, and to agree the actions needed to protect patients and the public.

**7.49** It also makes provision in order to ensure that the legislative framework governing the regulation of the social care workforce is kept up to date.

## Section 60 Programme

**7.50** The Department has embarked upon a significant programme of secondary legislation to implement other recommendations of the White Paper. At the end of 2007, it published two section 60 orders that, among other improvements, will enable reform of the regulatory body councils and will provide for regulation of practitioner psychologists. The next three years will see a range of other section 60 orders that will, among other things, provide for the setting up of the new General Pharmaceutical Council and the revalidation of doctors and other health professionals.

## Pay and pensions modernisation in the NHS

**7.51** During 2007-08, the Department, working with NHS Employers, made further progress on modernising NHS pay systems. Key progress has been made in terms of relaunching the Knowledge and Skills Framework, including a series of road shows for board directors and developing and agreeing a harmonised unsocial hours package to be put in place for 2008-09. Agreement has also been reached on new pay arrangements for staff and associate specialist doctors, intended to deliver benefits for patients, the service and staff. These new arrangements will be introduced from April 2008.

**7.52** As part of the closure on the annual pay round for 2007-08 for Agenda for Change staff groups, it was agreed that there would be discussions on the possibilities for a multi-year pay agreement. These discussions are ongoing, running parallel to the usual NHS Pay Review Body process.

**7.53** There has been continuing progress on ensuring that the pay reforms achieve the intended benefits on a number of fronts. The National Audit Office (NAO) has reported on the new Consultant Contract and suggested that many of the intended benefits of pay reform are being realised, but noting

that it is too soon to judge whether the intended productivity gains have been realised. Effective job planning was identified as key to realising the full benefits, and recent work has focused on ensuring rapid spread of the lessons learned and good practices from effective implementation. There is good evidence that this pay reform has delivered improvements in recruitment and retention, and the management of consultant time.

**7.54** Almost two-thirds of trusts surveyed by the NAO reported that the contract had improved management of consultant time and led to better control of pay inflation, with pay settlements and unplanned pay drift both reducing; however, there is still further progress to be made to realise the full benefits from the new contract.

### Pension reform

**7.55** On 21 September 2007, NHS trade unions and NHS Employers (the review partners) reached agreement on a root-and-branch reform of the NHS Pension Scheme. Under the agreement, endorsed by ministers, from 1 April 2008, changes were made to the current scheme for existing staff, together with the introduction of a new NHS Pension Scheme for new entrants. Staff joining the NHS for the first time from 1 April 2008 and some re-joiners will become members of the new scheme. This is a modernised final salary pension scheme based on accrual of 1/60th of pensionable pay each year, with new flexibilities around retirement at a higher normal pension age of 65. Arrangements for practitioners (medical, dental and ophthalmic) are slightly different as their pensions will continue to be based on earnings throughout a whole career and will be based on 1.87 per cent of pensionable pay for each year, but apart from this, all other changes introduced by the new scheme will apply equally to practitioners.

**7.56** During the summer of 2009, a Choice Exercise will begin. Existing staff will have an opportunity to move to the new scheme if they wish. The Pensions Division of the NHS Business Services Authority is responsible for NHS Pension Scheme

administration for England and Wales. It plans to support the implementation of the Choice Exercise for around 1.3 million members via the development of a Self-service Strategy. During 2009-10, the Pension Division aims to provide secure on-line access to each individual member where appropriate, and to allow members to request changes to personal pension information held by the division.

**7.57** If existing staff do not wish to transfer to the new scheme, they will retain their existing normal pension age of 60 and final salary pension arrangements based on 1/80th of pensionable pay for each year (a career average pension based on 1.4 per cent of pensionable pay for practitioners), but will forego many flexibilities available in the new scheme. The necessary system and procedural changes including communication of the changes to employers and staff are well under way.

**7.58** The new more equitable system of tiered staff contributions will meet the initial cost of the new scheme with staff paying on average an additional 0.5 per cent. Across the NHS, this means additional employee contributions projected to be about £175 million in 2008-09.

**7.59** To protect the taxpayer from the risks associated with the retention of the final salary pension, there will be an overall cap on employer contributions of 14.2 per cent up to 2016 and a cap of 14.0 per cent from 2016. Subject to the cost sharing arrangements agreed between NHS employers and trade unions, if costs increase to require any further increase beyond 14.2 per cent before 2016, the amount above 14.2 per cent will fall to employees. From 2016, any increased costs beyond 14 per cent fall to the employees. If in the future scheme costs reduce, any savings would go to the employees until the combined employee and employer contribution rate returns to 20.5 per cent. Under the new regulations, any subsequent reductions below 20.5 per cent would be shared equally between employers and employees, as would any increases back to 20.5 per cent and the employer cap of 14 per cent.

**7.60** Under this cost-sharing agreement (bearing in mind the employer cap operating up to and beyond 2016), variability will be handled through a four-year valuation cycle allowing adjustment of member and/or employer contributions or adjustment of scheme benefits if the latest scheme experience shows that costs are likely to be higher or lower than previously expected. (Each valuation is expected to be implemented with a four-year time lag, so that – for instance – the 2012 cap of 14.2 per cent applies to the outcome of the 2008 actuarial valuation.)

**7.61** The costs of the NHS pension scheme itself are considerable. The annual cost to the employer is circa 14 per cent of the annual wage bill now exceeding £30 billion – that is between £4 and £5 billion. Without pension reform, the estimated costs if the status quo was maintained would have meant an employer contribution rate of 15.3 per cent in 2008, potentially rising by a further 1.7 per cent to about 17 per cent of pensionable payroll by 2020. Following the reform, the employer contribution rate is held to 14.0 per cent of pensionable payroll in both 2008 and 2020. For the NHS and wider government, the package of pension reforms:

- supports terms and conditions of existing staff, while limiting and ultimately removing entirely any further pressure on employer contributions through the cost-sharing agreement;
- supports wider government policy on pension saving, by ensuring proper provision for retirement, without imposing a greater burden on the Exchequer;
- achieves long-term financial sustainability by addressing demographic changes, in particular increased longevity; and
- mitigates the risk of future financial pressures falling on NHS operational budgets because further increases in employer contributions are considerably reduced.

**7.62** During 2007-08, the Pension Division carried out a review of the operation of the NHS Injury Benefits Scheme (described as case review) to ensure that benefits are being paid correctly and to identify any over or underpayments. The case review, which considered around 26,000 injury benefit claims, concluded in November 2007. Around 10,000 injury benefits payments were adjusted and the correct payments made. A LEAP3 exercise involving a comprehensive publicity campaign is under way to notify those who may have been entitled to claim injury benefits but were precluded from doing so because of the incorrect interpretation of the *Injury Benefits Regulations*. Amendments to the legislation to resolve the anomalies, which led to the case review, were finalised during 2007 and were effective from 14 December 2007. In parallel with the case review, the Department commissioned a root-and-branch review of the NHS Injury Benefit Scheme, which has remained largely unchanged since its inception in 1974. NHS Employers in partnership with the NHS trade unions will lead the review. The Department expects final recommendations in the autumn of 2008.

## Social care workforce

**7.63** An estimated 922,000 people are in paid employment across core areas of social care, including social work, residential, day and domiciliary care staff in all sectors, agency staff and some NHS staff. The wider social care workforce is estimated to be 1.6 million including childcare and early years, additional NHS staff, foster carers and adopters, and some school staff.

**7.64** Of these, the adult social care workforce accounts for around 61 per cent working with older people, 19 per cent who work with adults with disabilities and 7 per cent within mental health services. There are around 76,000 professionally qualified social workers with approximately half working in adult services.

**7.65** Overall, it is estimated that 30 per cent of the entire social care workforce has a relevant qualification. In recent years, there have been severe problems of recruitment, retention and service quality in some areas of social care.

### Wider reform of social care

**7.66** The Department is in the process of a fundamental reform of wider social care services for adults, particularly in relation to *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care* (DH, December 2007), which sets out an ambitious agenda for the transformation of social care. The workforce is key to the enablement of this agenda and, over time, this wider service reform agenda will have implications for the workforce for ways of working and delivering services.

### Adult Social Care Workforce Strategy

**7.67** To identify the key workforce priorities from the reform agenda, the Department has set up an Adult Social Care Workforce Strategy Board and Executive Group comprising key delivery partner organisations. The board's remit is to develop a new strategic framework to underpin and enable delivery of the reform of social care.

**7.68** This builds on the work undertaken in the 2006 Options for Excellence Review carried out by the Department and the former Department for Education and Skills, which set out a series of proposals for the social care workforce. It was a wide-ranging, comprehensive review involving delivery partner organisations, people using services and front-line staff.

**7.69** The key output from the board is the planned publication of a Department of Health *Adult Workforce Strategy for Social Care* (interim release due during May 2008, with a fully developed strategy planned for release in October 2008) which will set the direction of travel for the adult social care workforce at a strategic level, enabling delivery

partners to align their workforce activity to focus on these areas.

**7.70** The strategy will also have a strong narrative and emphasis throughout on cross-government initiatives. It will build on sector commitments such as the recently published *Putting People First* ministerial concordat, and the raising of the status of the social care ministerial action plan announced in April 2007 following Dame Denise Platt's *Review of the Status of Social Care*.

**7.71** Through working with the strategy board and its executive group, the key priority areas for strategic focus have been identified as:

- leadership, management and commissioning skills;
- workforce development;
- recruitment, retention and career pathways;
- remodelling the workforce;
- regulation of the workforce; and
- integrated and joint cross-sector working.

**7.72** The Department's intention is that, under each of the priority areas, key activities will be set out as demonstrable commitments and aligned strategic activity to be undertaken by the Department and its delivery partners as part of wider reform of social care.

**7.73** Activity being taken forward currently within the Department as part of this developing strategic framework follows.

### Social Care Skills Academy

**7.74** The Department is supporting the social care sector in developing an expression of interest in becoming a National Skills Academy. It is proposed that the academy will focus on commissioning and leadership skills at all levels. The detail behind this is still being developed by a steering group consisting of a range of stakeholders including Skills for Care, the Social Care Institute for Excellence and social care employers.

## National social care recruitment campaign

**7.75** The Department will be running a national social care recruitment campaign during March 2008, using television, radio and press to attract more people into the social care workforce. The campaign will focus on the benefits of working in social care, including the emotional reward of helping others, and the variety and flexibility of work available. Employers and other social care organisations are being encouraged to think about how they could tie in with the March campaign with local activity, e.g. placing job adverts, media activity, open days etc. The PR Agency is working with the larger organisations to promote the roles in social care and the training and career paths available. Also, building on previous years' links with local employers and Jobcentre Plus, the Department aims to bridge the gap between national advertising and local vacancies by linking with named contacts in each region.

## New Types of Worker Programme

**7.76** The New Types of Worker Programme is about innovative work redesign in adult social care. It uses action research and action learning to build the evidence base for new types of worker and new types of working in adult social care, in order to develop the evidence base around how workforce development needs to adapt to meet the challenges of the next ten to 20 years. There is scope for the programme to become embedded in a range of delivery structures and, in the future, the Department is looking to be more involved with regeneration work, and community and leisure activities. The programme is focused on evidence-based workforce outcomes that enhance the lives of people who use services, being flexible enough to take account of emerging and changing policy drivers around models of delivery for adult social care. It also works to redress the balance of power between service provider and service user, and must fully embrace the philosophy of personalised care and self-directed support.

## Workforce regulation

**7.77** The *Care Standards Act 2000* gave the General Social Care Council (GSCC) responsibility for maintaining a register of social care workers. Registration seeks to ensure both a high level of protection for service users and higher standards of training and professionalism in the social care workforce. The registration of social workers and social work students began in 2005 and over 90,000 individuals have been registered. The Department continues to work with the GSCC to widen registration to other social care workers. It was announced on 15 February 2007 that the first groups to be registered, about 200,000 staff, will be those working in domiciliary care. Over the next few years, this will extend to a total of around 750,000 staff working in both residential and domiciliary care.

## National Minimum Data Set for Social Care

**7.78** Good information and knowledge about the workforce is vital. During 2006, the National Minimum Data Set for Social Care (NMDS-SC) was introduced with the aim of providing good-quality data about the whole workforce to support national, regional and local workforce planning and commissioning. By the end of January 2008, some 16,000 employers had submitted returns to the NMDS-SC. About 55 per cent of Commission for Social Care Inspection-registered employers have completed a return. The launch in November of NMDS-SC on-line is enabling employers to complete the NMDS-SC via the Internet and, during 2008, a bulk upload tool will become available to enable large organisations to upload data direct from their HR systems. The latest detailed analyses of the NMDS-SC, now available on the Skills for Care website ([www.skillsforcare.org.uk](http://www.skillsforcare.org.uk)), are based on data from 13,095 establishments and around 117,000 workers.

## Social care education and training

**7.79** In 2007, the second cohort of social work students began qualifying at honours degree level.

The number of students beginning training is at the same level as in 2006. This is around 37 per cent more than five years ago. The new Post-Qualifying Framework for social workers came into force in September 2007, and there are now 171 courses delivering training across five areas of specialism. Very considerable effort and resources are also being put across the whole service into training the workforce to national minimum standards.

### Newly qualifying social workers

**7.80** Work has been undertaken during 2007-08 to develop proposals to more effectively support social workers in their first year after qualification. These proposals are nearing completion and it is hoped to launch them in 2008. They have been developed with a wide range of stakeholders and in consultation with the Department for Children, Schools and Families.

### Social care bursaries

**7.81** Since 2003, a bursary has been paid to students on the social work degree who are not supported by their employer, as an incentive to train. The introduction of the bursary scheme has played a large part in securing the increase in applications to social work courses. In April 2007, the administration of the bursary transferred from the GSCC to the NHS Business Services Authority where it runs alongside the NHS Bursary Scheme. The transfer was seamless with no interruption in service to students.

### Quality in social work

**7.82** A three-year research project to evaluate the social work degree is nearing completion. Recommendations from the report will help to shape future work on quality. Work is continuing to address quality in social work education in the areas of e-learning and service user and carer participation.

### Learning resource networks

**7.83** Learning resource networks (LRNs) provide the focus for work-based learning across the social care workforce and support employers to ensure that staff are appropriately trained and qualified to provide high-quality services to the public. During 2007, Skills for Care and the Children's Workforce Development Council undertook a review of LRNs, to consider how best to support workforce development in the children and adult workforces. A decision is expected shortly on their proposals to the Department of Health and the Department for Children, Schools and Families on future arrangements to support workforce development.

# 8 NHS Connecting for Health – National Programme for IT

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## Introduction

**8.1** This chapter reports on the progress being made in delivering the new technological infrastructure to support the National Programme for IT (NPfIT). The programme aims to provide patients with more choice and health professionals with more efficient access to patient information.

## Delivering the National Programme for IT

**8.2** Modernising information technology to underpin service transformation and so enable better, safer care is the main aim of NPfIT. The programme has a number of key individual programmes. Each has its own purpose and contributes to the overall goal of linking a patient's health information to support their use of the NHS and assist those providing them with care.

**8.3** Some programmes, such as implementing a new broadband network for the NHS, provide important foundations for other work. The NHS National Network (N3) is connecting virtually all NHS organisations in England through one of the largest electronic infrastructures in the world. This infrastructure has paved the way for the implementation of the front-line systems and services from which major benefits for staff and patients will be realised. Those benefits include enabling choice, providing faster diagnosis and reducing waiting times for patients. IT alone will not deliver those benefits, but it can enable change across processes and organisations.

*"Nurses will have up to date information about the patients they are caring for which will facilitate efficient and smooth handovers and which can promote more effective multidisciplinary working. It will also allow nurses to have more time to 'care' for patients instead of wasting time on administration." Diane Sarkar, Associate Director of Nursing, Southend University Hospital NHS Foundation Trust.*

**8.4** During 2007, state-of-the-art digital technology, which revolutionises the way NHS organisations capture, record and use patient X-rays and scans, was implemented in all acute trusts in England. These Picture Archiving and Communications System (PACS) are providing faster diagnosis for patients, reducing reporting times for clinicians and bringing savings for the NHS (for example, due to no film or chemical processing costs being incurred). The electronic booking service Choose and Book continues to roll-out with over 50 per cent of patients now choosing and booking their hospital appointments electronically at a time, date and place which is convenient to them. Choose and Book has also helped some trusts to successfully reduce their 'did not attend' for appointment by, in some cases, over 60 per cent.

**8.5** During 2007, a number of primary care trusts (PCTs) began to implement Summary Care Records (SCRs) for patients in their area. The SCR provides a summary of a person's important health information (initially allergies, current medication and adverse reactions to medication). This can be securely accessed by the patient and by authorised healthcare professionals caring for them anywhere in England. It will be particularly useful for out-of-hours and emergency care. Half a million patients in early-adopter sites have been sent an information pack. Currently over 153,000 patients in Bolton and Bury (the first early-adopter PCT serving some 26 GP practices) are benefiting from having their patient records available on-line to hospital and community health professionals, so informed care can be provided, when needed, twenty-four hours a day, seven days a week.

**8.6** NHS Connecting for Health is supporting NHS organisations to implement the national programme and to realise the benefits it can bring. Those benefits will increase as the number of front-line and clinical systems and services are delivered according to local needs and priorities.

**8.7** The progress of NPfIT can be seen from the growth in use of the new systems, improving the quality of care to patients. During 2007-08:

- nearly 5 million hospital appointments were made using the Choose and Book service, with bookings now exceeding 23,000 a day;
- over 77 million prescription messages were issued electronically using the Electronic Prescription Service with the number now in excess of 340,000 a day;
- over 640 million digital images were stored on PACS;
- over 24,000 sites, including virtually all GP practices, except those currently in the process of moving or new builds, are now connected to N3; and
- on average, 1.1 million e-mails a day are now transmitted using NHSmail (the NHS e-mail service), serving an active user population of 153,000.

**8.8** New information technology and information systems are being designed and delivered to meet the needs of patients and the requirements of clinicians. They are driving the shift away from systems running along institutional lines, which segment patient care. In future and when they are fully deployed, patients and clinicians will benefit from systems that make patient information available across health and social care 'community' systems, to track and record a patient's care in the NHS.

### NHS Care Records Service

**8.9** The NHS Care Records Service (CRS) is a secure service that links patient information from different parts of the NHS electronically so authorised NHS staff and patients have the information they need to make care decisions. There are two elements to the NHS CRS; detailed records (held locally) and the SCR (held nationally). In due course, the NHS CRS will enable each person's detailed records to be securely shared

between the different parts of the local NHS, such as the GP surgery and hospital. Patients will also be able to have an SCR available to authorised NHS staff treating them anywhere in England. Patients will be able to access their SCR using the secure website HealthSpace ([www.healthspace.nhs.uk](http://www.healthspace.nhs.uk)). The early-adopter sites are being independently evaluated so that lessons can be learned and business processes tested and refined before SCRs start to roll-out across England, expected during 2008. Up to 27 March 2008, 153,000 SCRs have been created.

**8.10** HealthSpace provides an on-line personal health organiser for patients. In time, and after completing the registration process for an advanced HealthSpace account, patients who have an SCR will be able to access it using HealthSpace. Patients in early-adopter areas are beginning to register for HealthSpace advance accounts so they can view their own SCR.

**8.11** The *Care Record Guarantee* was developed by the Care Record Development Board and sets out the rules that govern how information held in the NHS Care Records Service will be used. It was first published in May 2005 and is reviewed annually. The guarantee deals with when, why and with whom information is shared and how this is controlled. It clarifies people's access to their own records, the control of access by others, how access will be monitored and policed, options people will have to further limit access, access in an emergency, and what happens when someone cannot make decisions for themselves.

**8.12** In October 2007 the National Information Governance Board was established, taking over the responsibilities of the Care Record Development Board including owning and revising the *Care Record Guarantee*.

### Choose and Book

**8.13** Choose and Book is a national service that combines electronic booking and a choice of place,

date and time for first outpatient appointments. It revolutionises the old booking system, by allowing patients to choose their initial hospital appointment, and book it on the spot in the surgery or later on the phone or via the Internet.

**8.14** The system supports the Government’s health policy on choice, giving patients more choice and involvement in the decisions made about their care. Choose and Book also supports the implementation of the Government’s 18-week wait target by allowing the local NHS to identify the ‘clock start’ time at the beginning of the patient’s care pathway.

**8.15** At the end of March 2008, 84 per cent of acute hospitals had a Choose and Book compliant Patient Administration System that had received an electronic referral and 95 per cent of all GPs had used Choose and Book to send an electronic referral. The NHS has increased its utilisation of the system with 50 per cent of first outpatient referrals being made through Choose and Book during March 2008. **Figure 8.1** shows Choose and Book bookings 2004 to 2008.

**Figure 8.1: Choose and Book system bookings 2004 to 2008 (quarter 1)**

	2004	2005	2006	2007	2008
Quarter 1	n/a	268	176,752	1,036,901	1,402,288
Quarter 2	n/a	1,096	384,399	1,059,912	
Quarter 3	9	7,254	666,283	1,150,449	
Quarter 4	63	62,119	820,716	1,194,604	
<b>Total</b>	<b>72</b>	<b>70,737</b>	<b>2,048,150</b>	<b>4,441,866</b>	<b>1,402,288</b>

Source: NHS Connecting for Health

**8.16** As a result of Choose and Book, trusts are reporting significant improvements in operational efficiency and service delivery across a number of different areas. Examples are:

**Reduced did not attends**

- Ashford and St Peter’s Hospitals NHS Trust conducted a study showing a total did not attend (DNA) reduction rate of 32 per cent, which under payment by results equates to £40,000 of income

that could be used to benefit patients and which otherwise might have been lost to the trust.

- Kettering General Hospital NHS Trust also reported that Choose and Book helped to cut their missed hospital appointments by approximately a third.
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust reported that the average DNA rate of Choose and Book referrals dropped by 60 per cent compared with those referred in the traditional way.

**Reduced waiting times**

- Ashford and St Peter’s Hospitals NHS Trust reported that waiting times for patients referred through Choose and Book reduced by one week when compared with the standard paper referral process, helping the trust on their way to meeting the 18-week wait pathway target.
- Kettering General Hospital NHS Trust reported that use of Choose and Book led to a nine working day reduction from date of referral to the start of patient care, when consultants used the system directly.

**18-week Patient Pathway Programme**

**8.17** NHS Connecting for Health is facilitating NHS organisations and their IT systems suppliers in the development and deployment of modified systems to support the delivery of the key government target that, by the end of December 2008, nobody will wait longer than 18 weeks from GP referral to the start of treatment. Systems and services are being adapted to provide the reporting information needed to verify the achievement of the target.

**Electronic Prescription Service**

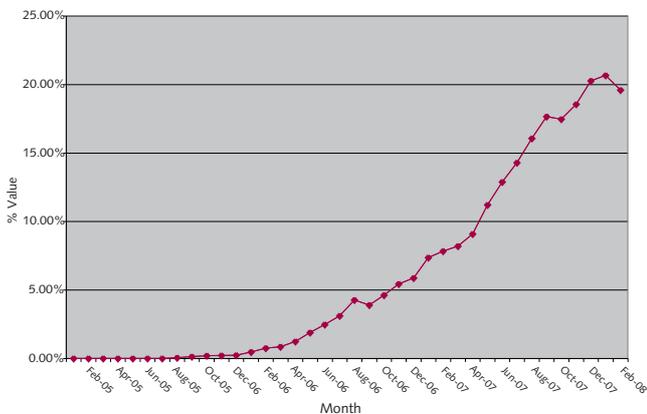
**8.18** The Electronic Prescription Service (EPS) enables prescribers in primary care settings to generate and transmit electronic prescriptions using their computer system. The electronic prescription is sent to the EPS where it can then be downloaded

by a dispenser who has upgraded their computer system to use the EPS.

**8.19** Once the service is fully introduced, patients will have the option to choose, or ‘nominate’, a dispensing contractor to receive their electronic prescription automatically – without the need for any paper.

**8.20** The first stage (Release 1) of the EPS has been rolling-out over the past two years, with nearly 80 per cent of GP practices and community pharmacies now having the technology required to operate the service. Over 1.5 million prescriptions are issued every working day in England and a fifth of these are now issued using the system. See **figure 8.2**, which shows the proportion of EPS prescriptions.

**Figure 8.2: Percentage of prescriptions through EPS**



Source: NHS Connecting for Health

**8.21** The roll-out of Release 2 will commence during 2008-09, bringing major new functionality for prescribers and dispensers. This will include the introduction of advanced electronic signatures and the option for patients to nominate dispensing contractors. Once Release 2 is fully operational, the need for paper prescriptions will reduce dramatically.

## Picture Archiving and Communications System

**8.22** The Picture Archiving and Communications System digital imaging has now been implemented in all English acute trusts, bringing more efficient diagnosis and treatment for patients. During 2008-09, the programme will implement systems to share images between different NHS organisations within a region at all trusts requiring it.

*“PACS has transformed the way we work in the radiology department. As well as almost eliminating the problems of film filing and retrieval, it has dramatically improved reporting efficiency and throughput. This means that not only are the images instantly viewable from anywhere in the hospital, but also that examination reports are available much earlier than previously. Patients benefit from an earlier diagnosis to facilitate prompter treatment and an earlier return home.” Dr Frank Jewell, Consultant Radiologist, Gloucestershire Royal Hospital.*

## NHS National Network (N3)

**8.23** N3 delivers the systems and services that enable the fast, secure exchange of information, files and data between more than 24,000 NHS sites in England. Following completion of the initial implementation, additional services are being developed to ensure that the network continues to meet the needs of all sites to be connected to it.

**8.24** Community of Interest Network designs, serving both national and local networking needs and providing significant economies of scale and the potential to make major savings, are being implemented in 2008-09 at up to 30 per cent of N3 connected sites. A major pilot involving more than 50 trusts is being run in London to assess the benefits that can be obtained from internet protocol services such as Voice over Internet Protocol telephony services.

## NHSmail

**8.25** NHSmail is the secure, encrypted e-mail and directory system for the NHS. It has been endorsed by the British Medical Association as the only NHS e-mail service secure enough for transferring patient information, and is being used by an increasing number of NHS organisations. In addition to the financial savings, which trusts and other NHS organisations can make through decommissioning local e-mail services in favour of NHSmail, there are direct, quantifiable benefits to clinicians and patients.

**8.26** The use of NHSmail for sending SMS messages as patient appointment reminders has continued to increase. In January 2008, three times as many messages were transmitted compared with the same month the previous year. GPs continue to report significant falls in 'did not attend' rates as a result. Additionally, in March 2008, the number of active NHSmail users had increased by 40 per cent on the previous year, and overall traffic volume by 57 per cent. During 2008-09, the NHSmail core service technology is moving to a platform based on Microsoft Exchange 2007. This will make migrations from local NHS trust exchange e-mail services much simpler. It will also, in a single step, give existing users a significantly enhanced set of features and functionality.

## Other systems and services

**8.27** The National Programme for IT supports primary care practitioners by developing and supporting systems that are used to provide management information, make payments to GPs and deliver improved patient care. These include the Quality and Outcomes Framework, specifying financial rewards for GP practices as part of the new general medical services contract, the GP Payments System and the Quality Management and Analysis System, which provides information on subjects such as the numbers of patients eligible for and receiving treatment for specific conditions from all practices and national disease prevalence rates.

**8.28** The GP2GP Project is enabling the transfer of patients' electronic records when they register at a new GP practice, reducing the average time taken to transfer records from several weeks for paper records, to within minutes for electronic records. This is giving GPs almost immediate access to the medical records of new patients and improving the quality of patient treatment, patient diagnoses and records available, since data does not have to be re-entered at the new practice and nearly all the historical data can be retained. The service is now being rolled-out nationally with over 4,700 practices GP2GP enabled and over 108,000 transfers having successfully taken place.

**8.29** GP Systems of Choice (GPSoC) is a new scheme through which the NHS will manage the provision of GP clinical IT systems in England. GPSoC allows practices and primary care trusts to benefit from a range of quality GP clinical IT systems from existing suppliers who will now be contracted to work within the National Programme for IT. GPSoC enables improved value for money in the delivery of GP clinical IT systems to the NHS and delivers on the new general medical services contractual commitment to provide GPs with a choice of accredited systems.

**8.30** NHS Connecting for Health continues to manage a portfolio of some 40 existing national IT services used across the NHS. These include National Cancer Screening Services, NHS Numbers for Babies, Ophthalmic Payments and the Blood Donor Register. New software enhancements to these systems are also being developed, such as that providing the ability for users to search the Personal Demographics Service for patient matches and, if necessary, to allocate NHS numbers directly.

**8.31** The Secondary Uses Service (SUS), which provides management information for the NHS, is being delivered incrementally through a series of releases continuing in 2008-09. It will capture, process and enable access to and report on all data relating to NHS-commissioned activity. Data

capture will be automatic from operational systems and enable the generation of summary reports. This will reduce the burden of data collection for the NHS, and enable a full range of reporting, which will support healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance at local and national levels, through the use of anonymised and pseudonymised data, which protects patient confidentiality.

**8.32** Supplier capacity and capability has been enhanced through a framework agreement. Known as Additional Supply Capability and Capacity Framework contracts, they offer a wide range of IT goods and services to support NHS business and clinical applications. They complement the existing suite of national programmes and NHS contracts and provide a contingency supply route in the event of a contracted supplier having difficulties in capacity and capability. Enterprise Wide Arrangements for the NHS, enabling the aggregated procurement of high-quality IT systems and services on a greater scale and at more competitive rates than would be achieved by any single NHS organisation, have saved the NHS in excess of £90 million in 2007-08, with similar savings expected in 2008-09.

### Service implementation

**8.33** NHS Connecting for Health's Service Implementation Team have been supporting the NHS nationally and locally in developing the culture, capability and capacity to embrace and exploit new information technology. The work has included looking at what change can be enabled locally by the introduction of new IT and how to prepare effectively for deployment. Commissioning and provider organisations alike are being assisted to maximise and realise benefits. As part of this work:

- The team has developed and implemented an enhanced set of education training and development (ETD) standards and quality

assurance processes for use within the ETD community across the NHS.

- Training has been practically enhanced on the ground with the implementation of Microsoft Skills Academies in eight strategic health authorities (SHAs). A ninth site is due to be implemented by May 2008.
- The procurement of a new basic IT and information governance course is now complete. The Essential IT Skills (EITS) programme launched in March 2008 and replaced the European Computer Driving Licence (ECDL) Service. The EITS programme was developed after lengthy consultation with the NHS and has been designed to meet NHS IT training needs in preparing NHS staff for NPfIT systems training.
- The Integrated Service Improvement Programme's Roadmap for Transformational Change website was extended and refreshed during the year. It has benefited from input from a wide number of NHS professionals with a wealth of NHS practical experience in service transformation. It is now a powerful organising framework for change, including IT-enabled change.
- eSpace, an on-line collaborative tool, was launched in 2007. Based on web 2.0 technologies, it embraces and enhances the old Health Informatics Community. eSpace offers the NHS a state-of-the-art platform for professional networking around IT-enabled change. It is proving to be a consistent and reliable performer and currently hosts over 30 vibrant communities of practice.
- The HIS Benchmarking and Accreditation Project will provide a national framework for the NHS to support the benchmarking/accreditation of Health Informatics Services (HISs). A Benchmarking Information Pack was successfully piloted in five HISs in late 2007.
- The Organisational Readiness Assurance Model was launched alongside the *NHS Operating Framework for 2008-09* and guidance for PCTs on

their accountability for information management and technology (IM&T) planning.

- The Mainstreaming IM&T Programme continues to support the NHS to identify, deliver, measure and report benefits that can be enabled by new information technology. Working with NHS organisations, a toolset has been developed to support the identification, registration and measurement of benefits.
- The Mainstreaming IM&T Programme has also supported the NHS in their planning cycle by publishing guidance, including a refreshed NPfIT catalogue, which has benefits work integrated within it.
- The Access Control Team continues to ensure that authorised NHS staff gain access to the information they need using the NHS Care Records Service (CRS). Rigorous access controls allow secure access, while protecting the confidentiality of patients' health information.
- NHS staff requiring access to the NHS CRS have to prove their identity 'beyond reasonable doubt' to the government e-GIF level 3 standard. They are then allocated appropriate access rights in relation to the role they undertake within their organisation. This means they can see only the information they need to do their job.
- Each user requiring access is provided with a Smartcard (similar to a chip and pin card), complete with photo. This allows access to the NHS CRS when combined with the user's unique passcode. To date 471,000 individuals are registered for access to the NHS CRS.

## Local responsibility

**8.34** In the summer of 2007, the individual SHAs in partnership with NHS trusts took responsibility for defining requirements and for the local implementation of NPfIT, as well as the realisation of benefits from the new systems. NHS Connecting for Health supports the local NHS organisations in this by drawing on its core strengths of managing large, national IT/IS programmes through third

party suppliers, handling the commercial arrangements and assisting them in the planning, development and deployment of the systems.

**8.35** During 2007-08, the Local Service Providers (LSPs) deployed new Patient Administration Systems (PASs) or upgraded existing PASs in 26 acute trusts, with 17 in the North, Midlands and East (NME), six in London and three in the South.

**8.36** The LSPs are developing their next generation of secondary care systems with Cerner Millennium Release 1 in the South and London and iSOFT Lorenzo Release 1 in NME. Work is well under way with three early-adopter hospital trusts in NME preparing to deploy this first version of the new Lorenzo system with clinical functionality including Results Reporting, Orders and Clinical Documentation as the first step towards a comprehensive system with rich clinical functionality designed specifically for the NHS. Likewise in London and the South trusts are preparing to deploy the next version of Millennium.

**8.37** In London, six mental health trusts have taken the RiO application deployed by BT. In the South, one mental health trust and seven primary care trusts have taken Millennium. In NME, 11 mental health trusts have taken the iSOFT iPM system deployed by the Computer Sciences Corporation and in primary care trusts there have been 46 such deployments.

## Governance

### Clinical assurance

**8.38** The Office of the Chief Clinical Officer continues to focus on a safety programme covering the Clinical Safety Management System, as well as a series of projects on patient safety. These involve safer handover, safer prescribing and the correct identification of patients. A safety training programme began in March 2008, delivering an accredited clinician training course 'Awareness training in human factors and risk assessment for

accrediting clinicians', as well as an Implementation Network that will allow NHS Connecting for Health programme and project managers access to up to date training, advice and support on patient safety issues. These courses will also be available to the wider NHS.

**8.39** Clinical influence was increased across the programme during 2007-08 with senior clinicians undertaking key roles in many programme areas. A National Clinical Reference Panel was established to work with Map of Medicine providers to ensure that the content of the product continues to meet the needs of the NHS as it is rolled-out across England. Clinicians have been appointed to key roles within the SNOMED implementation project and the integrated e-care pathways project as well as within the development of a clinical assurance framework for clinical content.

**8.40** The Clinical Leaders Network was developed in late 2005 as a structured programme to target senior and influential NHS clinical leaders in mutually valuable leadership and service development. The programme was initiated, with Department of Health and NHS Connecting for Health support, in the former Cheshire and Merseyside, Greater Manchester and Cumbria and Lancashire SHAs (now North West SHA) in February 2006 as a pilot initiative. The success of the pilot has led to further funding being allocated to roll the concept out across all the SHAs in the coming year.

**8.41** Clinical leadership within NHS Connecting for Health was strengthened by the appointment of two clinical directors, one focusing on primary care and the other on secondary care. These appointments supported the Chief Clinical Officer in influencing and directing clinical involvement in all areas of NHS Connecting for Health as well as engaging with senior NHS and Department of Health staff.

**8.42** The national clinical leads continue to drive forward clinical engagement and their numbers have been increased to cover pathology, mental health, ophthalmology, public health, medication management and diabetes. During 2007, two successful conferences were held. The clinicians' conference and mental health conference contributed to enhanced clinical engagement throughout the year.

### Technical assurance

**8.43** The National Integration Centre (NIC) ensures systems interoperability and safety. Robust assurance processes are in place to govern suppliers' product development, testing and integration into the national infrastructure. To date the NIC has:

- assured 20 National Spine Releases and 18 Choose and Book National Releases (3 major and 15 minor);
- assured 475 versions of 69 different products outside the Local Service Provider (LSP) contracts;
- released 144 Clinical Authority to Release certificates to suppliers outside the main LSP contracts; and
- assured 107 separate systems under the LSP contracts.

**8.44** With the reliance the NHS now has on NHS Connecting for Health systems, the challenges and resources required to assure a new national release are significant and the established assurance standards are critical to maintaining service integrity. Information exchange will become ever more important and clear standards have been developed and integrated into the national infrastructure by the NIC, adding even more value to the established applications and services for patient care across the NHS.

**8.45** A programme of work related to the coordination of the gathering of clinical content has been established at a national level and clinical content, including the first phase of a National Pathology Catalogue, has been delivered to suppliers

for inclusion in the systems they are deploying across the NHS. A framework for the assurance of clinical content by the relevant Royal Colleges has been piloted and work is under way to refine this to ensure that it can be scaled to meet the needs of NHS Connecting for Health programmes.

### Data security and information governance

**8.46** Although security of patient information is at the very heart of the new systems being delivered through the programme, NHS Connecting for Health has also initiated, with the NHS, a review of the existing security arrangements for safeguarding personal information. This has resulted in a tightening of procedures and identification of areas that need improvement, particularly in the transfer of patient data within trusts and to outside locations. Steps have been taken to ensure that personal identifiable data is properly protected and in support of this the NHS Chief Executive, following discussions with the Information Commissioner, has written to chief executives in the NHS with advice especially around the secure transfer of large amounts of personal data where this is necessary for business purposes.

**8.47** Since the Government announced a review of data handling procedures across all public services, the Department has reinforced the importance of data protection and handling in the NHS and arm's length bodies in a number of ways:

- Accountability for compliance with data protection legislation in NHS organisations rests with the respective chief executives and boards. The NHS Chief Executive has written to the chief executives of all NHS organisations reminding them of their data protection responsibilities and accountabilities under the *NHS Operating Framework for 2008-09*.
- A major review of data security arrangements across the NHS is being coordinated by strategic health authority chief information officers.
- New and revised guidance to the NHS on meeting new constraints on data handling and

reinforcement of extant security and confidentiality policies has been developed and promulgated by NHS Connecting for Health on behalf of the Department.

- Monitoring of compliance with NHS Information Governance standards (published by NHS Connecting for Health in the *Information Governance Toolkit*) is undertaken by the Healthcare Commission.

**8.48** The Government has also placed restrictions on the use of unencrypted laptops and removable media containing personal identifiable data. NHS Connecting for Health is undertaking a central procurement on behalf of the NHS for encryption software and tools to enable day-to-day patient care to continue in a secure environment and is also ensuring that bulk data flows across the NHS are encrypted where necessary.

## Digital information and health policy

### International developments

**8.49** The Department has continued to represent the UK in the development of national and international information and technical standards used in healthcare systems. NHS Connecting for Health now acts as the UK National Release Centre for clinical terminologies. It also provides an interface with the International Health Terminology Standards Development Organisation for all UK users of SNOMED clinical terms.

**8.50** The UK has also contributed to the development of policy on making better use of information and communication technologies to improve the delivery of healthcare services in Europe. The Department will continue to collaborate in the development of health systems interoperability standards to promote UK interests in line with the action plan for making healthcare better for all European citizens.

## Health Select Committee inquiry into the Electronic Patient Record

**8.51** On 13 September 2007, the Health Select Committee published its report on the Electronic Patient Record.

**8.52** In its commentary and recommendations the committee generally supported a careful and incremental implementation of electronic patient records that were aligned with public information and choice about participation and included adequate evaluation before full roll-out of the system. The report commented that the implementation was a “long journey best managed by a staged and piloted development not a big bang approach”. The committee expressly did not support a comprehensive independent review of NPfIT in the NHS as a whole.

**8.53** In reaching its conclusions, the committee heard evidence from Lord Hunt, as minister responsible at the time, Richard Granger, then Director General for IT in the NHS, and various supporting officials reflecting that, as a fundamental component of the NHS Care Record Service, the success of the Electronic Patient Record was key to realising the benefits of the overall NPfIT, by making relevant patient information available at the point of need through secure access by NHS and other practitioners.

**8.54** In its response, published on 12 November 2007, the Government accepted the majority of the committee’s recommendations, many of which were already part of the existing plans to implement an Electronic Patient Record incrementally. The Government also acknowledged that, while significant progress had already been made in implementing the programme, further and continuing effort was needed to engage with front-line NHS staff and to communicate plans to the public.

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## Introduction

**9.1** This chapter looks at NHS and Personal Social Services (PSS) revenue finance and efficiency. It details the level of investment in both areas and shows how these funds have been spent across the various programmes and how outputs have increased. It also details the movement in NHS productivity.

## NHS funding

**9.2** In 2008-09, the planned total public expenditure for the Department of Health is £108,476 million. This includes the NHS Pensions budget of £14,071 million.

**9.3** **Figure A.1** (annex A, core table 1) summarises the resource plans for the Department of Health for the years 2002-03 to 2010-11. More detailed information is provided in **figure A.2** and **figure A.3** (annex A, core tables 2 and 3).

**9.4** **Figure A.1** also includes a breakdown of the Departmental Expenditure Limit (DEL) in near and non-cash.

### Department of Health expenditure plans: 2007 Pre-Budget Report

**9.5** In the 2007 Pre-Budget Report, the Chancellor announced the 2007 Comprehensive Spending Review (CSR 2007) settlement for the Department of Health covering the financial years 2008-09, 2009-10 and 2010-11 (see **figure 9.1**).

**Figure 9.1: Department of Health CSR settlement 2007**

	£ million		
	2008-09	2009-10	2010-11
<b>NHS<sup>(1)</sup></b>			
NHS revenue	92,642	98,499	104,833
NHS capital	4,589	5,352	6,086
Depreciation	-800	-954	-1,113
<b>Total net NHS resource</b>	<b>96,431</b>	<b>102,897</b>	<b>109,806</b>
<b>Personal Social Services (PSS)<sup>(2)</sup></b>			
PSS revenue	1,237	1,293	1,395
PSS capital	121	121	121
Depreciation	-13	-13	-13
<b>Total net PSS resource</b>	<b>1,345</b>	<b>1,401</b>	<b>1,503</b>

Source: HMT pre-budget report 2007

Notes:

(1) Average annual real terms growth of 4 per cent.

(2) Average annual real terms growth of 1.9 per cent.

**9.6** The settlement set out plans for real terms increases in overall resources for the NHS of 4 per cent per annum over the next three years. Although below recent rates of funding growth, growth remains significantly higher than the historical average of 3.1 per cent per annum (from 1972-73 to 1996-97). This provides a solid platform to continue to provide improvements to services for patients.

**9.7** The CSR also makes clear the Government's priorities for those service improvements going forward. These are set out in the Public Service Agreements (PSAs) that are described in more detail in chapter 11. The PSAs in turn provide the context for the *NHS Operating Framework for 2008-09*, which focuses on the year ahead.

**9.8** The settlement provides the resources to deliver the Government's vision for the NHS, set out in the interim report *Our NHS, Our Future* published in October 2007. That vision is for services that are fair, personalised, effective, safe and locally accountable. As set out in the Operating

Framework, our priorities for 2008-09 in working towards this vision are:

- improving cleanliness and reducing healthcare-associated infection;
- improving access through achievement of the 18-week referral-to-treatment pledge, and improving access (including at evenings and weekends) to GP services;
- keeping adults and children well, improving their health and reducing health inequalities;
- improving patient experience, staff satisfaction and engagement; and
- preparing to respond in a state of emergency, such as an outbreak of pandemic influenza.

## The health and personal social services programmes

**9.9** The health and personal social services programmes consist of spending by the NHS on the following programmes:

- NHS hospital and community health services, and discretionary family health services (HCFHS).
  - This covers hospital and community health services, prescribing costs for drugs and appliances, general medical services (GMS) (which includes reimbursements of GMS GPs' practice staff, premises, out-of-hours and information management and technology expenses), general dental services and associated income from dental charges. It also includes other centrally funded initiatives, services and special allocations managed centrally by the Department of Health (such as service-specific levies, which fund activities in the areas of education and training and research and development).
  - HCFHS includes all GMS funding. The introduction of the new GP contract in April 2004 means that there is no longer any GMS non-discretionary funding. All GMS funding is discretionary. In order to present a consistent run of expenditure in **figure 9.2**, GMS non-

discretionary expenditure has been restated as HCFHS.

- NHS family health service (FHS) non-discretionary.
  - This covers demand-led family health services, such as the cost of general dental and ophthalmic services, dispensing remuneration and income from dental and prescription charges.
- Central health and miscellaneous services (CHMS).
  - Providing services that are administered centrally, for example certain public health functions and support to the voluntary sector.
- Administration of the Department of Health.
- Expenditure on PSS by way of:
  - funding provided by the Department of Health; and
  - funding provided by the Department for Communities and Local Government.

**9.10** More detail on PSS spending can be found at the end of this chapter.

## NHS, England – by area of expenditure

**9.11** **Figure 9.2** shows the main areas in which funds are spent for the years 2004-05 to 2008-09 on a stage 2 resource budgeting basis. Total NHS expenditure figures are consistent with those in **figure A.1**.

## Expenditure in 2007-08

**9.12** **Figure 9.3** compares estimated outturn expenditure in 2007-08 with planned expenditure published in last year's report.

**Figure 9.2: National Health Service (NHS), England – by area of expenditure**

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
	Outturn	Outturn	Outturn	Outturn	Outturn	Estimated outturn	plan	plan	plan
	£ million								
<b>Departmental programmes in Departmental Expenditure Limits</b>									
<b>NHS Hospitals community health, family health (discretionary) and related services and NHS trusts<sup>(1) (2)</sup></b>									
<b>Revenue expenditure<sup>(3) (4)</sup></b>									
Gross	55,051	60,931	66,802	74,863	79,700	88,622	94,158	98,908	105,300
Charges and receipts	-2,603	-2,519	-3,429	-4,106	-3,689	-4,164	-4,378	-3,754	-3,986
Net	52,448	58,412	63,373	70,757	76,011	84,458	89,779	95,154	101,315
<b>Capital expenditure</b>									
Gross	3,296	3,117	3,125	3,319	4,200	3,781	4,813	5,434	6,047
Charges and receipts	-1,253	-551	-533	-1,208	-1,167	-515	-286	-146	-30
Net	2,043	2,566	2,592	2,111	3,033	3,266	4,527	5,288	6,017
<b>Total</b>									
Gross	58,347	64,047	69,927	78,182	83,899	92,403	98,970	104,342	111,347
Charges and receipts	-3,856	-3,070	-3,962	-5,314	-4,856	-4,679	-4,664	-3,900	-4,016
HCHS depreciation	-405	-264	-417	-470	-948	-851	-798	-920	-1,066
Net	54,086	60,713	65,548	72,398	78,096	86,874	93,508	99,522	106,266
<b>NHS family health services (non-discretionary)<sup>(2)</sup></b>									
<b>Revenue expenditure</b>									
Gross	2,935	3,052	2,980	2,968	1,440	1,488	1,537	1,692	1,777
Charges and receipts	-911	-912	-850	-837	-419	-424	-444	-468	-500
Net	2,024	2,141	2,129	2,131	1,021	1,064	1,093	1,223	1,277
<b>Central health and miscellaneous services<sup>(5)</sup></b>									
<b>Revenue expenditure</b>									
Gross	1,143	1,450	1,514	1,439	1,603	1,784	1,783	1,959	2,090
Charges and receipts	-210	-138	-144	-159	-168	-173	-180	-74	-79
Net	933	1,313	1,370	1,280	1,435	1,611	1,603	1,885	2,012
<b>Capital expenditure</b>									
Gross	30	36	32	41	36	50	41	41	43
Charges and receipts	0	0	0	0	0	0	0	0	0
Net	30	36	32	41	36	50	41	41	43
<b>Total</b>									
Gross	1,173	1,486	1,546	1,479	1,639	1,834	1,824	2,000	2,133
Charges and receipts	-210	-138	-144	-159	-168	-173	-180	-74	-79
CHMS and administration depreciation	-23	-29	-29	-27	-28	-31	-31	-30	-29
Net	939	1,319	1,373	1,293	1,444	1,630	1,613	1,896	2,025
<b>Total National Health Service</b>									
<b>Revenue expenditure</b>									
Gross	59,128	65,434	71,296	79,269	82,743	91,893	97,478	102,559	109,167
Charges and receipts	-3,724	-3,569	-4,423	-5,102	-4,275	-4,760	-5,002	-4,296	-4,564
Net	55,405	61,865	66,873	74,168	78,468	87,133	92,475	98,263	104,603
Net percentage real terms change		8.5%	5.2%	8.6%	3.0%	7.5%	3.0%	3.4%	3.6%
<b>Capital expenditure</b>									
Gross	3,326	3,153	3,157	3,359	4,236	3,831	4,853	5,474	6,089
Charges and receipts	-1,253	-551	-533	-1,208	-1,167	-515	-286	-146	-30
Net	2,073	2,602	2,624	2,151	3,069	3,316	4,567	5,328	6,059
Net percentage real terms change		22.0%	-1.8%	-19.7%	38.8%	4.7%	33.7%	13.5%	10.7%
<b>Total</b>									
Gross	62,454	68,586	74,453	82,629	86,979	95,725	102,331	108,033	115,257
Charges and receipts	-4,977	-4,120	-4,957	-6,310	-5,442	-5,275	-5,288	-4,442	-4,594
Depreciation	-428	-293	-446	-497	-975	-882	-830	-950	-1,095
Net	57,049	64,173	69,051	75,822	80,561	89,568	96,213	102,642	109,568
Net percentage real terms change		9.3%	4.7%	7.5%	3.4%	7.7%	4.3%	3.8%	3.9%
GDP as at 28 March 2008	90.1	92.7	95.3	97.3	100.0	103.3	106.3	109.3	112.3

Source: Financial Planning and Allocations Division, DH

Notes:

(1) Includes Departmental Unallocated Provision (DUP) for 2005-06 to 2010-11.

(2) Funding for primary dental services in 2006-07 and 2007-08 is included in the HCFHS provision. From April 2006, general dental services and personal dental services have been commissioned from funds devolved to PCTs.

(3) Includes Annually Managed Expenditure (AME) funding available to NHS foundation trusts for 2003-04 and 2004-05.

(4) With the introduction of the primary medical services allocation in 2004-05, there is no longer any GMS non-discretionary funding. All GMS funding is now discretionary. Therefore, figures for HCFHS and FHS non-discretionary for 2002-03 to 2005-06 have been restated to present a consistent run in expenditure.

(5) Includes expenditure on key public health functions such as environmental health, health promotion and support to the voluntary sector. Also includes expenditure on the administration of the Department of Health.

(6) Net expenditure excludes NHS (AME).

(7) Figures may not sum due to rounding.

**Figure 9.3: Comparison of net NHS expenditure for 2007-08 with that in last year's Departmental Report (Cm 7093)**

	Departmental Report 2008 Cm 7393 Figure 9.2	Departmental Report 2007 Cm 7093 Figure 9.1	£ million 2007-08 difference
HCFHS current	83,607	84,045	438
HCFHS capital	3,266	4,120	854
FHS non-discretionary	1,064	987	-78
CHMS revenue	1,311	1,225	-86
CHMS capital	28	34	6
Dept. admin revenue	269	269	0
Dept. admin capital	22	23	0
<b>Total</b>	<b>89,568</b>	<b>90,702</b>	<b>1,134</b>

Source: Financial Planning and Allocations Division, DH

Notes:

(1) Totals may not sum due to rounding.

**9.13** The main areas of change (£10 million or over) to the spending plans for the various parts of the programme are shown in **figure 9.4**.

### NHS expenditure plans in 2008-09

**9.14** Planned NHS net expenditure in 2008-09 is £96.4 billion (see **figure 9.1**). NHS public spending is calculated as the total of the revenue budget plus the capital budget, less depreciation.

**9.15** The largest part of NHS spending is on hospital and community health services, discretionary family health services and related services.

**9.16** Of the planned revenue expenditure in 2008-09, primary care trust (PCT) initial resource limits amount to £74.2 billion with a further PCT allocation of £1.7 billion from centrally managed funding. The remainder is allocated to strategic health authorities (SHAs) and other centrally managed programmes.

### NHS resources

**9.17** **Figure 9.5** reflects the disposition of NHS resources in 2008-09. It shows that PCTs will control over 80 per cent of the total NHS revenue budget.

### NHS financial performance

#### Setting the context

**9.18** *The NHS in England: The Operating Framework for 2007-08* (DH, December 2006) recognised the importance of building on the financial recovery that the NHS delivered in 2006-07 to create a sustainable financial position for the future.

**Figure 9.4: Main areas of change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm 7093)**

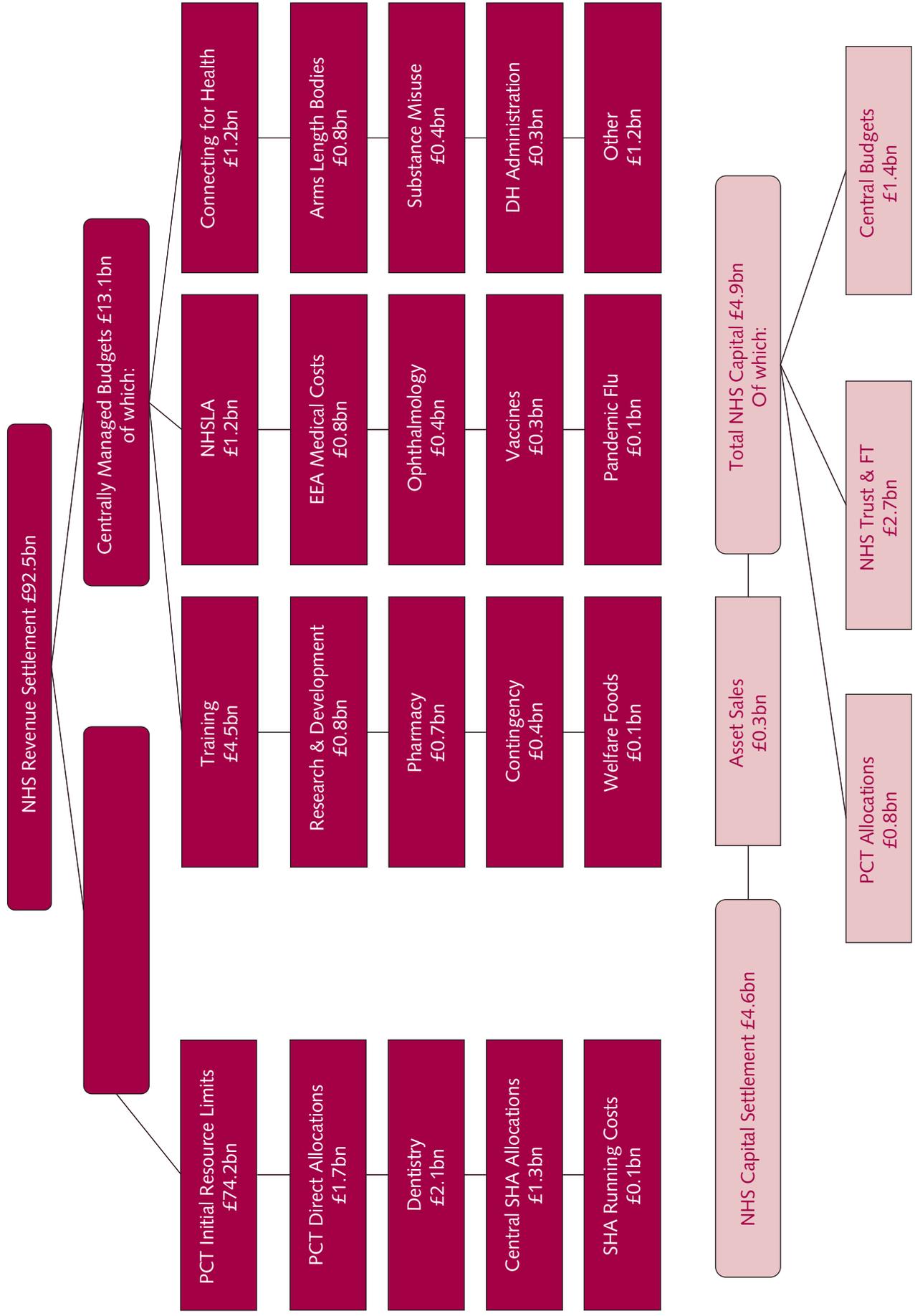
2007-08	Difference <sup>(1)</sup>	
HCFHS current	438	including: 77 Transfer to FHS non-discretionary -61 Transfer from Personal Social Services 70 Transfer to CHMS revenue for demand-led EEA medical costs and welfare food scheme 21 Transfer to CHMS revenue for CHMS other services -196 From impairments to provisions 533 Forecast underspend
HCFHS capital	854	including: 116 Transfer to Personal Social Services grants 750 Forecast underspend -11 Transfer from CHMS capital
FHS non-discretionary	-78	including: -77 Transfer from HCFHS current
CHMS revenue	-87	including: -70 Transfer from HCFHS current for demand-led EEA medical costs and welfare food scheme -21 Transfer from HCFHS current for CHMS other services

Source: Financial Planning and Allocations Division, DH

Note:

(1) Totals may not sum because only those changes over £10 million are included.

Figure 9.5: Disposition of NHS resources, 2008-09



**9.19** Accordingly, the NHS was set three clear financial objectives for 2007-08:

- delivery of a net surplus of at least £250 million as organisations generate surpluses to recover historic overspending;
- a significant reduction in the value of gross deficits; and
- all but a small handful of organisations operating in recurrent balance throughout the year.

**9.20** The Department publishes progress against these targets and other priorities to improve health and health services on a quarterly basis. This publication – *The Quarter* – demonstrates that these three financial objectives are being met without compromising the achievement of PSA targets.

**9.21** The financial performance of the NHS in 2007-08 has significantly exceeded the objectives it was set. In the first quarter of the year, the Department recognised that the NHS was likely to predict a surplus, well in excess of the £250 million minimum, because all organisations had been asked to create 0.5 per cent contingency (equivalent to at least £526 million) in their financial plans and, following changes to the financial regime at the end of 2006-07 concerning how NHS trusts are treated under the resource accounting and budgeting framework, the NHS was required to plan for a further £140 million surplus. On these measures alone, the Department would have expected a level of surplus of no less than £916 million.

**9.22** However, the financial surplus predicted by the NHS (excluding NHS foundation trusts) at quarter two and quarter three of £1,789 million demonstrates a significant achievement this year. Based on increased financial rigour and transparency, there are three key factors contributing to this healthy level of surplus for 2007-08:

- Many organisations are able to release contingencies over and above the 0.5 per cent

required because they are either on target or ahead of cost improvement plans.

- There has been a reduction in the reimbursement prices of generic medicines charged to PCTs that was not known for the 2007-08 planning cycle.
- Some NHS organisations are now forecasting a surplus or break even, having previously forecast deficits earlier in the year.

**9.23** The Department has also seen a significant improvement in the level of gross deficit reported and the number of NHS organisations predicting a deficit position for 2007-08. There are 17 organisations forecasting a deficit at the year end, compared with 82 in 2006-07. These organisations are forecasting a combined gross deficit of £143 million compared with a gross deficit of £917 million in 2006-07.

**9.24** The Department has already announced its approach to tackling the financially challenged trusts (FCTs) that were identified at the end of 2006-07. Only eight of the FCTs are forecasting a deficit for 2007-08 at the end of the third quarter. All of the FCTs have been subject to a rigorous review of both their financial and operational positions, to identify long-term solutions to maintain the provision and standard of patient care to the community they serve while still delivering value for money. These reviews are now completed and the SHAs are making proposals, which are under discussion with the Department, and acceptable solutions will be reported as they are agreed.

**9.25** The improvement in financial planning and delivery in the NHS has been strengthened with the appointment of the Director General of NHS Finance, Performance and Operations and the Director of NHS Finance. This will build on the Department's strategy to improve financial management and performance in the NHS through direct performance management discussions with SHA chief executives and finance directors as well

as direct intervention with specific failing organisations.

## Planning for 2008-09

**9.26** In *The NHS in England: The Operating Framework for 2008-09* (DH, December 2007), the Department stressed the importance of sustaining the level of NHS surplus forecast for 2007-08 as the NHS goes forward to 2008-09. At the same time, the Department published the tariff for 2008-09 having ‘road tested’ it with the NHS previously in the autumn.

**9.27** The framework builds on the principles underlying the management of NHS finances set in the previous year: transparency, consistency, independence and fairness.

**9.28** The key financial objectives for the NHS in 2008-09 are:

- to plan for the equivalent surplus forecast in 2007-08 in the SHA and PCT sector;
- to plan for sufficient surplus in the NHS trust sector to service working capital loan repayments and recover legacy debt positions; and
- for SHAs to resolve all outstanding legacy debt in PCTs by 31 March 2008, or in exceptional circumstances where agreed by the Department, 31 March 2009.

**9.29** To deliver these objectives, SHAs will have the flexibility to determine, within their economies, the level of contingency necessary to ensure the delivery of their financial plans and where this contingency is best held.

**9.30** The Department will continue to tackle the small number of NHS organisations that perform poorly with their finances. The operating framework clearly sets out the triggers for being deemed financially challenged and the consequences for triggering organisations. The responsibility of SHAs in preventing organisations getting into this position is also clearly set out.

## NHS financial regime changes

**9.31** The NHS financial regime was changed in response to two reviews commissioned by the Department – the Audit Commission report in July 2006 which reviewed the financial regime; and the Department of Health Chief Economists’ report on the causes of deficits, *Explaining NHS Deficits, 2003-04 to 2005-06* (DH, February 2007).

**9.32** Following these reports, *The NHS in England: The Operating Framework for 2007-08* (DH, December 2006) set out the continued developments to the regime. On 28 March 2007, the new arrangements for the application of resource accounting and budgeting rules to NHS trusts were announced.

### Application of resource accounting and budgeting to NHS trusts

**9.33** The resource accounting and budgeting (RAB) system is a cross-government system designed to help ensure that public sector organisations manage their money with an eye on longer-term commitments and not just short-term cash flow.

**9.34** Strict application of the arrangements to an NHS trust that overspends means that a trust has the overspending reduced from its income in the following year while also being required to generate a surplus in subsequent years to recover the deficit.

**9.35** It has been applied in this way because it provides a strong disincentive to overspending. But the Audit Commission called for the RAB system to be no longer applied to NHS trusts because:

- it was not applied consistently by SHAs;
- it is not compatible with payment by results – where the annual income for providers is determined by the number of patients they treat; and
- it cannot be applied to NHS foundation trusts.

**9.36** In March 2007, the Secretary of State announced that NHS trusts would no longer be subject to RAB income adjustments. This impacted on NHS trusts in three ways:

- Income deductions applied in 2006-07 were reversed. This totalled £178 million for 28 NHS trusts. In order to allow this, the £450 million centrally held contingency was allocated to NHS trusts.
- RAB income deductions for earlier years can be taken out of the breakeven note. NHS trusts have agreed these adjustments with their auditors locally; the Department does not have records centrally to do this.
- From 2007-08, NHS trusts are not subject to income adjustments based on the previous year's surplus/deficit.

### Replacement of cash brokerage with loans

**9.37** When an organisation is in deficit, its expenditure exceeds its income. For an organisation in deficit to pay its staff wages and other bills, it must seek additional sources of cash. For many years, cash to finance deficits has been made available to NHS trusts through an informal and opaque system of cash brokerage between NHS organisations, often funded by capital underspending.

**9.38** From the final quarter of 2006-07, cash brokerage ceased and was replaced by a formal system of loans. The loans are clearly visible in the accounts, and trusts pay interest on the borrowing.

**9.39** It should be stressed that the provision of loans is cash only, and will not disguise deficits. The increased transparency and the requirement to pay interest provide a strong incentive for organisations to tackle their problems.

**9.40** In March 2007, a total of £778 million was loaned to 56 trusts. These loans were issued under government accounting rules. NHS trusts will make equal six-monthly payments of principal over the period of the loan. Interest is payable six-monthly on the outstanding balance; however, the Department does allow NHS trusts the flexibility to make extra repayments to reduce balances and so interest charges, but there is not flexibility to miss repayments. The interest rate is the relevant National Loan Fund rate for the day of the loan and varies with the term.

**9.41** Any NHS trust that defaults on a working capital loan repayment will be deemed financially challenged. This is set out in the 2008-09 operating framework.

## Resource allocation policy

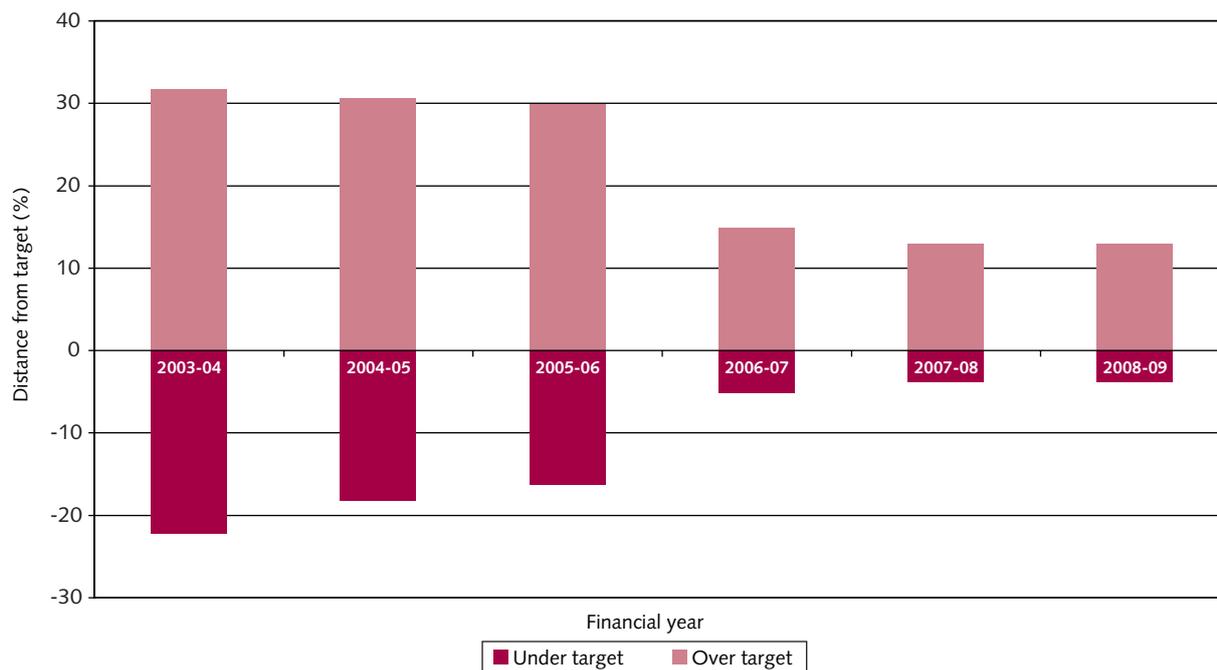
### Revenue allocations to PCTs for 2008-09

**9.42** Revenue allocations to PCTs for 2008-09 were announced in December 2007. PCTs will receive a total of £74.2 billion, a cash increase of £3.8 billion or 5.5 per cent. Further information about these and earlier allocations can be found at: [www.dh.gov.uk/allocations](http://www.dh.gov.uk/allocations)

**9.43** The intention had been to announce allocations to PCTs for the three years 2008-09 to 2010-11. However, the Secretary of State agreed to a request from the Advisory Committee on Resource Allocation (ACRA) for more time to finalise its recommendations on a revised resource allocation formula (see paragraph 9.49).

**9.44** As it was not possible to grant ACRA an extension to its work programme and make allocations to PCTs for three years, a one-year allocation for 2008-09 was announced.

**9.45** Allocations for 2009-10 and 2010-11 will be announced in the summer of 2008.

**Figure 9.6: Range of PCT DFTs between 2003-04 and 2008-09**

Source: PCT revenue resource limit exposition books

## Elements of revenue allocations

**9.46** Generally, four elements are used to set PCTs' actual allocations:

- Weighted capitation targets – set according to the national weighted capitation formula which calculates PCTs' target shares of available resources based on the age distribution of the population, additional need and unavoidable geographical variations in the cost of providing services.
- Recurrent baselines – represent the actual current allocation that PCTs receive. For each allocation year, the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year.
- Distance from target (DFT) – this is the difference between weighted capitation targets and recurrent baselines. If a weighted capitation target is greater than a recurrent baseline, a PCT is said to be under target. If a weighted capitation target is smaller than a recurrent baseline, a PCT is said to be over target.
- Pace of change policy – this determines the level of increase that all PCTs get to deliver on national

and local priorities, and the level of extra resources to under target PCTs to move them closer to their weighted capitation targets. The pace of change policy is decided by ministers for each allocations round.

**9.47** However, for 2008-09 the funding formula has been frozen while ACRA finalises its recommendations for a revised formula, and a uniform increase of 5.5 per cent has been given to all PCTs.

**9.48** PCT DFTs will remain in 2008-09 as they were in 2007-08. **Figure 9.6** shows the range of PCT DFTs between 2003-04 and 2008-09. When allocations were first made to PCTs in 2003-04, some PCTs were 22 per cent under target. By 2008-09, no PCT will be more than 3.7 per cent under target.

## Advisory Committee on Resource Allocation

**9.49** ACRA is an independent committee comprising NHS management, GPs and academics.

**9.50** ACRA's remit is to oversee the development of the weighted capitation formula used to inform revenue allocations to PCTs, to ensure equity in resource allocation. ACRA reports to ministers on possible changes to the formula before each allocations round.

**9.51** ACRA's work programme is set every year. The key strands of the current work programme are to:

- determine a population base for allocations;
- review the market forces factor;
- review the need element of the formula;
- further consider how the formula takes account of issues in rural areas; and
- help inform the development of a formula at practice level to aid the work on practice-based commissioning.

**9.52** Ministers will consider ACRA's recommendations before implementation. The intention is that the revised formula will inform PCT allocations for 2009-10 and 2010-11.

## Analysis of expenditure

### Programme budgeting

#### Background to programme budgeting

**9.53** Programme budgeting is an internationally recognised technique for recording how resources have been expended and broken down into meaningful programmes, with a view to tracking future resource spending in those same programmes.

**9.54** The Department has been collecting financial returns from PCTs and SHAs over the last four years showing their expenditure in 23 categories of care based upon the International Classification of Disease. Examples of the programme budgeting categories include expenditure on cancer and tumours, circulatory system problems and mental health. By focusing on medical conditions, the Department's objective is to forge increasingly closer links between

NHS expenditure and the resulting patient care and outcomes.

**9.55** One of the Department's original objectives for initiating the collection of programme budgeting data was to gain a clearer understanding of how the NHS spent its financial allocation. Given the richness of the data set, the Department has increasingly focused its attention on making the data useful to the NHS in terms of benchmarking local and similar organisations, as well as making available to the NHS data, that links expenditure and relevant health outcomes.

#### Financial year 2006-07

**9.56** This is the fourth year the Department has collected programme budgeting data from the NHS. Between the 2005-06 and 2006-07 financial years, there have been a number of changes made to the data collection, including:

- amendments to the way activities are grouped and costed;
- changes to the methodology for mapping some of the diagnoses to programmes; and
- changes to the way non-admitted patient care costs were apportioned across the programme budgeting categories, with more expenditure allocated to the 'Other' category.

**9.57** Due to these changes, the Department has essentially broken the time series of programme budgeting expenditure data, a change that was deliberately implemented in the same year the number of PCTs fell from 303 to 152.

**9.58** **Figure 9.7** provides details of resources by programme budget categories for 2005-06 and 2006-07.

**Figure 9.7: Resources by programme budget categories 2005-06 and 2006-07**

Programme budget	£ million	
	2006-07 Gross	2005-06 Gross
Mental health disorders	9,126	8,539
Problems of circulation	6,898	6,362
Cancers and tumours	4,352	4,303
Problems of the gastrointestinal system	3,852	3,973
Problems of the genito-urinary system	3,755	3,508
Problems of the musculoskeletal system	3,531	3,769
Problems of the respiratory system	3,540	3,469
Maternity and reproductive health	2,932	2,930
Problems due to trauma and injuries	2,992	3,853
Neurological	2,987	2,120
Dental problems	2,644	2,760
Problems of learning disability	2,494	2,596
Endocrine, nutritional and metabolic problems	2,133	1,895
Social care needs	1,720	1,745
Problems of the skin	1,553	1,335
Healthy individuals	1,482	1,341
Problems of vision	1,382	1,356
Infectious diseases	1,301	1,258
Disorders of blood	1,035	1,051
Adverse effects and poisoning	756	708
Conditions of neonates	802	786
Problems of hearing	330	322
Other areas of spend/conditions:		
• General medical services/personal medical services	7,257	7,308
• Strategic health authorities (including WDCs)	3,514	3,818
• Miscellaneous	11,825	9,081
<b>Gross operating cost</b>	<b>84,193</b>	<b>80,185</b>

Source: Department of Health Resource Accounts 2006-07

Notes:

(1) Due to a combination of new HRG4 data, a reassignment of primary diagnosis codes to programme budgeting category, the introduction of the new sub-categories and a change in the methodology for calculating non-admitted patient care costs, comparison between 2005-06 and 2006-07 is not straight forward.

**9.59** Implementing programme budgeting is a process that will be subject to continual refinement. While recognising that it will never be possible to perfectly allocate all NHS expenditure between the 23 programmes (for example, due to co-morbidities), the objective is to ensure that programme budgeting data is sufficiently robust to be used to inform programme-level investment decisions.

**9.60** Within the NHS, programme budgeting is now seen as much more than a financial return, hence its inclusion in two of the 11 *World Class Commissioning Competencies* (DH, December 2007).

Schedule 5

**9.61** In addition to the analysis of net operating costs by programme budgeting category, Schedule 5 of the 2006-07 Resource Accounts also published details of expenditure to meet the Department's objectives.

**9.62** The Department's two high-level objectives (from the 2002 Spending Review) are to:

- improve service standards; and
- improve health and social care outcomes for everyone.

**9.63** These objectives were further disaggregated (from the 2004 Spending Review) with 'Improve service standards' split between 'Access to services' and 'Improving the patient/user experience' and 'Improve health and social care outcomes for everyone' split between 'Health of the population' and 'Long-term conditions'.

**9.64** Expenditure was allocated to these objectives through the PSA target that most closely contributes to them (see **figure 9.8**).

**Figure 9.8: Consolidated statement of operating costs by Departmental aim and objectives**

	£ million		
	2004-05	2005-06	2006-07
Improve Service Standards			
– Access to services	24,545	26,749	23,322
– Improving the patient/user experience	5,709	5,807	5,990
Improve Health and Social Care Outcomes for Everyone			
– Health of the population	26,207	29,111	26,788
– Long-term conditions	6,455	6,672	14,353
Other	9,007	11,846	13,740
<b>Gross operating cost</b>	<b>71,922</b>	<b>80,185</b>	<b>84,193</b>
Total income	(18,144)	(17,660)	(20,470)
<b>Net operating cost</b>	<b>53,778</b>	<b>62,525</b>	<b>63,723</b>

Source: Department of Health Resource Accounts 2006-07

Notes:

(1) Resources by Departmental aim and objective for the year ended 31 March.

## Accounting for the additional resources

**9.65** A breakdown of how the additional resources have been consumed in 2006-07 is included in **figure 9.9**. This is calculated using gross expenditure (total revenue plus income and excluding capital), taken from audited summarisation schedules for NHS trusts' and NHS foundation trusts' annual accounts.

**Figure 9.9: Breakdown of additional resources consumed in 2006-07**

Item of expenditure	%
Pay – directly employed staff	30.6
Pay – not directly employed	-8.7
Primary care services	1.1
Capital, supplies and other services	44.2
Primary and secondary care drugs	12.6
Other	20.3

Source: Financial Planning and Allocations Division, DH

Notes:

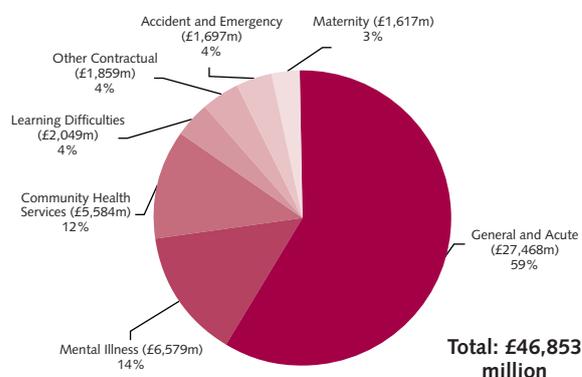
- (1) The pay category includes the total staff costs including 'on-costs' such as pension and national insurance.
- (2) Primary care services includes expenditure on dentistry, ophthalmology and general medical services.
- (3) Capital supplies and other services includes expenditure on clinical supplies and services (excluding drugs), general supplies and services, establishment and transport costs, premises and fixed plant, capital expenditure including depreciation, capital charges and the purchase of healthcare from non-NHS bodies.
- (4) The other category includes EEA medical costs, NHS Litigation Authority, departmental administration, technical adjustments and others.

## Expenditure by sector

**9.66** **Figure 9.10** shows a breakdown of current gross expenditure on hospital and community health services (HCHS) in 2006-07. The HCHS expenditure does not include spending on family health services (FHS) and primary care prescribing. It is derived from audited PCT summarised accounts on commissioning expenditure and includes the purchase of healthcare from non-NHS

providers. **Figure 9.11** provides the definitions of the different sectors of HCHS expenditure.

**Figure 9.10: Hospital and community health services gross current expenditure, 2006-07**



Source: Financial Planning and Allocations Division, DH

Note:

(1) The categories and related expenditure above will not be the same as those shown in **Figure 9.7** due to: the programme budgeting categories additionally include primary care expenditure for family health services; date collection sources and assumptions made for the classification of expenditure; and differences in categorical definitions.

**9.67** The total shown here differs from the figure shown in **figure 9.2**, which shows expenditure in the HCFHS.

## Regional breakdown

**9.68** **Figures A.7, A.8** and **A.9** (see annex A) show analyses of the Department's spending by country and region, and by function. The data presented in these tables is consistent with the country and regional analyses published by HM Treasury in chapter 9 of *Public Expenditure Statistical Analyses (PESA) 2008*.

**9.69** The analyses are set within the overall framework of total expenditure on services (TES). TES broadly represents the current and capital

**Figure 9.11: Hospital and community health services expenditure components**

Component	Definition
Learning difficulties	Includes community learning difficulties services, single specialty hospitals and units on district general hospital (DGH) sites and community type units.
Mental illness	Includes mental illness, child and adolescent psychiatry, forensic psychiatry, psychotherapy, old age psychiatry. Includes the elderly mentally ill. Services include community mental illness services, single specialty hospitals and units on DGH sites.
Maternity	Includes obstetrics for patients using a hospital bed, obstetrics for ante-natal and post-natal outpatients, and general practice (maternity). Services include community maternity services.
General and acute	Includes all specialty functions not identified separately in the above. Includes units for the younger physically disabled.
Accident and Emergency (A&E)	Includes expenditure relating to service agreements for A&E treatment services.
Community health services	Includes all community health services except community services for mental handicap, mental illness and maternity.
Other contractual	Includes all other expenditure on secondary healthcare.

expenditure of the public sector, with some differences from the national accounts measure of total managed expenditure. The figures show the central government and public corporation elements of TES. They include current and capital spending by the Department and its non-departmental public bodies, and public corporations' capital expenditure, but do not include capital finance to public corporations. They do not include payments to local authorities or local authorities' own expenditure. TES is a near-cash measure of public spending. Further information on TES can be found in appendix E of PESA 2008.

**9.70** The data is based on a subset of spending, identifiable expenditure on services, which is capable of being analysed as being for the benefit of individual countries and regions. Expenditure that is incurred for the benefit of the UK as a whole is excluded.

**9.71** Regional attribution of expenditure for the years 2002-03 to 2006-07 is based on NHS annual accounts, and for 2007-08 to 2010-11 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.

**9.72** The functional analyses of spending in **figure A.9** are based on the United Nations Classification of the Functions of Government, the international standard. The presentations of spending by function are consistent with those used in chapter 9 of PESA 2008. These are not the same as the strategic priorities shown elsewhere in this report.

### Family health services

**9.73** Family health services (FHS) are services provided in the community through doctors in general practice, dentists, community pharmacies and opticians, most of whom are independent contractors. Originally, terms of service were set centrally by the Department following consultation with representatives of the relevant professions. Funding for the services was demand-led and not

subject to in-year cash limits at PCT level (although FHS expenditure had to be managed within overall NHS resources).

**9.74** Recent reforms have progressively shifted the balance towards the local commissioning of services managed within discretionary budgets delegated to PCTs. By 2004-05, PCTs had taken over responsibility for all GMS as well as the drugs bill. The GMS non-discretionary element ceased to exist as the funding became part of overall PCT allocations as part of the new GMS (nGMS) contract. As part of the Government's fundamental reform of primary dental care services, all former non-discretionary general dental service (GDS) and discretionary personal dental service pilot services were integrated within permanent local commissioning arrangements managed by PCTs from 1 April 2006.

**9.75** In line with this, the Department proposes that the remaining centrally held funding for pharmaceutical services should be devolved to PCTs and included in their baseline allocations from a future date, no earlier than April 2009. These new arrangements are being introduced through the *Health and Social Care Bill*, which was published on 16 November 2007.

### Family health services: primary dental care services

**9.76** The first year of operation of the integrated primary dental care service was 2006-07. The former central GDS budget was devolved to PCTs as individual discretionary allocations. The year-on-year growth in gross expenditure between 2005-06 and 2006-07 (0.3 per cent) was distorted by the fact that the expenditure record for 2005-06 was enhanced by an accounting adjustment to increase the estimate of GDS creditor payments outstanding at the year end. Closure of the former GDS with effect from 31 March 2006 revealed that the value of payments due for work undertaken within the financial year but not claimed and paid until after the year end had been significantly underestimated

**Figure 9.12: Family health services: primary dental care services, 1996-97 to 2006-07, England**

	Cash					Resource							£ million
	1996-97	1997-98	1998-99	1999-2000	2000-01	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	
GDS <sup>(1)(2)(5)</sup>	1,323	1,348	1,438	1,477	1,555	1,561	1,638	1,709	1,767	1,671	1,448	n/a	
PDS (discretionary) <sup>(3)</sup>	n/a	n/a	4	13	22	22	36	41	48	280	757	n/a	
Total primary dental care <sup>(4)</sup>	1,323	1,348	1,442	1,490	1,577	1,583	1,674	1,750	1,815	1,951	2,205	2,212	

Source: Dental Practice Board and PCT accounts data

Notes:

(1) General dental services (GDS) costs are gross of patient charge income.

(2) Cash data for the years 1996-97 to 2000-01 incorporate some minor corrections to data published in previous reports.

(3) Personal Dental Services (PDS) schemes were Primary Care Act pilots designed to test locally-managed approaches to the delivery of primary care and were mainly based on dental practices which converted from GDS to PDS terms of service. PDS expenditure figures were drawn from HAs' income and expenditure accounts, with the exception of the 2004-05 figure for gross PDS which is an estimate based on payments data obtained from Dental Practice Board. All PDS expenditure figures are gross of patient charge income, and exclude any related capital investment by NHS trusts.

(4) Under the new service framework introduced from 1 April 2006 for local commissioning of primary dental care services, PCTs may commission general dental or specialist personal dental services according to local needs but only report aggregate primary dental care expenditure in central financial returns.

(5) Expenditure in 2005-06 was enhanced by an accounting adjustment to correct an historic under-estimate of GDS creditor payments outstanding at the year end.

in previous years. Longer-term comparisons eliminate this distortion. For example, in real terms, (using the March 2008 GDP deflator), the growth in resource expenditure between 2000-01 and 2006-07 was 19 per cent (see **figure 9.12**).

**9.77** Further information on primary dental care services is included in chapter 3.

### Family health services: primary medical care services

**9.78** **Figure 9.13** charts all new GP contract (nGMS) practice-based spend for 2004-05, 2005-06 and 2006-07, and the latest 2007-08 available forecast. Figures are derived from the four combined contracting service routes: GMS, primary medical services, alternative provider medical services and PCT medical services. The figures also include dispensing fees and drugs costs for dispensing doctors and non-dispensing doctor personal administration, which are reported as part of the contract remit.

**Figure 9.13: Family health services: primary medical care services expenditure, 2004-05 to 2007-08**

	£ billion			
	2004-05	2005-06	2006-07	2007-08 <sup>(1)</sup>
nGMS	6.9	7.7	7.8	7.8

Source: PCT Financial Information Monitoring (FIMs)

Notes:

(1) 2007-08 forecast outturn i.e. still subject to validation.

(2) Figures include dispensing fees and drugs costs for Dispensing Doctors and Non Dispensing Doctors Personal Administration. The drugs costs are also reported as part of the drugs bill (**figure 9.14**).

**9.79** Chapter 3 provides details of the improvement of services to patients resulting from the introduction of the nGMS contract.

### Family health services: drugs bill

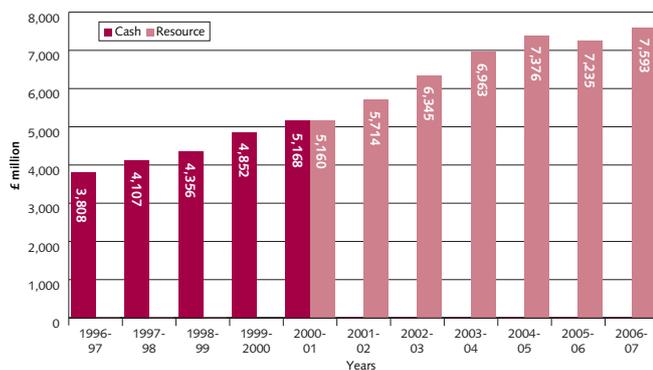
**9.80** Drugs bill gross expenditure is the amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs, medicines and certain listed appliances that have been prescribed. Net drugs bill expenditure is total gross expenditure minus Pharmaceutical Price Regulation Scheme (PPRS) receipts (see **figures 9.14** and **9.15**).

**9.81** The 2006-07 gross FHS drugs bill outturn for England was £7,593 million; this represents an increase of 4.9 per cent over 2005-06.

**9.82** In 2006-07, the number of items increased by 4 per cent over 2005-06. The major drivers of this growth were lipid-regulating drugs (mainly statins), which increased by 17 per cent, antihypertensives (12 per cent), ulcer-healing drugs (9 per cent) and nitrates, calcium blockers and potassium activators (7 per cent).

**9.83** Costs fell for some areas with large reductions in the cost in ulcer healing (-33 per cent), nitrates, calcium blockers and potassium activators (-18 per cent), antidepressants (-11 per cent) and drugs affecting bone metabolism (-13 per cent). These reductions were influenced by price changes resulting from the Category M scheme for generic drugs. In particular, the advent of a generic version of lansoprazole and the margin between the price of the branded drug and the generic version produced a sharp fall in costs for ulcer healing despite the increase in the number of items prescribed.

**Figure 9.14: Family health services: gross drugs bill, cash 1996-97 to 2000-01 and resource 2000-01 to 2006-07, England**



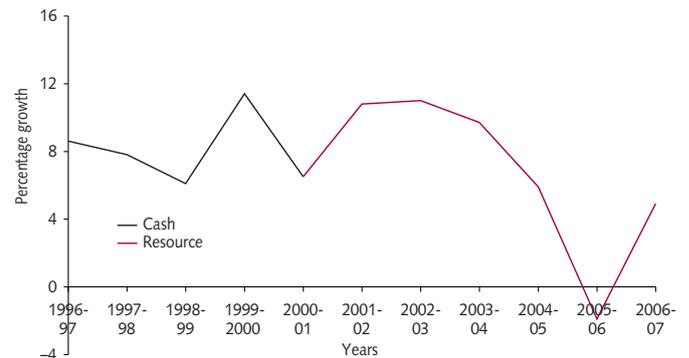
Source: Prescription Pricing Division of the NHS Business Services Authority, England and PCT summarisation schedules

Notes:

(1) Figures include amounts paid to pharmacy and appliance contractors by the Prescription Pricing Authority/Division and amounts authorised for dispensing doctors and personal administration in England. The data do not cover costs for drugs prescribed in hospital but dispensed in the community or private prescriptions.

(2) Resource expenditure represents the actual cost of the prescriptions for drugs, medicines and appliances prescribed in the period April to March. Cash expenditure represents the amounts paid between April to March to contractors for drugs, medicines and appliances that have been prescribed and relates to February to January prescribing.

**Figure 9.15: Family health services: gross drugs bill, percentage growth, cash 1996-97 to 2000-01 and resource 2000-01 to 2006-07**



Source: Prescription Pricing Division of the NHS Business Services Authority, England.

### Branded medicines

**9.84** The 2005 PPRS, a voluntary agreement negotiated with the Association of the British Pharmaceutical Industry, controls the prices of branded prescription medicines supplied to the NHS by regulating the profits that companies can make on these sales.

**9.85** In September 2005, the Office of Fair Trading (OFT) announced a market study of the PPRS to assess whether the scheme is the most effective means of securing value for money for the NHS, while offering appropriate incentives for pharmaceutical companies to invest in new medicines for the future. The OFT published its report on 20 February 2007. Its key recommendation was that the Government should reform the PPRS, replacing current profit and price controls with a value-based approach to pricing which would ensure that the price of drugs reflects their clinical and therapeutic value to patients and the broader NHS.

**9.86** In its interim response to the OFT, published in August 2007, the Government set out the principles that it would take into account in reforming the scheme:

- delivering value for money;
- encouraging and rewarding innovation;
- assisting the uptake of new medicines; and
- providing stability, sustainability and predictability.

**9.87** At the same time, the Secretary of State for Health announced the Government's intention to renegotiate the PPRS. The aim is to reform the PPRS through a voluntary agreement, taking into account the principles set out in the interim response to the OFT. Negotiations are currently taking place between the Department and the industry.

### Generic medicines

**9.88** The long-term arrangements for generic medicines reimbursement continue, in line with the arrangements agreed as part of the community pharmacy contractual framework. Category M generic medicine prices continue to be adjusted in line with market prices and adjusted to take account of the findings of the medicines margins survey.

### Family health services: community pharmacy services

**9.89** **Figure 9.16** shows the expenditure for the community pharmacy contractual framework introduced in April 2005.

**Figure 9.16: Family health services: community pharmacy contractual framework expenditure, 2005-06 to 2007-08, England**

	£ million		
	2005-06 Resource	2006-07 Resource	2007-08 Resource
Community Pharmacy Contractual Framework	1,175	1,247	1,306

Source: Prescription Pricing Division of the NHS Business Services Authority, England.

Notes:

(1) Introduced in April 2005.

(2) The above represent expenditure against the funding made available through the central global sum and money released in PCT budgets by lower generic medicine prices. In addition to these two funding sources, pharmacies also have access to funding of around £500 million from the margin retained on medicine purchases.

**9.90** From 2005-06, with the introduction of the community pharmacy contractual framework, the provision of pharmaceutical services includes funding for dispensing fees, establishment and practice payments, medicines use reviews and the electronic transmission of prescriptions. The total funding package agreed nationally is met from various sources of funding, namely the central global sum, money released in PCT budgets by

lower generic medicine prices (Category M) and the medicine margin retained by pharmacies. The medicine margin of £500 million represents the difference between the prices paid by contractors to wholesalers for medicines and the sums reimbursed to contractors by the NHS Business Services Authority.

**9.91** Further information on NHS pharmacy services is included in chapter 3.

### Family health services: general ophthalmic services

**9.92** **Figure 9.17** shows the expenditure on general ophthalmic services (GOS).

**9.93** The (unadjusted) growth in 2006-07 over 2005-06 was 6.1 per cent. In real terms (using the March 2008 gross domestic product deflator), the growth in resource expenditure on GOS between 2000-01 and 2006-07 was 12.1 per cent. This included the service absorbing the impact of the move from 1 April 1999 to extend the eligibility criteria for NHS sight tests to include all patients aged 60 and over.

**9.94** Further information on GOS is included in chapter 3.

### Centrally managed NHS programme

**9.95** The budgets in the centrally managed NHS programme fund additional NHS-related expenditure.

**9.96** **Figure 9.18** provides details of the programme's current budget levels for 2007-08 and 2008-09.

**9.97** This programme funds additional allocations to the NHS via the NHS Bundle and other specific allocations. Other funding is for NHS-related expenditure directly incurred by the Department within the NHS (for activity such as research and development), or within the independent sector on behalf of the NHS, such as the Connecting for Health project. The programme also funds special health authority allocations.

**Figure 9.17: Family health services: general ophthalmic services (cash and resource), 1996-97 to 2006-07, England**

	1996-97	1997-98	1998-99	1999-2000	2000-01	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07
	Cash					Resource						
GOS	237	241	240	281	292	290	302	304	322	340	359	381

Source: PCT accounts

**Figure 9.18: Centrally managed NHS budgets 2007-08 and 2008-09**

Budget	2007-08	2008-09
NHS Bundle <sup>(1)</sup>	6,945.878	5,859.434
Arm's length bodies (including NHS Litigation Authority, NHS Business Services Authority, Healthcare Commission) <sup>(2)</sup>	1,207.494	1,607.241
Connecting for Health (NHS IT Programme) <sup>(3)</sup>	917.806	1,057.500
Research and development <sup>(4)</sup>	742.836	824.884
Substance Misuse Pooled Treatment budget <sup>(5)</sup>	388.000	405.700
Immunisation Programme <sup>(5)</sup>	205.400	307.600
Other allocations <sup>(6)</sup>	1,450.535	993.789
<b>Total</b>	<b>11,857.949</b>	<b>11,056.148</b>

Source: DH central budget records

Notes:

(1) Reduction due to National Specialist Commissioning Group, Accelerated Discharge Programme, primary medical services and various other smaller budgets being removed from the Bundle to form part of PCT's initial resource limit allocations.

(2) Increase in NHS Litigation Authority provisions in 2008-09.

(3) Reprofile of planned activity and expenditure.

(4) Funding in line with HM Treasury agreement.

(5) Increase in funding for 2008-09.

(6) 2007-08 figures include contingency budget.

## Central health and miscellaneous services (CHMS)

**9.98** The CHMS revenue budget programme includes:

- the Welfare Food Scheme;
- European Economic Area medical costs for treatment given to UK nationals by other member states;

- funding for medical, scientific and technical services, including the National Biological Standards Board and the Health Protection Agency; and
- grants to voluntary organisations, mainly at a national level, across the spectrum of health and social services activity.

**9.99** Figure 9.19 provides details of the CHMS programme 2007-08 and 2008-09 budget levels.

**Figure 9.19: Central health and miscellaneous services budgets, 2007-08 and 2008-09**

Budget	2007-08	2008-09
European Economic Area medical costs <sup>(1)</sup>	673.292	709.000
Arm's length bodies (includes National Biological Standards Board, Health Protection Agency, Commission for Social Care Inspection)	315.003	328.763
Welfare foods	114.500	117.592
Other <sup>(2)</sup>	464.442	511.469
<b>Total</b>	<b>1,567.237</b>	<b>1,666.824</b>

Source: DH central budget records

Notes:

(1) Increase in new provisions in 2008-09.

(2) Includes tobacco control, national school fruit and communication budgets as well as grants to voluntary bodies.

## NHS efficiency

### Gershon Efficiency Programme

**9.100** The Gershon report, *Releasing Resources to the Front Line* (HM Treasury, March 2004), committed the Department to achieving the following targets as part of the 2004 Spending Review:

- annual efficiency gains of £6.5 billion by March 2008, at least half of which should be cashable;
- a reduction in whole-time equivalent civil servants of 720 by March 2008; and
- the relocation of 1,110 whole-time equivalent posts out of London and the South East by March 2010. This target has since been reduced to 1,030, to reflect the transfer of responsibility for the Mental Health Tribunal, a planned relocation, to the Department for Constitutional Affairs, since replaced by the Ministry of Justice. The respective target for the Ministry of Justice has been increased to compensate.

### Efficiency gains

#### Programme structure

**9.101** The programme comprises five main workstreams:

- **Productive time:** modernising the provision of front-line services to be more efficient and also improving the quality of patient treatment and service, by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce.
- **Procurement:** making better use of NHS buying power at a national level to get better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies and other consumables and pharmaceuticals.
- **Corporate services:** ensuring that NHS organisations can share and rationalise back office services, such as finance, information and communication technology and human resources.

- **Social care:** improving commissioning of social care and other cash-releasing and non-cash-releasing gains from the design of social care processes by local authorities.
- **Policy funding and regulation:** reducing the operating costs of the Department, arm's length bodies, SHAs and PCTs through reducing processes and functions and restructuring, merging or abolishing existing organisations.

#### Measurement processes

**9.102** Aggregate efficiency gains are assimilated through a large number of projects and business changes. Detailed measurement and assurance processes have been developed for each resulting efficiency gain. These have been verified and agreed with HM Treasury and the Office of Government Commerce (OGC).

**9.103** Details of agreed measurement processes are provided in an efficiency technical note (ETN) available on the Department's website at: [www.dh.gov.uk](http://www.dh.gov.uk). The ETN has recently been updated and expanded so that it reflects fully the final scope of contributing programmes and projects, the additional or amended measures, and the service quality and data assurance processes introduced by the OGC in 2006.

**9.104** In response to specific issues raised by the National Audit Office (NAO) in its report *The Efficiency Programme: A Second Review of Progress* (NAO, February 2007), the calculation of hospital length of stay has been revised. The calculation now uses a more statistically robust moving average calculation to resolve the issue of volatile baseline data (this will create a one-year time lag on final figures). Previously declared savings relating to reduced GP bureaucracy have been removed, as it was not cost effective to undertake a new full validation survey on the savings previously agreed by a smaller group of GPs. These two changes reduced reported savings by just under £200 million. The NAO did, however, also note within its report that some health efficiency

calculations were more prudent than Gershon guidelines required, and also that the complexities of health processes and data availability can result in understated or incomplete reported efficiencies.

**9.105** Other projects have been identified that were part of the original programme on which the £6.5 billion target was predicated, but where robust attributable financial values cannot be derived within a strict definition of efficiency. The Department does not therefore include these within its reported Gershon savings but does recognise them as contributing to improved value for money.

**9.106** Measurement processes and declared gains will be reviewed by the Department's internal auditors prior to final declaration and reporting of Gershon savings.

**9.107** Efficiency gains reported under Gershon provide a specific perspective on NHS efficiency. Calculating gains by aggregating specific individual projects does not take account of wider changes in input costs or activity output across the NHS. The limited number of outcome measures that have been used do not capture all locally realised cost improvements and efficiency gains. The dynamic and complex nature of the NHS, with continuous changes to the levels and nature of demand for services, makes it difficult to derive robust stand-

alone efficiency measures for some projects or outcomes. These constraints were recognised explicitly for health in the NAO report.

#### Reported gains to date

**9.108** Figure 9.20 shows the gains that have been recorded for 2004-05, 2005-06, 2006-07 and up to quarter 3 of 2007-08. By this last reported quarter, gains had increased to £7.2 billion, surpassing the £6.5 billion target.

**9.109** One further reporting quarter remains, and some further gains will be realised in quarter 1 and quarter 2 of 2008-09 from data lags relating to performance up to March 2008. The Department currently expects to report a final outturn against the Gershon target ranging from £7.5 billion to £8.0 billion.

**9.110** In 2006, the OGC introduced a classification process for differentiating reported efficiency gains against two sets of criteria – status of the gains and robustness of the measurement and assurance process. Status may be classified as preliminary, interim or final, dependent on whether source data or service quality assurance may be subject to change. Robustness may be classified as full, substantial or partial, dependent on the reliability of source data and the degree of audit or external assurance. A full explanation of these

**Figure 9.20: Reported gains to date and forecast outturn**

Workstream					£ million
	2004-05	2005-06	2006-07	2007-08 quarter 3	Cashable gains <sup>(4)</sup>
Productive time <sup>(1)</sup>	508	963	1,756	3,101	253
Procurement	333	1,322	2,448	2,890	2,890
Corporate services	14	38	57	65	30
Social care	0	179	390	600	445
Policy funding and regulation <sup>(2)</sup>	13	77	270	501	501
<b>Total<sup>(3)</sup></b>	<b>868</b>	<b>2,579</b>	<b>4,921</b>	<b>7,157</b>	<b>4,119</b>

Source: Financial Planning and Allocations Division, DH

Notes:

(1) Productive Time gains now based on measurement processes agreed with HM Treasury to address issues raised by National Audit Office in 2007 relating to measurement of length of stay. This measurement now uses a three-year moving average. The reported saving currently assumes no further improvement in 2008-09

(2) £30 million of savings attributable to the core Department change programme were achieved in 2003-04. An early baseline was agreed with OGC and HM Treasury as the programme, which had commenced in 2003, delivered a key Gershon recommendation on reducing central bureaucracy, and was used to calculate the contribution to target and to report actual gains.

(3) Savings from reduced central budgets will not be included due to difficulties in imputing efficiency gains to an acceptable level of robustness.

(4) Cashable gains account for 57% of the total. The calculation of cashable gains does not include the value of productive time service redesign changes. These improvements reduce the cost of patient episodes which each organisation may choose to make cashable (by eliminating the spare capacity) or may use the released capacity for additional activity or services. If these were to be included, the percentage of cashable gains would increase to over 94%. The split of cashable and non-cashable gains for social care is advised by local authorities in the Annual Efficiency Statements.

classifications is provided in the ETN. **Figure 9.21** shows the breakdown of latest gains using this classification.

**Figure 9.21: Classification of reported efficiency gains**

	£ million			
	Preliminary	Interim <sup>(1)</sup>	Final	Total
Status of gains	0	626	6,531	7,157
	Partial	Substantial	Full	Total
Data assurance	0	2,957	4,200	7,157

Source: Financial Planning and Allocations Division, DH

Notes:

(1) Interim gains relate to 2007-08 savings in procurement, social care, corporate services and policy funding and regulation that are subject to year end validation. The final year element of the three-year moving average productive time length of stay calculation is also interim, but as this assumes no further reduction from current stay duration this is likely to be an under-estimate.

**9.111** With the agreement of HM Treasury, over-achievement of cashable Gershon efficiencies can be offset against new value-for-money targets from the 2007 Comprehensive Spending Review. It is anticipated that around £400 million of the £700 million over-delivery to date will be offset against future value-for-money targets. The final roll-forward figure will be published in the 2008 Autumn Performance Report.

### Assurance of service quality

**9.112** For each separate efficiency project or area of gain, it has to be demonstrated that service quality has at least been maintained. Balancing quality measures appropriate to individual workstreams and projects are set out in the ETN. The latest position on agreed quality measures is set out in **figure 9.22**.

**Figure 9.22: Service quality measures**

Workstream	Quality measures
Procurement	Maintained or improved product quality standards are inherent in procurement contracts and specifications. NHS organisations will choose not to purchase if standards not maintained. Drug price savings are for named drugs for which quality must be unchanged.
Productive time	<p>Patient satisfaction improved by average 0.5% (latest data 2006).</p> <p>In-patient waiting times improved from 10.2 to 7.6 weeks and outpatient waiting times from 5.2 weeks to 3.1 weeks (2007).</p> <p>Main PSA targets delivered or on-track.</p> <p>Post in-patient mortality reduced from 1.76% to 1.69% (2005).</p> <p>Hospital readmissions increased from 9.0% to 10.1% (2006).</p>

Workstream	Quality measures
Social care	Quality assurance of individual projects by councils not reported to central government. Performance on each of five key performance indicators and overall star ratings for councils show improvement since 2004 (2006).
Corporate services	Shared services – no evidence of SLA breaches or penalty payments. Electronic Staff Record – awaiting results of independent Gateway 5 review in 2008.
Policy funding and regulation	Main NHS PSA targets delivered or on-track (quality measure for DH and SHA restructuring as these functions support NHS delivery). Arm's length bodies are meeting service level agreements and basket of service quality indicators. National Audit Office (January 2008) reported favourably on the implementation of the new sector structure.

**9.113** The assurance measures in place are all showing maintained and, in most cases, improved service quality, with the exception of hospital readmissions. Readmissions as a percentage of total admissions have been rising since 2002, prior to the start of the efficiency programme. This is most likely linked to a number of systemic healthcare changes such as the changing mix of in-patients as less complex cases are treated outside of hospital, and the treatment of patients with long-term conditions. These would not imply any increased risk to patients, indeed mortality after in-patient stay is falling. Initial analysis by the National Centre for Health Outcomes Diagnosis to isolate specific causes proved inconclusive. Further, more detailed analysis has been commissioned.

### Progress highlights

#### Productive time

- The average length of stay for hospital in-patients has reduced by over 15 per cent since March 2004 as a result of service redesign and more effective management of patient treatment pathways.
- There has been a reduction of over 3 million emergency bed days per year since March 2004 and this continues to increase as the strategies for treatment of long-term conditions and *Our Health, Our Care, Our Say* (DH, January 2006) (keeping patients out of hospital) are fully embedded.
- Emergency care practitioners treating emergency patients in situ have reduced the number of A&E admissions.

- The trend increase in outpatient appointments of 2.6 per cent per year has been reversed, saving over 1 million appointments.
- Over 10 million patient appointments in GP surgeries were administered by nurse practitioners in the last year, freeing GPs to spend more time with patients suffering more urgent and complex illnesses.
- Improving medical techniques, technology and associated process redesign means that an increasing number of treatments are being done as day cases. Almost 73 per cent of all planned procedures are now done this way, reducing treatment costs and enabling more patients to go home earlier.
- NHS organisations are now provided with quarterly performance information on key measures of service efficiency. This enables them to benchmark their performance against similar providers and identify further potential opportunities for improvement. The metrics are supplemented by productivity guidance setting out the best practices associated with high efficiency performance. This benchmarking process has helped to deliver significant further gains in the year since their introduction.
- NHS organisations are using techniques such as Lean to identify and realise significant cost savings and improved patient service. Savings and improvements are being achieved in many elements of service delivery and support processes and not all are captured by national performance indicators used to calculate Gershon efficiency savings.

#### Procurement

- A second wave of national procurement contracts for NHS supplies and services is now fully in place enabling cost savings across a substantially wider range of goods and services.
- By the end of 2007, procurement hubs were established in all SHAs except the London and South West SHAs, both of which have informal

collaborative processes prior to implementing more formal hubs during 2008-09.

- The contract with DHL Logistics has been operational for one year. Following initial embedding of operations, significant procurement savings are expected over the next three years.
- significant further savings were realised on generic prescribed drugs in 2007 through the annual negotiation of the pharmacy contract.

#### Corporate services

- The Shared Services Joint Venture Company established in 2005 has over 100 NHS organisations contracted for financial services. A payroll processing service is now operational. Additional organisations continue to be recruited.

#### Policy funding and regulation

- The Commissioning a Patient-led NHS Programme aimed at restructuring and reducing the number of SHAs and PCTs resulted in a fully operational new structure from October 2006. Planned savings in operating costs resulting from downsizing and restructuring have been realised, although these are offset by redundancy costs in 2007-08.
- Organisational changes resulting from the Arm's Length Body Programme will be complete by the end of 2008-09 and planned savings of £250 million in operating costs will be exceeded.

#### Social care

- The 2006-07 annual efficiency statements from local authorities confirmed annual efficiencies increasing to £518 million and confirmed plans for 2007-08 that will result in the original Gershon target of £685 million by 2008 being exceeded.
- The Care Services Efficiency Delivery Programme has established a highly effective partnership with local authorities, supporting the roll-out of six major efficiency initiatives that should contribute

over £250 million of new annual efficiency savings by March 2008. These comprise:

- redesign of the referral, assessment and care management process for care service users;
- adoption of automated electronic systems for monitoring visits and time spent by homecare workers resulting in a number of efficiency and service improvement opportunities;
- developing solutions to better forecast demand for services and resulting capacity planning enabling more efficient use of resources;
- targeting direct support interventions of service users to maximise their long-term independence and reduce whole-life cost of care;
- developing tools and solutions to embed value-for-money principles into buying and commissioning processes for social care; and
- reviewing community equipment and wheelchair services providing an improved model of service delivery.

### Reduced Civil Service headcount

**9.114** The Department committed to a gross reduction of 1,400 full-time equivalent civil servant posts in the core departments through its change programme launched in early 2003. Of these, approximately half (680) were expected to be transfers to other NHS bodies and the remainder (720) were net reductions as defined in the Gershon target.

**9.115** Although the initiation of this programme pre-dated the formal baseline for the Gershon programme, its objectives aligned wholly to Gershon's recommendations on reducing central regulatory and administrative functions. A 2003 baseline was agreed and the 720 net target was agreed on this basis.

**9.116** The substantive programme of workforce reduction took place during 2003-04 and remained stable for the following three years. During 2007-08, the Department has taken robust action to meet a tighter operating cost budget and a

requirement to reduce costs further by 5 per cent per year during the 2008 to 2011 settlement period. These actions have included a rigorous business planning and prioritisation process and a voluntary exit scheme that resulted in 47 leavers.

**9.117** As a result of these actions, the net full-time equivalent headcount reduction from 2003 at the end of December 2007 is 819, which is 99 in excess of the March 2008 Gershon target.

### Lyons relocations

**9.118** The Department is committed to the relocation of 1,030 posts out of London and the South East by March 2010. By December 2007, 870 relocations had been completed, 84 per cent of the March 2010 target.

**9.119** During the last year, relocations have been completed by the General Social Care Council (GSCC) (49 posts to Rugby) and the National Institute for Health and Clinical Excellence (18 additional posts created in Manchester).

**9.120** The Department has agreed and communicated an accommodation strategy that will result in further relocation of posts to Leeds and a rationalisation of the estate from the existing five buildings. Thirty-eight posts have moved to Leeds and a further 59 posts are scheduled to relocate during 2008.

**9.121** Further relocations will result from posts relocated by the GSCC. The business needs of other organisations continue to be reviewed and may lead to other confirmed moves during 2008. The Department is therefore confident that the overall Lyons target can be achieved.

### New value-for-money targets from 2008

**9.122** Gershon targets concluded at the end of 2007-08 (with the exception of the Lyons target, which has an end date of March 2010). The 2007 CSR covering the period 2008-09 to 2010-11 includes a commitment to 3 per cent per year

cashable value-for-money savings, totalling £8.2 billion by March 2011. Agreed over-delivery against Gershon will count towards this target.

**9.123** The current efficiency programme to deliver the Gershon target has continued to evolve over the last three years and the main delivery strands will form the core of the programme to deliver the new value-for-money target.

**9.124** Main elements of the new programme include:

- reducing variation in front-line service delivery efficiency (referrals and appointments, admissions, length of stay);
- redesign and realignment of services across traditional acute, primary and community care boundaries;
- mental health and public health;
- improved procurement processes and contracts for goods and services and drugs; and
- pay settlements that are affordable and represent value for money.

**9.125** Further details of these new plans are provided in the *Value for Money Delivery Agreement*, which was published on the Department's website ([www.dh.gov.uk](http://www.dh.gov.uk)) in December 2007.

**9.126** The Department is continuing to work closely with NHS leaders to identify and develop further efficiency and value-for-money opportunities. A joint NHS and Department of Health Efficiency Leadership Group has identified key opportunities that will be incorporated into an updated strategy due to be published in early summer 2008.

**9.127** There will not be a new target for reducing headcount, although a 5 per cent per year cumulative reduction in the Department's budget will necessitate tight control of spending and a likely reduction in staffing levels over the period.

## NHS productivity

**9.128** In January 2008, the Office for National Statistics (ONS) published its latest article on NHS productivity.

**9.129** The article distinguishes three separate phases of productivity performance since 1995:

- From 1995 to 2001, productivity was stable, falling slightly by 0.1 per cent.
- From 2001 to 2005, productivity fell by 2.5 per cent per year.
- From 2005 to 2006, productivity levelled off, falling by only 0.2 per cent.

**9.130** Since 1995, NHS output has risen by 50 per cent (see **figure 9.23**).

**9.131** The ONS article shows falling NHS productivity from 2001 to 2005. This coincides with the period of extra investment focused on improving access and improving outcomes in the big killer diseases of cardiovascular disease and cancer.

**9.132** The upturn in productivity from 2005 reflects the levelling off of investment, the slowing of workforce growth, and the focused prioritisation of the NHS on improving efficiency.

**9.133** The ONS productivity formula compares inputs (staff and resources) with outputs (activities such as prescriptions, appointments or operations). It excludes cost savings from better procurement (and any extra costs of above-inflation pay), does not measure the outcomes of NHS treatments, and is unable to account fully for changes such as more cost-effective alternative care pathways.

**9.134** The objective of the NHS is not to maximise activity but to maximise the health and well-being of the population, improve access and reduce health inequalities. Following the 2005 *Atkinson Report* on public sector productivity, the Department and ONS accepted that productivity measures must take

account of quality and outcomes (health and well-being, patient satisfaction and service levels such as waiting times).

**9.135** The Department published an article in October 2007 – *Further Developments in Measuring Quality Adjusted Healthcare Output* – which puts forward potential enhancements to address some of these omissions. Although these new quality adjustments have not been fully accepted by ONS, its latest article (January 2008) recognises that its measurement of quality is not comprehensive and probably understates quality improvement.

**9.136** The Department and ONS will continue to work together to improve the measurement of NHS output and productivity. A key focus of this work will be on how to use clinical outcome data to measure health benefit arising from NHS treatment.

**9.137** Patient-reported outcome measures offer an opportunity to measure outcomes as assessed by patients themselves. A hip replacement questionnaire, for example, compares patients' own assessment of their mobility and pain before and after a hip operation, creating a measure of clinical

success and health benefit. The Standard NHS Contract for Acute Services, published as annex E of the *NHS Operating Framework for 2008-09*, included the requirement from 1 April 2009 for patient-reported outcome measures for all NHS patients undergoing hip and knee replacements, groin, hernia and varicose vein procedures.

### Management costs in the NHS

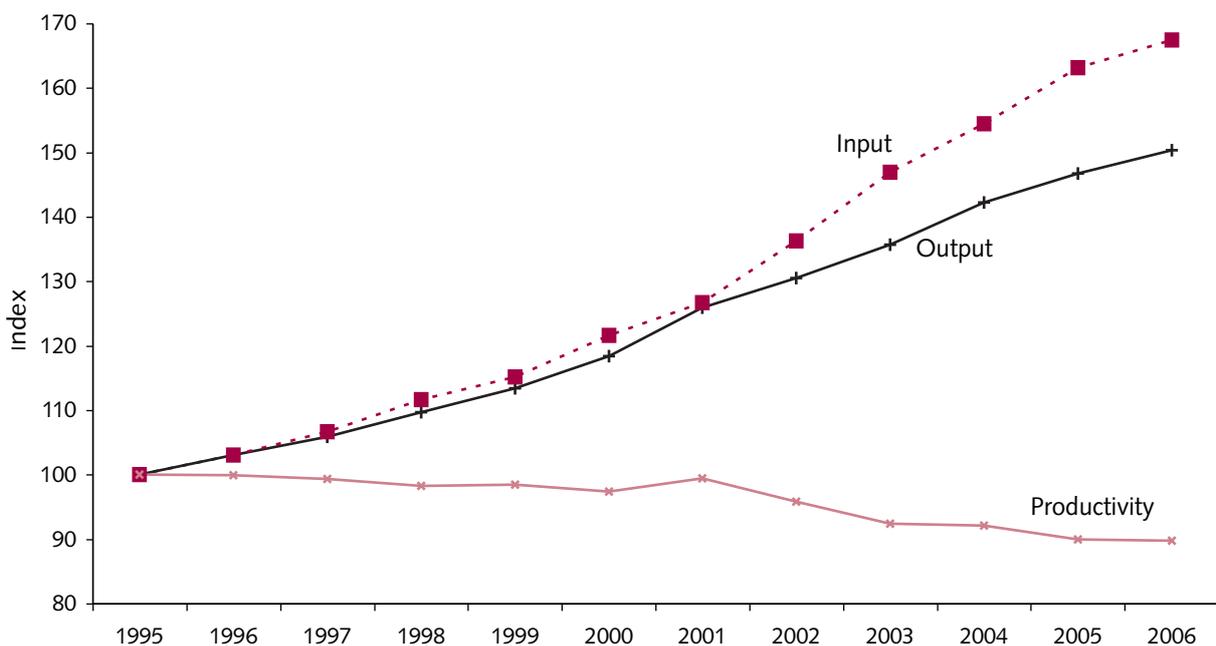
**9.138** The cost of managers in the NHS, as a percentage of overall spend, continues to fall.

**9.139** Currently, the figure for management costs is under 4 per cent of total NHS expenditure, whereas it was 5 per cent in 1997-98 (see **figure 9.24**).

**9.140** In addition, NHS organisations have been working towards producing a recurrent saving of £250 million in the costs of administration and management across the NHS, to be reinvested in services in 2008-09.

**9.141** As at 31 December 2007, there were 1,876 compulsory redundancies in the NHS in the 2007-08 financial year, of which 86 per cent were

**Figure 9.23: NHS productivity 1995–2006 (excluding quality)**



Source: ONS Article on Health Care Productivity January 2008

in non-clinical grades, which includes managers and administrative staff.

## Personal Social Services

**9.142** As part of the CSR 2007, the Chancellor confirmed the central government provision for local authorities through the Revenue Support Grant. Overall, the settlement gave local government a growth of 1 per cent in real terms for the period. The settlement includes an expectation that local authorities will also deliver 3 per cent efficiencies to contribute to the rising costs due to the changing demographic profile of the country.

## Total PSS expenditure

**9.143** Figure 9.25 shows the latest available local authority current and capital expenditure on social care services. The gross expenditure figures from 2004-05 relate only to adult PSS due to the transfer of responsibilities for children's social care services from the Department.

**9.144** In 2006-07, gross current expenditure in England on adult PSS was £14 billion. The largest items of expenditure were for residential care (50.6 per cent) and day care and domiciliary provision (36.7 per cent). Within spending on

**Figure 9.24: NHS management costs, 1996-97 to 2006-07 (cash terms)**

Year	Total (S)HA, PCT and NHS trust management costs (£ thousands)	NHS total expenditure (£ million)	% management costs of NHS budget
1996-97	1,675,800	32,997	5.10%
1997-98	1,727,556	34,664	5.00%
1998-99	1,703,364	36,608	4.70%
1999-2000	1,783,212	40,201	4.40%
2000-01	1,867,239	43,932	4.30%
2001-02	1,992,453	49,021	4.10%
2002-03	2,131,891	54,052	3.90%
2003-04	2,387,709	64,184	3.70%
2004-05	2,576,984	69,308	3.70%
2005-06	2,724,336	76,339	3.60%
2006-07	2,802,820	80,844	3.50%

Source: NHS Finance, Performance and Operations, DH

Notes:

(1) NHS trusts 1996-97 to 2006-07.

(2) Health authorities for 1996-97 to 2001-02.

(3) Strategic health authorities 2002-03 to 2006-07.

(4) Primary care trusts 2000-01 to 2006-07.

(5) Figures exclude NHS foundation trusts from 2004-05.

**Figure 9.25: Expenditure by local authorities on Personal Social Services**

	1998-99 outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	£ million
<b>Current expenditure<sup>(1)</sup></b>										
gross <sup>(2)</sup>	10,850	12,050	12,850	13,600	15,200	16,840	12,830	13,727	14,314	
charges <sup>(2)</sup>	1,790	2,000	2,150	2,230	2,310	2,080	1,955	2,009	2,068	
net <sup>(3)</sup>										
cash	9,060	10,050	10,700	11,370	12,890	14,190	10,873	11,718	12,246	
real terms <sup>(4)</sup>	10,986	11,946	12,540	13,013	14,306	15,305	11,412	12,040	12,246	
<b>Capital expenditure<sup>(2)</sup></b>										
gross	140	134	156	158	199	260	285	387	364	
income	53	51	63	70	75	74	75	84	85	
net	87	83	93	88	124	186	210	303	279	

Source: PSS EX1, RO, RA LAs returns and Capital Outturn

Notes:

(1) Figures for current expenditure from 2004-05 relate only to adult's personal social services due to the transfer of responsibilities for children's social services from the Department.

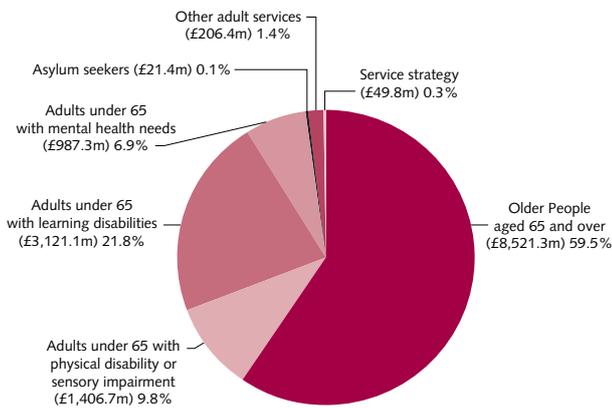
(2) Gross current expenditure, income from charges and capital figures are not available for 2007-08.

(3) Net expenditure figures exclude the Supporting People Grant, which began in April 2003.

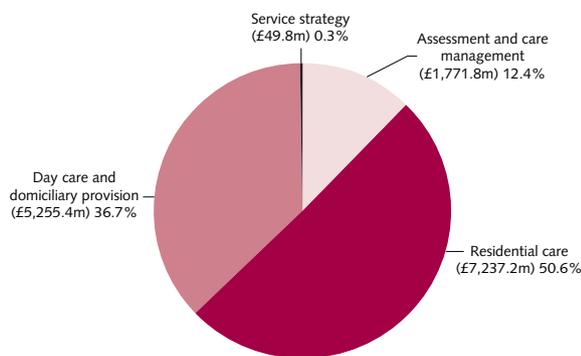
(4) At 2006-07 prices using the GDP deflator (as at 28 March 2008).

residential care, most was spent on residential and nursing home care provided by the independent sector (see **figures 9.26** and **9.27**).

**Figure 9.26: Local authority adult personal social services gross expenditure by client group, 2006-07**



**Figure 9.27: Local authority adult personal social services gross expenditure by type of service, 2006-07**



### PSS revenue provision

**9.145** **Figure 9.28** sets out the revenue (and capital) resources to be made available for adult social care services between 2008-09 and 2010-11 with funding levels for 2007-08 included for comparative purposes.

**9.146** Following the 2007 Budget, from 2008-09, nearly all of the grants from the Department of

Health are now included in the new Area Based Grants. This gives local authorities the freedom to allocate these resources to meet the priorities within their Local Area Agreement, while the Department will continue to encourage authorities to meet the policy directives for which these grants were initially intended.

### Social Care Reform Grant

**9.147** The CSR 2007 includes the new Social Care Reform Grant. The grant will make available more than £500 million of funding to all councils with social services responsibilities (CSSRs) over the next three years (2008-09 to 2010-11) to support councils to redesign and reshape their local systems. This includes supporting all CSSRs to create a strategic shift in resources and culture from intervention at the point of crisis towards early intervention and improved well-being in line with the needs of their local population. This grant includes money from the NHS, in recognition of the positive impact investing in social care through early intervention and re-ablement can have on people's health.

**9.148** The Department of Health is currently working with its partners to develop a facilitation and support programme. This will include ensuring that the key learning from the Partnerships for Older People pilots and other initiatives such as Individual Budgets pilots and the Department for Work and Pensions' LinkAge Plus pilots can be made available to councils to support their work to transform local systems.

**9.149** The expectation is that, by 2010-11, councils will have made significant steps towards redesign and reshaping their adult social care services, with the majority having most of the core components of a personalised system in place. Councils should be able to demonstrate to their partners better use of resources across the entire system by investing in early intervention to ensure that they embed the new systems at a local level.

**Figure 9.28: Personal Social Services provision for adults, 2007-08 to 2010-11**

	2007-08	2008-09	2009-10	£ million 2010-11
<b>Revenue</b>				
<b>Ringfenced specific grants</b>				
AIDS Support	16.500	19.800	21.800	25.500
Learning Disabilities: closure of campuses		14.000	31.000	51.000
Social Care Reform Grant		84.000	194.000	239.000
<b>Subtotal</b>	<b>16.500</b>	<b>117.800</b>	<b>246.800</b>	<b>315.500</b>
<b>Contributions to Area Based Grant<sup>(1)</sup></b>				
Adult Social Care Workforce <sup>(2)</sup>		139.000	143.000	147.000
Carers <sup>(3)</sup>	185.000	224.000	240.000	256.000
Child and Adolescent Mental Health Services (CAMHS) <sup>(3)</sup>	90.539	94.998	100.045	105.036
Learning Disability Development Fund		43.752	43.752	43.752
Local Involvement Networks (LINKs) <sup>(3)</sup>		27.000	27.000	27.000
Mental Capacity Act and Independent Mental Capacity Advocate Service	14.625	23.825	30.090	28.926
Mental Health	132.900	139.545	146.854	154.180
Preserved Rights	275.248	260.200	247.000	235.400
<b>Subtotal</b>	<b>698.312</b>	<b>952.320</b>	<b>977.741</b>	<b>997.294</b>
<b>Grants rolling into Revenue Support Grant in 2008-09</b>				
Access and Systems Capacity	546.000			
Delayed Discharges	100.000			
<b>Grants ended by 2008-09</b>				
CSCI Reimbursement	0.750			
Human Resources Development Strategy	49.750			
National Training Strategy	107.859			
Individual Budget Pilots	6.000			
Partnerships for Older People Projects (POPP)	40.000			
Preventative Technology	50.000			
<i>DH funded. Allocated by other government departments<sup>(4)</sup></i>	7.500			
<b>Total revenue grants</b>	<b>1,622.671</b>	<b>1,070.120</b>	<b>1,224.541</b>	<b>1,312.794</b>
<b>Capital</b>				
<b>Single Capital Pot</b>				
Single Capital Pot – social care element (non-ringfenced)		27.727	27.727	27.727
Single Capital Pot – mental health element (non-ringfenced)		22.593	22.593	22.593
<b>Subtotal</b>		<b>50.320</b>	<b>50.320</b>	<b>50.320</b>
<b>Specific capital grants</b>				
AIDS/HIV	3.100	3.100	3.100	3.100
Common Assessment Framework		11.000	11.000	11.000
Extra Care Housing Grant	40.000	40.000	40.000	0.000
Infrastructure Support		0.000	0.000	40.000
Social Care IT Infrastructure		15.000	16.000	17.000
<b>Subtotal</b>	<b>43.100</b>	<b>69.100</b>	<b>70.100</b>	<b>71.100</b>
<b>Grants ended by 2008-09</b>				
Improving Information Management Grant	25.000			
<b>Total capital resources</b>	<b>68.100</b>	<b>119.420</b>	<b>120.420</b>	<b>121.420</b>
<b>Total PSS provision</b>	<b>1,690.771</b>	<b>1,189.540</b>	<b>1,344.961</b>	<b>1,434.214</b>

Source: Directorate for Social Care, Local Government and Care Partnerships, DH

Notes:

(1) The Area Based Grant begins in 2008-09. Contributions listed for earlier years were specific grants.

(2) The Adult Social Care Workforce Grant beginning in 2008-09 combines two previous grants, Human Resources Development Strategy and National Training Strategy, that ended in 2007-08.

(3) Human Resources Development Strategy and National Training Strategy (up to 2007-08), Carers, CAMHS and LINKs include an element of funding for children's services.

(4) Funding allocated by other government departments includes:

– CAMHS £3 million transfer to the Department for Education and Skills for 2007-08.

– Young People's Substance Misuse £4.5 million transfer to Home Office recurring in 2007-08.

**9.150** Adult social services are funded by the general grant, distributed by the Department for Communities and Local Government (DCLG), by each council's ability to raise revenue through council tax and by specific grant allocation from central government departments. From 2006-07, a new method of allocating Formula Grant was used. This new allocation model, developed by DCLG, contains four funding blocks:

- the central allocation;
- relative needs amounts;
- relative resource element; and
- floor damping blocks.

**9.151** To avoid any potentially misleading inference that formula amounts could approximate to required expenditure at local authority level, the former Formula Spending Share has been replaced by relative needs formulae (RNF) for each service block (e.g. older people, younger adults, children). Each local authority now receives a proportionate share of the overall control total for a service block, where that share is expressed as a proportion and not in monetary terms.

**9.152** The new needs-based RNF allocation formulae for adult social care incorporate the latest available 2001 Census data, and have been developed following a rigorous process of academic research. These formulae will better reflect actual need for services, and will therefore allocate resources more accurately and equitably. The Department also recognised that the new model has produced significant step changes in allocations for some councils, and has therefore applied appropriate floor damping mechanisms to help local authorities manage any redistributive effect.

### **PSS capital resources**

**9.153** In addition to the revenue grants made available by the Department of Health, there are additional capital resources available to local authorities to meet key priority areas. These are specific ring-fenced capital grants.

**9.154** Alongside these grants is a further allocation of non ring-fenced grants for mental health services and for personal adult social care services, totalling £50.32 million for all three years (see **figure 9.28**).

### **How the resources are used**

**9.155** The Department's social care allocations support services for three main client groups:

- children and adolescents, insofar as they are supported by the Child and Adolescent Mental Health Services (CAMHS) Grant and elements of the Carers Grant, National Training Strategy Grant, Human Resources Development Strategy Grant and Improving Information Management Grant;
- younger adults aged 18 to 64, requiring services ranging from specialist services for those with physical and learning difficulties, mental health problems, and issues relating to drugs or HIV and AIDS; and
- older people aged 65 and above, requiring principally specialised residential and intensive home care services.

**9.156** The Department is responsible for establishing overall policy in respect of social care, leaving councils with a significant degree of flexibility in delivering their adult social care commitments according to local priorities and the needs of the community they represent.

### **PSS efficiency**

**9.157** The Department of Health funds the Care Services Efficiency and Delivery Team to support local authorities in their work to deliver services in a more efficient way. It has developed a series of products and toolkits to assist authorities. The Department is expecting to spend £4.402 million supporting this programme in 2007-08, which includes £1.500 million for developing new retail models for community equipment and retail services. This programme will continue in 2008-09 with a wider range of products, which will assist local councils in delivering further efficiencies.

# 10 Capital Finance

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## Introduction

**10.1** This chapter reports on the priorities for NHS capital investment in 2008-09. It also explains the changes to the NHS capital investment regime and details the overall level of capital available, including that provided through public private partnership (PPPs), and how it is being put to use. It provides an update on the Hospital Building Programme and the various ways in which capital funding is provided in the NHS and Personal Social Services.

## Characteristics of capital investment

**10.2** In contrast with revenue expenditure, which is expenditure on goods and services to be consumed in the current financial year, capital investment is expenditure now (typically on buildings and large pieces of equipment) that will continue to provide benefits over a number of future financial years. To count as NHS capital expenditure, the expenditure must generally be on assets that individually cost £5,000 or more and that are recorded on the balance sheet as fixed assets.

## Available NHS capital resources

**10.3** 2008-09 is the first year covered by the 2007 Comprehensive Spending Review (CSR) settlement. The public capital resources available to the NHS will increase to total almost £4.6 billion, from their 2007-08 level of £4.2 billion (and actual net capital expenditure of £3.3 billion), giving the health service scope to further improve the quality of the assets with which services are delivered.

**10.4** As in previous years, there will also be further investment through the private finance initiative (PFI) and through the NHS Local Improvement Finance Trust (LIFT), the PPP vehicle for transforming primary care premises. Some capital assets will also result from the Independent Sector Treatment Centres Programme.

**10.5** The capital resources available to health are set out in **figure 10.1**, which includes an estimate of the capital funding that will be supplied under PFI. The remainder of this chapter explains how public capital resources will be distributed to the NHS, and outlines some of the capital investment priorities for 2008-09 and progress with some of the PPP arrangements for delivering improved NHS facilities.

**Figure 10.1: NHS capital spending, 2006-07 to 2008-09 (resources)**

	2006-07 outturn	2007-08 estimated outturn	£ million 2008-09 plan
Government spending	3,069	3,316	4,567
<i>Percentage real terms growth<sup>(1)</sup></i>		4.7	33.7
Receipts from land sales <sup>(2)</sup>	1,167	515	286
PFI investment	1,121	1,195	1,379
<b>Total</b>	<b>5,357</b>	<b>5,026</b>	<b>6,232</b>

Source: NHS Finance, Performance and Operations, DH

Notes:

(1) Real terms growth calculated using GDP deflators as at 28 March 2008.

(2) The figures for outturn and estimated outturn receipts from disposals include disposals between NHS organisations because these are not separately identified in the accounts of NHS organisations.

## Allocation of capital to fund local investment priorities

**10.6** Until recently, much of the capital resource available to the NHS was allocated on a formulaic basis to NHS trusts and primary care trusts (PCTs), as operational capital (based on depreciation and thus the current asset bases), and to strategic health authorities (SHAs) as strategic capital (based on weighted capitation). Although this system could be considered equitable, the fixed allocations did mean that some organisations were prevented from undertaking much-needed investments, while others were entitled to more capital than they could actually spend effectively, contributing to overall underspends.

**10.7** Because of this scope for inconsistency between formulaic allocations and optimal levels of investment, it was decided that NHS foundation

trusts, the first of which were established in 2004, should be free to determine the level of capital investment that was appropriate for them. In doing this, they would balance the capital investment needs of their services against their ability to meet the servicing costs of their capital investment (capital charges) to arrive at an optimal level of investment.

**10.8** To fund this investment, NHS foundation trusts are free to reinvest all cash generated from their operations (mainly the cash released through the depreciation charged in their accounts, but also operating surpluses) as well as any cash from disposing of surplus property. They were also allowed to borrow under a *Prudential Borrowing Code* (Monitor, March 2005).

**10.9** Loans differ from the public dividend capital (PDC) that is currently issued to cover most additional investment in that they are repayable according to a pre-agreed repayment schedule and attract interest at a fixed rate on the balance that is outstanding at any time. NHS foundation trusts are authorised to borrow from commercial banks and also from the Department of Health. The Department has established a loan facility to make long-term loans available to them and £238 million of loans have been agreed to date, of which £26 million was drawn in the last year.

**10.10** At the time of writing, there are 96 NHS foundation trusts, with further applications under consideration by the Department and Monitor, the independent regulator of NHS foundation trusts.

**10.11** Because of the allocative benefits, and because the prudential borrowing arrangements provide a strong incentive to improve financial performance (surpluses permitting additional investment), prudential-based capital allocation arrangements were rolled out to the remaining NHS trusts from the beginning of 2007-08. They too now choose a level of investment that is sustainable

and appropriate for their operations, rather than having capital allocated to them.

**10.12** From the beginning of 2008-09, PCTs will also be allowed to set their own local investment plans. In the *NHS Operating Framework for 2008-09* (DH, December 2007), indicative budgets were issued for locally driven capital investment by the PCT sector, with the instruction that they should work with their SHAs to produce robust, deliverable capital investment plans for submission to the Department.

**10.13** In 2008-09, for the first time, the entire NHS will be free to implement local capital investment priorities without having to live within fixed capital allocations. It is anticipated that this greater freedom will produce more reliable investment plans that are implemented more quickly by local NHS organisations.

## Transitional arrangements including programme budgets for funding centrally driven initiatives

**10.14** Although prudential borrowing contains an appropriate balance of freedoms and incentives for the provider sector, allocations of PDC will continue to be made on a transitional basis, until all NHS trusts and NHS foundation trusts are fully adjusted to the new system.

**10.15** Allocations will continue to be made to fund the completion of projects started under the previous arrangements, the cut-off point being for schemes that let contracts before December 2006, when the *New Capital Regime* guidance was issued to NHS trusts.

**10.16** PDC will also be available to the trust sector to fund specific policy announcements that have been made centrally. These are referred to as programme budgets. With the prudential arrangements now in place, it should not be necessary to announce further targeted capital

budgets, but the Department will continue to make PDC available to fund investment commitments that have already been announced.

**10.17** In the above instances, PDC is only available where the NHS trust or NHS foundation trust is already reinvesting all of the cash generated through its depreciation charge and any cash from disposing of fixed assets. The PDC contribution is reduced by the value of any uninvested depreciation or asset disposal cash.

**10.18** With the new 'bottom-up' arrangements for allocating capital to PCTs, the justification for further central programme capital budgets for this sector is also reduced. The programme budgets aimed at PCTs will nevertheless continue to be centrally funded until the programmes are complete.

**10.19** Some of the larger programme budgets aimed at both provider and PCT sectors in 2008-09 are outlined below.

### Community hospitals

**10.20** The largest programme budget is the £750 million that was announced to facilitate the development of community hospitals and services in accordance with the objectives set out in the policy document *Our Health, Our Care, Our Community: Investing in the Future of Community Hospitals and Services* (DH, July 2006). Some £95 million of this expenditure has been allowed for in 2008-09 plans.

**10.21** In December 2007, the Health Minister Ben Bradshaw announced a third tranche of nine community hospitals and services, bringing the total number of schemes funded through the programme to 23. The total investment in these schemes is in excess of £272 million, of which £190 million has been sourced through the Community Hospitals and Services Programme.

**10.22** The first completed scheme is at Felixstowe, where the community hospital has been given a £1.8 million refurbishment. The hospital provides

modern and well-equipped services for local people, including a minor injuries unit, improved X-ray facilities, 16 in-patient beds and a base for the local healthcare team of district nurses, occupational therapists and physiotherapists.

### Fluoridation

**10.23** SHAs are under a statutory obligation to reimburse water companies for the costs they incur in setting up and running fluoridation schemes. A central budget has been created for the capital costs of the necessary buildings and plant in water treatment works. A total of £14 million has been allocated to the budget in each of the three years 2008-09 to 2010-11. Some calls on the budget are expected from SHAs for the renewal of plant in existing fluoridation schemes, but significant new expenditure will only be incurred if an SHA can show, through public consultations, that the local population is in favour of a new fluoridation scheme.

### Substance misuse

**10.24** Some £41 million of 2008-09 capital funding has been made available to fund the capital costs of increasing the number of in-patient places for drug treatment and drug rehabilitation. In-patient and residential facilities are under-provided within drug treatment pathways, and, unlike other types of drug treatment, have not grown in recent years. A shortage of these facilities reduces patient choice and the proportion of patients who become drug-free.

### Learning disability

**10.25** A total of £105 million is available in the 2008-09 capital plan as part of a £175 million initiative for the re-provision of those still living in NHS-provided learning disability campus accommodation to more appropriate supported living in the community, an initiative that has been shown to dramatically improve outcomes among this group of people.

## Mental health

**10.26** Capital totalling £91 million is available centrally in 2008-09 for investment in mental health facilities. In addition to funding improvements to in-patient psychiatric wards and intensive care environments, and increasing the provision of 'dedicated places of safety' for psychiatric assessment as required by section 136 of the *Mental Health Act 1983*, there will be continued investment in developing high secure facilities and facilities for people with dangerous severe personality disorder. There will also be investment in facilities to permit the transfer of some patients into more appropriate care settings and to develop specialist facilities for particular client groups.

## Energy efficiency

**10.27** In January 2006, the Department announced that a £100 million capital fund would be available to finance improvements in energy efficiency in NHS facilities and, in particular, for schemes that will contribute to achievement of the carbon reduction target currently applicable to the NHS. The NHS has been tasked with reducing the level of primary energy consumption by 15 per cent or 0.15 MtC (million tonnes carbon) from March 2000 levels by March 2010. Some £80 million has been set aside in the 2008-09 capital budget for this purpose.

## Public capital investment enabling works for major capital schemes

**10.28** As part of the review of major capital schemes that took place during 2007-08, central capital contributions were agreed to support the delivery of a number of major PFI hospital schemes. Altogether, £127 million is expected to be allocated to these schemes during 2008-09.

## Investments contracted for by the Department and its agencies

**10.29** Where it is commercially and operationally appropriate to do so, the Department will sign contracts for the provision of services that may include the provision of fixed assets. In these circumstances, the expenditure is counted as expenditure by the Department, even where the main beneficiaries of the services are NHS trusts and PCTs.

**10.30** In the last few years, the most significant example of this has been NHS Connecting for Health, the National Programme for IT that will transform information provision in the NHS.

**10.31** Further information on this programme, including the key deliverables, its benefits to patients and clinicians and its important role in achieving several Public Service Agreement targets, can be found in chapter 8. In summary, the national programme will deliver:

- electronic appointment booking;
- an NHS Care Records Service;
- an Electronic Prescription Service; and
- an underpinning IT infrastructure with sufficient capacity to support the critical national applications and local systems.

**10.32** There will also be a significant value of capital funding invested centrally in a range of other bodies that provide services to the NHS, including bodies such as the Healthcare Commission that provide regulatory services, and bodies such as NHS Blood and Transplant that provide essential input for NHS services. There will also be some capital funding for initiatives to improve the efficiency of capital procurement and for implementing an Electronic Staff Record IT system and a range of smaller initiatives.

## Restrictions on capital-to-revenue transfers

**10.33** In 2008-09, the Department expects to have no flexibility to vire capital funds to revenue. There are, however, flexibilities to facilitate capital grants to the private sector and to public corporations. These are accounted for as revenue expenditure in the Department's resource accounts, but are reclassified as capital investment in the national accounts. However, the funding must be used to invest in buildings and equipment assets and cannot be diverted to other uses, such as financing deficits.

## Delivery of public capital-funded buildings and works – NHS ProCure21

**10.34** ProCure21 is a procurement route for publicly funded NHS capital schemes. It was launched in April 2000 as the NHS's response to *Rethinking Construction* and HM Treasury's *Achieving Excellence*. It is compliant with the Office of Government Commerce's *Common Minimum Standards*, a preferable alternative to traditional tender procurement, and is current construction industry best practice. So far over 350 schemes (£2.4 billion) have been registered, of which over 200 have been completed (£1.05 billion).

**10.35** ProCure21 provides a standardised approach using a framework of pre-approved contractors. NHS trusts select a partner without having to go through the *Official Journal of the European Union* process, saving at least six months in tendering time. They work together using a partnering contract to deliver the scheme. Good performance by the contractor is generally rewarded with a long-term relationship with the NHS trust. All schemes receive dedicated support from the Department of Health's ProCure21 Implementation Advisors. These offer support on all aspects of the ProCure21 Programme, provide access to scheme guidance tools and provide as much impartial advice for the scheme as is needed.

**10.36** Performance results have been very positive, with 93 per cent of schemes finished on budget and 84 per cent delivered on time in 2007. On average, ProCure21 schemes were given an 8.5 out of 10 rating on product and service by NHS trusts.

**10.37** Examples of completed ProCure21 schemes include the following:

- Royal Liverpool and Broadgreen University Hospital NHS Trust – cardiothoracic treatment centre – £72 million;
- Newham University Hospital NHS Trust – diagnostic and treatment centre – £15 million;
- Basildon and Thurrock University Hospitals NHS Foundation Trust – cardiac unit – £35 million; and
- West London Mental Health NHS Trust – Orchard clinic – £26 million.

**10.38** Long-term partnerships are being developed between the NHS and its construction partners. Eighty-three per cent of NHS trusts with more than one scheme use the same partner for all. This promotes a better understanding of the NHS, improves delivery and enables schemes to be delivered on time and within budget.

**10.39** The ProCure21 Programme will deliver many of the facilities commissioned through the Community Hospitals Initiative. It is also being used to deliver primary care centres, mental health units, paediatric units, cardiac care units and outpatient units across the country.

## Public private partnerships and innovative investments

**10.40** The NHS is continuing its major programme of investment through the use of PPPs:

- the PFI, which continues to deliver most of the major hospital building schemes; and
- NHS LIFT, an investment vehicle for modernising primary care premises.

**10.41** Recent progress of these initiatives and their plans for 2008-09 are outlined below.

### **PFI and the 100 hospital schemes target**

**10.42** During 2007, a further eight PFI schemes with a combined capital value of £669 million became operational and a further 14 PFI schemes reached financial close and commenced building, with a combined capital value of £2.1 billion. This means that, in total, 93 hospital schemes (70 of which are PFI) are now operational and a further 34 are under construction, of which 29 will be operational by 2010. This means that the Department is now certain to deliver the *NHS Plan* target of ensuring that over 100 hospital schemes will be delivered by the end of 2010.

**10.43** The new schemes under construction continue to vary widely in terms of size, purpose and location. Examples include:

- a joint £375 million scheme to provide a major acute hospital for University Hospital of North Staffordshire NHS Trust and a new Haywood Community Hospital for Stoke PCT;
- a new £21 million cancer centre at Taunton and Somerset NHS Foundation Trust with in-patient beds as well as chemotherapy and haematology day case units; and
- a £75 million replacement of St Luke's Hospital in Middlesbrough by Tees, Esk and Wear Valleys NHS Trust, providing a wide range of mental health services.

**10.44** The Department has continued to work with trusts as part of the reappraisal process set up in 2006 to ensure that trusts with a prospective PFI scheme are able to demonstrate that their projects are affordable and meet both current and future patient needs.

**10.45** To date, 14 PFI schemes have been successfully reviewed, 12 of which are now under construction with the remaining two working towards financial close. The Department's review

team is now working with those PFI schemes that have yet to engage with the market.

### **NHS LIFT**

**10.46** NHS LIFT continues to contribute to the redevelopment of the primary care infrastructure.

**10.47** NHS LIFT has, from the outset, addressed many of the issues subsequently taken up in the White Paper *Our Health, Our Care, Our Say*. For example, it addresses issues such as inter-agency working; improved access to services for patients; and the transfer of diagnosis and treatment from hospitals to primary care facilities where practical.

**10.48** NHS LIFT is flexible in respect of the type of building it provides – buildings are designed around service need rather than vice versa. NHS LIFT is providing a range of building types including re-provision of GP premises, one-stop primary care centres, integrated health and local authority service centres and community hospitals.

**10.49** In many instances, services previously only available in an acute hospital setting, such as minor surgery for hernia repairs, sports injuries and even vasectomies, are increasingly available in new local facilities. In addition, X-rays, medical tests, speech and language therapy, chiropody, physiotherapy, dentistry and pharmacy are available in some of the new centres.

**10.50** NHS LIFT is also one way of taking forward community hospitals under the Community Hospitals and Services Programme.

**10.51** So far there are 48 NHS LIFT schemes, of which 45 have reached financial close and the remaining three are working with their preferred partner. As at 31 January 2008, over 162 primary care premises were open to patients with around 50 more under construction. NHS LIFT has now attracted over £1.3 billion of private capital investment and this level of investment will continue to grow in 2008-09 and beyond.

**10.52** Examples of the new premises being built under NHS LIFT include:

- the new £8 million Stourbridge Health and Social Care Centre (Dudley LIFT), housing a six-partner GP practice and offering a wide array of services including minor surgery, learning disabilities and clinics for chronic conditions such as coronary heart disease, diabetes, asthma, heart failure (diagnosis and maintenance) and lymphoedema; and
- a £10.3 million four-storey building at Barkantine in Tower Hamlets (East London LIFT), which has a birth centre with care provided by midwives from Barts and The London NHS Trust. This includes five en-suite bedrooms, each with a birthing pool. In addition, the building hosts 16 dental surgeries with state-of-the-art equipment, including equipment specially to cater for people with disabilities or dental phobia.

**10.53** During 2007, Partnerships for Health, the Department-owned NHS LIFT delivery vehicle, changed its name to Community Health Partnerships.

## Asset disposal

**10.54** The Department is continuing with the programme of disposal of surplus property in the ownership of the Secretary of State for Health. In doing so, the Department will continue to work closely with English Partnerships, both in respect of the portfolio of nearly 100 surplus sites transferred to them as part of a ground-breaking agreement with the then Office of the Deputy Prime Minister in April 2005 (referred to in last year's Departmental report), and also in respect of other surplus sites that would assist the Government's Sustainable Communities Programme.

**10.55** Income from central disposals has made a valuable contribution to the Department's capital funding in recent years. Including 'overage' payments from sales completed in earlier years, a

further £30 million is expected to be released for reinvestment during 2008-09, from sales of centrally held surplus property.

**10.56** Sales of surplus property owned by NHS trusts and PCTs are expected in 2008-09, yielding in the region of a further £256 million for reinvestment to benefit the NHS.

## Investment in Personal Social Services

**10.57** In social care, new investment has been primarily through revenue funding, which allows local authorities to commission, develop or purchase services, to launch jointly funded partnerships and to develop innovation in social care. These goals may also be pursued through the use of the PFI, for which PFI credits are available to local authorities to help meet the capital costs of such developments.

**10.58** In each year covered by the 2007 CSR, beginning with 2008-09, £121 million is identified for capital grant schemes aimed at encouraging particular service improvements and innovations in social care. The Department of Health identified the uses to which this funding will be put in a letter to local authorities' social services departments (LASSL(DH)(2007)3). In 2008-09, the uses include a contribution to the single capital pot, as well as specific grants for AIDS/HIV schemes, Extra-care housing, demonstration sites for developing the Common Assessment Framework and developing social care IT infrastructure.

**10.59** Asset-based services can also be supported via the mechanisms set out in the *Health Act 1999* partnership arrangements, which enable:

- pooled funds;
- lead commissioning;
- integrated provision; and
- money transfer powers.

**10.60** All of these have been taken up as new forms of investment in joint services, incorporating a mix of health and social services and also housing and education.

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## Introduction

**11.1** This chapter is concerned with the management of the Department of Health and how it operates. It explains how the Department is structured to undertake its key roles and provides some key staffing data and performance statistics along with information on accommodation strategies. It describes the approach being taken to aid better policy development and sets out the Department's performance on sustainable development and equality and human rights.

**11.2** As described in chapter 1, the Department's overall aim is to improve the health and well-being of the people of England.

**11.3** The Department's medium-term objectives are defined by its Public Service Agreement (PSA), as agreed in the 2004 Spending Review. For 2007-08, the seven high-level objectives reflect those PSA priorities and were identified in the Department's *Planning Framework for 2007-08*.

**11.4** The seven high-level objectives for 2007-08 were to:

- improve and protect the health of the people of England – with special attention to the needs of disadvantaged groups and areas;
- enhance the quality and safety of services for patients and users, giving them faster access to services and more choice and control;
- deliver a better experience for patients and users, including those with long-term conditions;
- improve the capacity, capability and efficiency of the health and social care systems;
- ensure system reform, service modernisation, IT investment and new staff contracts to deliver improved value for money and higher quality;
- improve the service it provides as a Department of State to – and on behalf of – ministers and the public, nationally and internationally; and
- become more capable and efficient in the Department, and cement its reputation as an

organisation that is both a good place to do business with, and a good place to work.

**11.5** The 2007 Comprehensive Spending Review (CSR), announced in October 2007, heralded a new approach to both PSAs and Departmental Objectives. All of the Department's objectives rely on working in partnership with front-line staff and rely on close partnerships at regional and local level to achieve a balanced focus between national and local priorities for health and social care. This is common to many parts of the public sector. Hence, in the Comprehensive Spending Review this led to a new approach to PSAs and to improving performance more widely. This has led to an overarching framework built of:

- a streamlined set of 30 new PSAs, which articulate the Government's highest priority outcomes for the CSR 2007 period and span departmental boundaries;
- a small basket of national, outcome-focused indicators to support each PSA, ensuring robust and transparent performance monitoring;
- targets used only where appropriate to deliver improved performance and accountability, with nationally set targets reserved for a small subset of PSA indicators, leaving far greater space for local target setting; and
- a more comprehensive approach to assessing overall performance, with each department publishing a set of Departmental Strategic Objectives (DSOs) alongside the smaller, prioritised set of PSAs. This brings together both the Government's highest priorities and the wider span of departmental business.

**11.6** Within this wider system, the broad range of objectives of the Department of Health are captured by its three DSOs:

- To promote better health and well-being for all – helping people stay healthy and well, empowering them to live independently – and tackle health inequalities.

- To ensure better care for all – providing the best possible health and social care services, offering safe and effective care, when and where people need help and empowering them in their choices.
- To ensure better value for all – delivering affordable, efficient and sustainable services contributing to the wider economy and nation.

**11.7** Of these DSOs, both promoting better health for all and ensuring better care for all are also PSAs on which the Department leads for all of government. As well as leading on two PSAs, the Department contributes to some PSAs led by other government departments and this can include taking lead responsibility for a PSA indicator. This includes, for example, improving health and well-being of children and young people and promoting greater independence and well-being in later life. Where the Department contributes to a PSA, this is reflected in the detail of indicators supporting our three DSOs.

**11.8** Clearly, the Department must work with and through the NHS and local authorities to deliver on its DSOs. This means that, where relevant, they have been cascaded to both the NHS and local government as part of their new performance frameworks:

- As part of the *NHS Operating Framework for 2008-09* (DH, December 2007), the Department has issued the ‘vital signs’ to the NHS. All the Department’s DSO indicators are part of these vital signs, underlying how central the NHS remains to the delivery of better health, better care and better value.
- For local government, a single set of 198 national indicators (the National Indicator Set or NIS) measures those national priority outcomes (PSAs and DSOs) that are delivered by local authorities working alone or in partnership. These will be the only indicators upon which local authorities and their partnerships will be performance managed by government. Thirty-one of the indicators in the NIS are specifically relevant to improving the

health and well-being of local people. (These measures are also included in the vital signs.)

## Managing the Department of Health

**11.9** During 2007-08, the Department has continued to develop in response to changing needs, and to take account of the conclusions of its *Capability Review* report, published by the Cabinet Office in June 2007.

**11.10** The *Capability Review*, an independent assessment of the Department’s capability to meet the challenges it faces, concluded that:

- on delivery, the Department’s performance has equalled the best in government;
- on strategy, the Department has made progress but needs to go further and faster; and
- on leadership, the review highlighted a serious concern, concluding that the Department needed to articulate a compelling vision for the whole health and social care system and to demonstrate stronger corporate leadership.

**11.11** Following wide discussion with staff, the Department published its response to the review in its *Development Plan* in September 2007. This set the goal that by the time the *Capability Review* process is repeated in summer 2009 the Department will be a more effective organisation and genuinely feel like a better place to work.

**11.12** The plan set out a two-year work programme, covering five areas for action:

- establishing a vision and clear strategic direction for the health and care system;
- agreeing the Department’s role, purpose, values, and business plan;
- taking a new approach to leadership;
- supporting the Department’s staff to succeed; and
- improving the Department’s organisation and business processes.

**11.13** For the remainder of 2007-08 the first phase of the work programme Planning our Future Together has focused on setting strategic direction and working with the Department's staff to build and embed a stronger corporate sense of role, purpose and values for the Department itself.

**11.14** The outcome of the 2007 Comprehensive Spending Review, the NHS Next Stage Review interim report and subsequent planning frameworks for the NHS and the Department, as well as input to guidance for local government and its partners on Local Area Agreements (LAAs), have set out the way forward for the health and care system and the Department itself.

**11.15** Within the Department, the senior leadership has worked with staff from across the organisation to develop the statement of purpose, role and values (see page 6). This statement has been used to inform the Department's business planning for 2008-09 and to shape work on values and behaviours throughout the organisation.

**11.16** Corporate leadership in the Department has been strengthened. The smaller, more strategic Departmental Board is supported by:

- the NHS Management Board, bringing together the NHS Chief Executive, his senior leadership team in the Department of Health, and all strategic health authority (SHA) chief executives, to give system leadership to the NHS, ensure effective two-way communication, manage NHS performance and shape policy and strategy for the NHS;
- the Corporate Management Board, bringing together all the Department's directors general, focusing on the corporate leadership of the Department itself;
- a new Performance Committee, to monitor the delivery of the Department's PSAs, its contribution to cross-government PSAs, its delivery of financial targets, and progress on other key programmes and projects;

- a new Board of the Regions to monitor delivery of the Department's performance, policy and corporate priorities through its regional presence and delivery of Regional Plans for Health and Well-being, which will set out how departmental resources (working alongside Government Office teams and with SHAs) deliver the defined 11 roles and functions the Department expects to be delivered at that level. This board offers a clear line of sight to delivery at Local Strategic Partnership level;
- a Policy Committee, advising on policy priorities and promoting good policy governance; and
- an Audit Committee.

**11.17** A new senior leadership forum for the Department has been created, including all members of the Senior Civil Service.

**11.18** There have been a number of changes to the Department's top structure during the year, mainly consequent on the decision in 2006 to recreate the roles of Permanent Secretary and NHS Chief Executive, to sharpen accountabilities for both NHS and Department of State functions, and to support the wider strategic direction. The main developments have been:

- establishing the NHS leadership team, within the Department, with some restructuring of responsibilities including the creation of new posts of:
  - Director General Finance, Performance and Operations;
  - Director General Commissioning and System Management; and
  - Director General NHS Medical Directorate and Deputy Chief Medical Officer.
- a new role of Director General Finance and Chief Operating Officer for the Department;
- reorganisation of responsibilities to support a broader approach to health inequalities and health and well-being;

- a refocusing of the Department's Commercial Directorate towards a wider-ranging role providing commercial expertise in support of Department of Health procurements and transactions and helping build the commercial capability needed in the NHS to underpin local procurement and market management; and
- a restructuring of responsibilities for information and information systems following an informatics review, leading to the creation of new posts of Chief Information Officer for Health (director general grade) and a Director for Programme and System Delivery.

**11.19** The Department's presence within regions is primarily through the Regional Public Health Groups. These teams work alongside Government Offices for the Regions on a range of shared priorities including the negotiation of LAAs and delivery of national policy. With the need to reinforce social care policy delivery within the regions, the Department's ongoing programme of work *Strengthening the Regional Presence* will improve capacity within each of the nine English Government regions alongside Government Offices and with SHAs and enable a more coordinated relationship with local government and delivery of policy outcomes.

## Administration costs and staffing

**11.20** The administration costs for the Department, as agreed in the 2004 Spending Review, reflected the reduction in size and shape of the Department as a consequence of the departmental change programme which commenced in 2003. The changes support the on-going transformation of the whole NHS and social care system.

**11.21** Following the 2007 CSR, the planned expenditure continues to reduce over the three-year period, 2008-09 to 2010-11, at a rate of 5 per cent per annum real costs. This is similar to the CSR settlements for other government departments.

The figures are reflected in **figure A.5** (annex A, core table 5) which gives detailed information on Departmental administration costs. Information on staffing levels is provided in **figure A.6** (annex A, core table 6).

**11.22** One maladministration payment of £5,000 was made in 2007.

## The Departmental risk register

**11.23** Risk management remains at the heart of the governance arrangements for the Department and is supported by a risk policy and risk management guidance. During the last year, the Department continued to maintain a high-level risk register, which is considered quarterly by the Departmental Board. A new director-level Risk Forum was established to keep the register under review, advise the board on upcoming risks, and promote good practice in risk management across the Department.

**11.24** The Departmental Board, the NHS Management Board, the Corporate Management Board, and sub-committees of these boards take responsibility for ensuring that mitigation strategies are in place for all risks, and that these are followed through. Each risk on the high-level risk register has a senior responsible owner at director general level.

**11.25** The risks on the register are regularly updated through the Department's central programme and project management arrangements, and by the governance team through its work with directorates. These mechanisms, together with the Department's forward business planning exercises, enable emerging and new risks to be identified.

**11.26** The Department's Audit Committee reviews the Department's risk management arrangements as a key element of its overview of assurance in the organisation. It reviews the high-level risk register at each of its quarterly meetings, prior to the quarterly consideration of risk by the Departmental Board.

**11.27** The number of risks on the register has varied during the year as new risks have been added and others removed, for example where mitigation strategies have reduced the rating of a particular risk so that it no longer requires consideration by the board. Key areas of the Department's work, in relation to which there were risks on the register during 2007-08, included:

- improving the capacity, capability and efficiency of the health and social care system, including work in the Department and the NHS to maintain financial balance in the NHS, and work with the pharmaceutical industry to secure good value, branded drugs for the NHS;
- improving and protecting the health of the nation, including the work of the Department to prepare contingency plans for a possible influenza pandemic and taking actions to reduce the incidence of healthcare-associated infection;
- ensuring that system reform, service modernisation, IT investment and new staff contracts deliver improved value for money and quality; and
- strengthening the Department's capacity to function as an effective department of state, ensuring that it delivers on the commitments made in response to the Capability Review and gives sufficient priority to the promotion of the Government's equality legislation in all aspects of its work.

## **Non-departmental public bodies, special health authorities and executive agencies**

**11.28** At national level, but at 'arm's length' from the Department, a network of organisations has been created to regulate the system, improve standards, protect public welfare and support local services.

**11.29** These non-departmental public bodies, special health authorities and executive agencies continue to operate under measures introduced by the Government in 1998. These policies have increased the public accountability of the Department's arm's length bodies (ALBs) and strengthened public confidence in them. They each have members' codes, published registers of members' interests and websites. Where possible, and appropriate, they also hold open meetings and publish summary reports of meetings on websites, in annual reports or in press releases.

**11.30** In 2004, the Department published proposals as part of a wider programme of change to improve efficiency and cut bureaucracy in the management of the NHS and free up more resources for the delivery of front-line services.

**11.31** Between 2003-04 and 2008-09, the ALB Change Programme is reducing the number of ALBs from 38 to 20 by the end of 2008-09. This programme will reduce the number of posts by 25 per cent and redistribute £500 million of recurrent spend to the front line.

**11.32** As a consequence, the 2007-08 budget for the ALB sector was set with recurrent costs of over £200 million a year less than 2003-04. Further significant savings are also planned in 2008-09 leading to delivery of the £250 million reduction in ALB costs when compared with their baseline costs and activity in 2003-04.

## Public appointments

**11.33** The Department of Health is responsible for public appointments to a wide range of bodies, as detailed in **figure 11.1**.

**Figure 11.1: Public appointments sponsored by the Department – members in post at 1 January 2008**

Type of body	Chairs	Members	Total
Strategic health authorities	10	48	58
NHS trusts	150	783	933
Primary care trusts	150	893	1,043
Special health authorities	9	170	179
Advisory non-departmental public bodies	32	437	469
Executive non-departmental public bodies	10	122	132
Other bodies	3	93	96
<b>Total</b>	<b>364</b>	<b>2,546</b>	<b>2,910</b>

Source: *The Appointments Commission*

**11.34** As at 1 January 2008, the gender and ethnic balance and the proportion of non-executive members who are disabled on the boards of public bodies for which the Department is responsible are set out in **figure 11.2**.

**Figure 11.2: Public appointments – diversity of those appointed at 1 January 2008**

Total number of appointments	2,910
% of non-executive board members (including chairs) who are women	37.3
% of non-executive board members (including chairs) from black and ethnic minorities	11.0
% of non-executive board members (including chairs) who are disabled	4.0

Source: *The Appointments Commission*

## The Appointments Commission

**11.35** The Appointments Commission is an executive non-departmental public body established under provisions in the *Health Act 2006*. It is a specialist organisation with particular expertise in issues relating to governance and public appointments. Its main operational responsibility is to recruit, select and appoint people to public appointments on behalf of the Department of Health. The bodies to which the Commission appoints include NHS trusts, primary care trusts

(PCTs) and SHAs. It also appoints NHS charity trustees and to the Department's non-departmental public bodies and special health authorities, and ensures that those appointed have access to appropriate appraisal and induction training and support. In addition, it provides specialist recruitment and selection and training and support services to a growing number of NHS foundation trusts and other government departments.

**11.36** In January 2008, the Commission published *Adding Value to a 21st Century NHS – A Review of the NHS Public Appointments Process*. The review, commissioned by the Department but led by the Commission and its stakeholders, looked at the range of services the Commission provides to the NHS in particular. In response to the review's conclusions, the Commission will:

- adopt a more customer-focused, flexible and inclusive way of working;
- enhance induction training and provide better support for new appointees; and
- develop a more flexible and streamlined appraisal process, which will give greater local autonomy to trusts.

**11.37** Work is already under way on the implementation of these new initiatives.

**11.38** Also in January 2008, the Commission held a national chairs conference. The conference was addressed by the Secretary of State and looked at the role of chairs and non-executives and effective governance in relation to the key issues facing the NHS. The event was well received and attended by 380 people.

## Recruitment

**11.39** Approximately two-thirds of staff in the core Department are based in London and around one-third are based in Leeds. Some 40.6 per cent of staff at Senior Civil Service (SCS) level in the Department and its agencies are women, which is above the 2008 cross-Civil Service target of 37 per

cent. In total, well over half of staff in the Department and its agencies are women. Of staff at SCS level in the Department and its agencies 8.5 per cent are from black and minority ethnic (BME) groups, above the 2008 cross-Civil Service target of 4 per cent. Around 20 per cent of staff in the Department and its agencies are from BME groups. Some 4.7 per of staff at SCS level in the Department and its agencies have declared themselves as having a disability, above the 2008 cross-Civil Service target of 3.2 per cent.

**11.40** In compliance with departmental human resources policy, vacancies within the Department have continued to be advertised internally in the first instance. Where necessary, posts have then been advertised under fair and open competition across government and, as a last resort, externally.

**11.41** Any external recruitment has continued to be conducted on the basis of fair and open competition in accordance with the provisions of the *Civil Service Commissioners' Recruitment Code*. The aim at all times has been to ensure that the best person is appointed to each post. The Department's Human Resources Directorate and network of

independent assessors have continued to work within the internal recruitment policy and code in promoting good practice and compliance.

**11.42** The number of appointments in external competitions is shown in **figure 11.3**, broken down by gender, ethnicity and disability. Exceptions permitted under the code were exercised on the following number of occasions:

- 12 extensions, up to a maximum of 24 months, of appointments originally made for up to 12 months. These appointments were extended to enable the completion of work that required more time than originally estimated;
- 37 secondments;
- 19 extensions of secondments; and
- 3 reappointments of former civil servants.

**Figure 11.3: Recruitment into the Department of Health in 2007 – by gender, ethnicity and disability**

	By gender:		By ethnicity:			By disability:			Total
	male	female	white	BME <sup>(1)</sup>	unknown	not disabled	disabled	unknown	
<b>Permanent staff joining in 2007 who were still employed by the Department on 31 March 2008</b>									
Senior Civil Service	4	2	2	1	3	4	0	2	6
Fast Stream	8	12	14	1	5	13	2	5	20
Posts at former UG6 and below	49	81	93	22	15	108	7	15	130
<b>Total</b>	<b>61</b>	<b>95</b>	<b>109</b>	<b>24</b>	<b>23</b>	<b>125</b>	<b>9</b>	<b>22</b>	<b>156</b>
<b>Permanent staff joining in 2007 who were no longer employed by the Department on 31 March 2008</b>									
<b>Total</b>	<b>7</b>	<b>12</b>	<b>7</b>	<b>2</b>	<b>10</b>	<b>8</b>	<b>0</b>	<b>11</b>	<b>19</b>
<b>All permanent staff joining in 2007</b>									
Senior Civil Service	5	2	3	1	3	5	0	2	7
Fast Stream	8	12	14	1	5	13	2	5	20
Posts at former UG6 and below	55	93	99	24	25	115	7	26	148
<b>Total</b>	<b>68</b>	<b>107</b>	<b>116</b>	<b>26</b>	<b>33</b>	<b>133</b>	<b>9</b>	<b>33</b>	<b>175</b>

Source: Personnel & Related Information System (PARIS), DH

Notes:

(1) Black and minority ethnic.

## Senior Civil Service salaries

**11.43** Details of SCS salaries for the Department of Health are given in **figure 11.4**.

**Figure 11.4: Salaries of Senior Civil Service staff in post in the Department of Health at 1 April 2007**

Payband (per annum)	Number of staff
£55,000 – £59,999	4
£60,000 – £64,999	28
£65,000 – £69,999	29
£70,000 – £74,999	50
£75,000 – £79,999	32
£80,000 – £84,999	22
£85,000 – £89,999	30
£90,000 – £94,999	19
£95,000 – £99,999	12
£100,000 – £104,999	2
£105,000 – £109,999	7
£110,000 – £114,999	9
£115,000 – £119,999	5
£120,000 – £124,999	8
£125,000 – £129,999	4
£130,000 – £134,999	1
£135,000 – £139,999	4
£140,000 – £144,999	2
£145,000 – £149,999	0
Over £150,000	8
<b>Total</b>	<b>276</b>

Source: Payroll System, DH

Notes:

(1) Figures include staff on secondment out of the Department and exclude staff on secondment into the Department.

(2) Salaries include all pay-related allowances.

## Expenditure on professional services

**11.44** Expenditure by the Department of Health and its executive agencies on professional services was around £229 million in 2007-08 using the new Office of Government Commerce definitions. This figure includes expenditure on consultancy, systems management and temporary agency staff/interim personnel (see **figure 11.5**).

**11.45** The figures show a decrease in expenditure in the core Department of Health for all professional services.

**11.46** The Department has improved its data collection systems, but the data should be regarded as an approximation. The Department plans further

improvements to its systems to make the data more accurate in the future, for example through Programme Showa.

**Figure 11.5: Expenditure on professional services, 2007-08**

Organisation	£ million Spend
Department of Health consultancy expenditure (including systems delivery and temporary agency staff/interim personnel)	217
Executive agency consultancy expenditure (including systems delivery and temporary agency staff/interim personnel)	12
<b>Total</b>	<b>229</b>

Source: Commercial Directorate, DH

Notes:

(1) Expenditure is reported against the Office of Government Commerce definition of professional services.

(2) NHS consultancy spend is not included in the above table.

## Accommodation and information and communication technology

### Accommodation

**11.47** The Department has embarked on a new Accommodation Strategy and will continue to rationalise its estate from the existing five buildings. The project to implement the strategy commenced in 2007 and is planned to be complete by 2011. The refurbishment of Quarry House in Leeds was successfully completed in August 2007.

### Information and communication technology

**11.48** During 2007, Information Services developed a three-year strategy for the delivery of systems and services to support the aims and objectives of the Department.

**11.49** The strategy addressed four themes:

- Improved business intelligence – systems, applications and technologies for collecting, providing access to, and analysing information, the purpose of which is to inform decisions throughout the Department.
- Improved working environment – the working environment includes access to IT equipment and related services. Most staff spend a great deal of time using these services to access information

held on systems and deliver their business. The prevalence of portable IT devices and the desire for mobile usage has significantly increased IT demand. The objective is to ensure that IT helps staff to perform tasks and is not a task in itself. The Department aims to provide fit-for-purpose technology and a first-class support service to maximise IT exploitation.

- Managing, retrieving and exploiting information – the Department relies on good knowledge management and easy access to all the information it needs to do its work. Ministers, staff and external audiences must be able to rely on a knowledge base that is accurate, of high quality and up to date. Performance on freedom of information requests, correspondence and parliamentary questions depends on timely access to the right information on current and past policy and decisions. Staff need to know how best to keep, use and share information, whether held as documents, in corporate systems, as published material or as knowledge from colleagues and experts.
- Corporate governance – Information Services has extensive governance responsibilities ranging from security and health and safety to supplier contract management. Information Services has introduced strong, formal governance structures around IT-related activities. These structures involve business users, in areas such as IT applications, and an appropriate mix of internal and external expertise in areas such as IT infrastructure and security.

**11.50** Projects and initiatives are under way to deliver the strategy and will continue through 2008 and beyond.

### Programme Showa

**11.51** The Department is making significant investment, through Programme Showa, to improve the efficiency and effectiveness of its financial, procurement and HR functions, thereby enabling more accurate, focused and relevant management reporting. Showa is expected to go live on 1 July 2008.

### Relocation (Lyons Review)

**11.52** The Department is committed to the Lyons target relocation of 1,030 whole-time equivalent posts out of London and the South East by March 2010. The Department's original target of 1,110 was reduced by 80 posts as a consequence of the transfer of the Mental Health Review Tribunal to the Department for Constitutional Affairs, since replaced by the Ministry of Justice. By December 2007, 870 relocations had been completed.

**11.53** During 2007, relocations have been completed by the General Social Care Council (49 posts to Rugby), the NHS Institute (55 additional posts created in Warwick), and the National Institute for Health and Clinical Excellence (18 additional posts created in Manchester).

**11.54** In addition, 38 posts from the core Department have already moved to Leeds. Fifty-nine posts are scheduled to relocate to Leeds by May 2009. Further relocations are being planned to meet the March 2010 target.

### Knowledge management

**11.55** The Department's programme continues on a number of fronts. It addresses the need to continually improve information management and builds on the greater levels of awareness and understanding of how good knowledge management practice supports business effectiveness and policy development. As a result:

- work to improve document and records management continues, with the initiation and pilot stages of a pan-departmental project to encourage a better balance in the use of e-mail, collaborative tools, network storage and the electronic records system;
- the knowledge management induction course is fully embedded within the Department's corporate induction process. Together with workshops, training and events for existing staff, this contributes to sustaining the necessary

momentum to embed knowledge management good practice. There is encouraging evidence on the effectiveness of the 2005-06 training and engagement programme action plans undertaken by a number of the divisions that participated;

- improvements to the Department's knowledge base are ongoing – for example, the Intranet underwent an extensive rationalisation, while the departmental website was relaunched with a new look and feel and other improvements. Work is under way to enhance the ministerial briefing system; and
- the successful relocation of the London library to provide a one-stop service in Leeds achieved efficiency savings through rationalisation of services and an improved focus on support for evidence-based policy development.

## Performance in responding to correspondence from the public

**11.56** Since the centralisation of the correspondence function in 2004, the Department has become consistently high performing in handling the significant increase in the volume of communications it receives (see **figure 11.6**). In 2007, the Department received:

- 19,182 letters from MPs and Peers. Ninety-two per cent of those requiring a reply were responded to within the Department's target time of 20 days;
- 33,668 letters and 28,595 e-mails from members of the public. Ninety-nine per cent of those requiring a reply were responded to within 20 days; and
- 143,000 telephone calls from members of the public, of which 81 per cent were answered within 30 seconds and 96 per cent within 90 seconds.

## A healthier workplace

**11.57** The Department is committed to promoting staff well-being, dignity and respect within the workplace and fulfilling its responsibility for the health and welfare at work of all employees, underpinned by its duty of care. The Department is striving to be an exemplar employer and is committed to the provision and embedding of a range of employee health and well-being policies and initiatives which provide specific support, guidance and awareness for everyone within the workforce.

**11.58** The Department is committed to reducing employees' carbon footprint as part of its sustainable development plan, and to promoting employee health and well-being events for all staff as well as developing new policies and guidance. This year's health and well-being events took place in London and Leeds in the first quarter of 2008, highlighting employee health and the services the Department offers to staff, and promoting new policies on domestic violence and mental ill health. The Department provides a number of flexible working arrangements that help staff to achieve a good work-life balance, offers interest-free bicycle loans and supports an in-house Bicycle User Group.

**11.59** The Department is currently reviewing its volunteering policy and guidance to encourage and support corporate social responsibility. It is also developing a new policy and guidance on work experience, to encourage under-represented groups within its community by building links with local schools and colleges. Both policies are planned to be published in spring 2008.

**11.60** In addition to its Annual Staff Survey in March 2008, the Department administered a specific health and well-being survey in February 2008. This covered lifestyle, job perceptions, attitudes towards the Department, health and bullying and harassment. The results will be used

**Figure 11.6: Correspondence from the public – achievement against performance targets**

Type of correspondence	2003	2004	2005	2006	Percentage 2007
Private office case <sup>(1)</sup>	54.0	80.9	90.1	88.9	92.0
Treat official case <sup>(2)</sup>	67.2	88.0	97.3	92.3	99.0
Departmental e-mail <sup>(3)</sup>	87.1	95.4	96.6	95.8	99.0
Calls <sup>(4)</sup>	n/a	42.0	76.1	88.1	84.0

Source:

Correspondence : From 2004, all private office, treat official and Departmental e-mail cases from Department of Health (DH) Correspondence Database. Figures include all cases with Whitehall Standard target date and exclude cases where no reply is required. Figures do not include cases for other government departments, or agencies which are reported separately.

Calls : Department of Health (DH) CALLSCAN SYSTEM. Figures include all calls taken during the period. Data is not available before 2004.

Notes:

(1) Letters signed by ministers.

(2) Letters signed by officials on behalf of ministers.

(3) E-mails received through the Department's website.

(4) Telephone calls received in the call centre.

to identify initiatives to improve staff well-being in the coming year.

## Health and safety policy

**11.61** The Health and Safety Unit (HSU) is part of the IS Accommodation and Building Services Branch. It provides advice and guidance to all Department of Health employees and works with Facilities Management, HR and line managers to maintain and improve health and safety in the workplace. The HSU has been involved in:

- health and safety policy – the HSU has continued to review departmental policy to ensure compliance with current legislation and best practice;
- training – the HSU has arranged a series of fire warden, first aid and workstation assessment courses for staff across the Department;
- promotion and publicity – the HSU took part in the 2008 Employee Health and Well-being Road Show, providing health and safety advice to staff, together with a free eyesight testing service;
- health and safety inspections – the HSU has implemented a system of regular joint health and safety floor inspections and Health and Safety Committee meetings across the Department; and
- trade unions – the HSU meets quarterly with representatives of all the trade unions to discuss health and safety issues and recommend appropriate action.

**11.62** Accident statistics for 2007 are shown in **figure 11.7**.

**Figure 11.7: Department of Health accident statistics, 2007**

	Number
Total reported accidents	33
Of which:	
Resulting in absence <sup>(1)</sup>	4
Total reported near misses <sup>(2)</sup>	4

Source: Health & Safety Unit, DH

Notes:

(1) One absence was RIDDOR. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. Reports are sent to the Health and Safety Incident Centre.

(2) Near misses are any unplanned occurrence that does not lead to injury of personnel or damage to property, plant or equipment, but may have done in different circumstances.

## Sustainable policy and operations

### Department of Health annual Sustainable Development Action Plan

**11.63** The Department's first *Sustainable Development Action Plan 2005-06* (DH, March 2006) committed the Department to sustainable action on both operational performance and on policy issues.

**11.64** During 2006-07, the Department developed an overarching sustainable development (SD) governance structure as a high-level steering group chaired by the Permanent Secretary. The Department also produced its 2006-07 *Sustainable Development Action Plan Progress Report* (DH,

October 2007), which includes a clear line of sight on delivery to date of the Department's five commitments made in 2005 in *Securing the Future*, the UK Sustainable Development Strategy. These address the NHS as a good corporate citizen; food and health; transport and health; healthy sustainable communities; and health impact in collaboration with the regions. The report was particularly commended by the Sustainable Development Commission (SDC) for the Department's progress on sustainable operations.

**11.65** The Department's *Sustainable Development Action Plan 2007-08* was published in October 2007. A key objective for this year is the development of a Department strategy for SD. This action plan therefore focuses on:

- moving towards developing and achieving a more coherent and integrated departmental SD strategy for taking forward work on SD;
- starting to identify what kind of support related to SD the Department can give the NHS, both centrally and in the regions; and
- setting out the different roles and responsibilities of the Department and the NHS in implementing SD.

### **Sustainable operations**

**11.66** In May 2006, new government operational targets were published, requiring activity in the priority areas of climate change and energy; sustainable consumption and production; and natural resource protection. The Department is committed to achieving the targets and is currently developing strategies to ensure that it succeeds. The Department is in the process of establishing a Sustainable Operations Working Group to identify and develop policies and procedures that will facilitate and encourage sustainable practices throughout its estate. This group will report to the Departmental Sustainable Development Forum.

**11.67** The performance of all government departments against these targets is scrutinised by the SDC. The SDC report, *Sustainable Development in Government* (SDC, 18 March 2008), presents its findings based on data submitted for 2006-07. This placed the Department in first place, with a particularly strong performance in reducing its overall carbon emissions from its buildings and road-based transport.

**11.68** The reduction in the size of the Department's estate in 2005-06, and increased staffing numbers in its remaining buildings has had an impact on the target for energy efficiency (measured as consumption per m<sup>2</sup>), but overall carbon emissions have reduced. The Department's electricity efficiency is stabilising, and it is focusing on measures to improve its performance in this area, as well as striving to increase the reliability of all its data through enhanced monitoring and reporting.

**11.69** The *SD Action Plan* has an operational focus on reducing carbon emissions. Specific actions include starting work with the Carbon Trust to develop a carbon management programme and producing a 'green IT' strategy. The Department has also replaced its energy and water data-monitoring systems, with the aims of increasing the reliability of its data and quickly identifying problems with excessive consumption.

### **Sustainable development in the NHS**

**11.70** The Department's Estate and Facilities Division (EFD) works closely with other government departments to develop policies that have an impact on the NHS. EFD prepares leading-edge guidance and advice to promote the SD agenda across the NHS in England and informs decision-making. EFD continues to work in partnership with the Carbon Trust with the introduction of the NHS Carbon Management Programme which is delivering significant carbon savings and is contributing very positively to the climate change programme.

**11.71** The NHS Management Board agreed at its September 2007 meeting to further develop SD in the NHS. In accordance with the government commitment on climate change, the NHS was set stretching mandatory energy and carbon efficiency targets. This is to achieve, by March 2010, a 15 per cent energy or 0.15 million tonnes carbon efficiency saving (with 2000 as the baseline year) and also to achieve performance indicator standards for new builds and refurbishments and for the existing estate. A mid-term analysis of progress towards the target shows that with a growing estate, expanding service provision and increasing use of medical and other technologies, the NHS might not meet this target.

**11.72** To assist the NHS, in January 2007 the Department made available a £100 million Energy and Sustainability Capital Fund for the NHS to bid against for robust schemes that demonstrate carbon efficiency with associated revenue savings. This fund has been remarkably successful, with the whole of the fund now committed.

**11.73** The Department continued to fund the SDC's Healthy Futures Programme during 2006-07, to support and develop the NHS contribution to sustainable development and public health. Central to Healthy Futures is the NHS's Good Corporate Citizen Self-Assessment Model. Developed by the SDC, this web-based interactive model enables NHS organisations to self-assess their performance as corporate citizens and obtain advice about how to improve. The model allows trusts to build on existing work and is structured around the areas of procurement, employment and skills, community engagement and partnership working, buildings, facilities management and transport. Over 400 organisations have registered to use the self-assessment model, including over 200 NHS bodies.

**11.74** The NHS Environmental Assessment Tool is being developed and reviewed. In line with government recommendations, it will be reissued as BREEAM Healthcare by summer 2008 as a more demanding accreditation tool that will encourage and facilitate a more dynamic approach to sustainable construction within the healthcare sector. The NHS in England will continue to receive advice and guidance to address sustainable construction and sustainable buildings and how this will facilitate more sustainable operational services; plus a further publication on water management and conservation is in production.

### Sustainable procurement

**11.75** In March 2007, the Government's *Sustainable Procurement Action Plan* (SPAP) was published. The Department and the NHS Purchasing and Supply Agency (PASA) published a sustainable procurement action plan for the health and social care sector, *Procuring for Health and Sustainability 2012*, alongside local government in November 2007.

**11.76** *Procuring for Health and Sustainability 2012* makes a commitment to purchasing goods and services that will support achievement of carbon reduction goals, incorporation of sustainable development into best practice procurement guidance, creation of a health suppliers sustainability award, and adoption of the flexible framework (as identified in the UK Government SPAP).

**11.77** The Department has made good progress against the requirements of level 1 on the flexible framework through the focused activity identified under the procurement section of its *Sustainable Development Action Plan*, and is on course to meet its target of level 3 in all areas and level 5 in one area in 2009. Notable progress this year has included the development of a sustainable procurement policy for the Department, the delivery of sustainable procurement training for key procurement staff and the review of contracts against minimum sustainability product standards.

**11.78** NHS PASA continues to support the sustainable procurement agenda in the NHS through the provision of guidance, training and engagement with cross-government initiatives. Notable progress has been made with the development of training modules, guidance on the *Waste Electrical and Electronic Equipment Regulations 2006*, building SD considerations into contracts and buyers guides, and the establishment of the Suppliers Creating Sustainable Communities Award.

## Modernising Government Action Plans

### Better regulation

**11.79** The Department is committed to ensuring delivery of its priorities through better regulation. This includes developing and implementing an ambitious programme, which reduces burdens on business, charitable and voluntary sectors and on front-line public sector staff and enhances public confidence.

### Better regulation culture governance

**11.80** The better regulation agenda is supported by a Departmental board-level better regulation champion and a better regulation network of officials throughout the Department and key arm's length bodies. Delivery of the agenda is overseen by the Department's Policy Committee, a committee of the Departmental Board, and supported by the Better Regulation and Simplification Branch, in the Secretariat. Supporting action includes:

- incorporation of better regulation governance checks into the private offices guide;
- a rolling programme of targeted training for business units and general awareness training on impact assessment and the simplification plan;
- the Department of Health's External Gateway and financial challenge panel for public sector policy proposals; and
- *Better Policy-making: Plans for a System of Policy Governance* (DH, April 2007), which reminds staff of the importance of driving down the

administrative and regulatory burden on businesses and front-line services.

### Simplification Plan and Administrative Burdens Measurement Exercise

**11.81** The Department of Health (like other government departments) participated in the Administrative Burdens Measurement Exercise in 2005-06. The administrative cost of compliance for the private sector with the Department's 90 regulations in force in May 2005 was £1.2 billion. The Department has agreed to aim for a net reduction of 25 per cent (i.e. £300 million) by March 2010.

**11.82** The Department published its second annual *Simplification Plan* (DH, December 2007), which details progress towards the 25 per cent burden reduction target and how the Department proposes to deliver its key priorities through better regulation to 2010. The programme covers work to address regulatory burdens on NHS and social care front-line services and the Department's business and third sector partners while continuing to safeguard public health, ensuring that medicines are safe and effective, and that those providing care services continue to ensure protection for the vulnerable and elderly.

**11.83** The plan builds on the Department's tradition of reducing bureaucracy in the NHS, and key initiatives include the following.

#### Private sector

- The Healthcare Commission and its risk-based inspections are providing £1 million in administrative savings for targeted, proportionate inspections.
- BROMI company 'name changes' administrative burden savings for manufacturers and suppliers of medicines, through the Better Regulation of Medicines Initiative (BROMI) aimed at reducing burdens from relaxation of the time period, from three to six months for organisational name

changes following a company merger, with estimated savings of £12 million. Further savings will follow as various pilots due for completion are 'mainstreamed' across the sector.

- The *Health and Social Care Bill* will create the Care Quality Commission, covering regulation and inspection of both health and adult social care and delivering estimated administrative burden savings of £3 million.
- The Human Fertilisation and Embryology Authority (HFEA) has implemented a number of initiatives to remove regulatory irritants and reduce the burden of regulation, with an estimated saving of £0.4 million to date. Further initiatives to reduce the burden are in the pipeline.

#### Public sector

- The number of arm's length bodies, SHAs and PCTs will be rationalised – with a redistribution to health and social care front-line services of £500 million a year by the end of 2008-09.
- A national framework for continuing long-term NHS care will be implemented. There were 28 sets of local eligibility criteria in England. This created concern about variability of awareness and competence throughout the NHS around important decisions about a person's future care. The introduction of a framework and supporting tools will provide annual savings estimated at £50 million.
- The Department will move to a risk-based, proportionate inspection process. The Healthcare Commission estimates that £10 million of NHS trusts' money will be saved by replacing the previous system of week-long, inspection-based assessments.
- Healthcare Concordat signatories, the Healthcare Commission and NHS Litigation Authority have agreed to share relevant information during assessments of NHS trusts, to avoid duplication significantly reducing the burden of inspection.

#### Public sector strategy

**11.84** In June 2007, the Cabinet Office launched *Cutting Bureaucracy for our Public Services*, a better regulation strategy for the public sector. The aim of the strategy is to ensure that policy, operational and corporate service elements of public services work together to deliver a tangible and permanent reduction in unnecessary bureaucracy that affects public service delivery.

**11.85** This has given the Department the opportunity to consolidate its existing and planned work to deliver effectively on the four key themes within the strategy:

- fewer and better coordinated requests for data from the front line – the Department has agreed to aim for a 30 per cent reduction in the data burden on the front line by 2010;
- a voice for front-line workers in decisions about bureaucracy – a Provider Advisory Group has been established, with senior representation from public and private sector healthcare providers to contribute to the debate, and ensure that the programme of action on burden reduction is tackling the issues that matter;
- a reduction in the stock of unnecessary bureaucracy the front line cares most about; and
- better regulation that is understood and mirrored through the delivery chain resulting in cultural change.

#### Better regulation Europe

**11.86** At a meeting on 9 March 2007, the European Council agreed to set a target to reduce administrative burdens derived from European Union (EU) legislation by 25 per cent by 2012. An EU-wide burdens measurement exercise is under way and the European Commission is taking fast-track action to reduce burdens in priority areas, which include pharmaceutical and clinical trials. A European/US workshop was held in autumn 2007 bringing the successes and approach of BROMI to the international stage – streamlining processes and

making changes to regulations without changing the regulations. The Medicines and Healthcare products Regulatory Agency is taking the lead on a number of key EU initiatives:

- BROMI principles adopted for EU burdens reduction on medicines regulation;
- simplification of medicines variations regulations; and
- developing common standards for the electronic transfer of data between EU members.

**11.87** These initiatives have the potential for significant UK and EU burdens reduction.

### Impact assessments

**11.88** The regulatory impact assessment process changed in May 2007, with a greater focus on quantification of economic impact. One of the changes was that regulatory impact assessments became impact assessments. Sixteen (regulatory) impact assessments were published on the Department's website in 2007-08. In addition, 12 full final (regulatory) impact assessments, accompanying regulations, were placed in the libraries of both Houses of Parliament. The Department's compliance with the (regulatory) impact assessment process was 100 per cent during this period. No legislation introduced by this Department included a sunset clause (sun setting allows a law to be removed automatically after a fixed period unless action is taken to keep it in place).

**11.89** Regulatory measures, which stem from the EU and are supported with a (regulatory) impact assessment, included:

- the potential impact of the EU *Tissues and Cells Directive* on UK establishments handling human tissues for human application;
- the introduction of picture warnings on cigarette packs;

- regulation of the European Parliament and the Council on Advance Therapy Medicinal Products and amending directive; and
- the *European Qualifications (Health and Social Care Professions) Regulations 2007*.

### Legislation

**11.90** One Department of Health Bill received Royal Assent during 2007-08.

**11.91** The Department made 85 Statutory Instruments (including Orders that are not laid before Parliament) during the period April 2007 to March 2008.

### Post-implementation reviews

**11.92** During 2007-08, the Department and its agencies began a number of reviews including:

- introduction of the European Health Insurance Card;
- *the Medicines (Advertising) Amendment Regulations 2004*; and
- *the Tobacco Advertising and Promotion (Specialist Tobacconists) Regulations 2004*.

### Taking a more risk-based approach to enforcing regulation

**11.93** The new health and adult social care regulator, the Care Quality Commission, subject to parliamentary approval, will replace three current regulators, in line with the Department's arm's length bodies review and the *Hampton* recommendation for fewer, sector-based regulators.

**11.94** A number of duties on the face of the *Health and Social Care Bill* are intended to ensure that it will operate in accordance with the principles of better regulation and inspection and enforcement best practice:

- to ensure that its actions are proportionate to risk;
- to reflect best practice among other inspectorates;

- to cooperate with particular bodies;
- to appoint advisory committees involving regulated bodies, patients and users, and have regard to their advice;
- to consult on and publish details about when and how it will carry out inspections; and
- to carry out its functions effectively, efficiently and economically.

**11.95** The new regulator will carry out its functions in accordance with the Government's five principles of better regulation, i.e. activities should be proportionate, targeted, accountable, consistent and transparent.

**11.96** The new regulator will also have a number of powers designed to ensure, working in collaboration with other sector gatekeepers, that the burden on the front line created by other bodies that operate in the health and adult social care sector is minimised.

## Public consultations

**11.97** During the last 12 months, the Department has worked to ensure compliance of its public consultations with the Cabinet Office *Code of Practice on Consultations*, and there has been an increase, compared with 2006-07, in the compliance of consultations with the standard, minimum consultation period of 12 weeks. The role of Departmental Consultation Coordinator and responsibility for the oversight and assurance process now sits within the Better Regulation Team. This has given the opportunity to promote positive consultation activity within the Department, helping consolidate impact assessments and other strategic assurance processes at an early and relevant part of the policy-making cycle.

**11.98** The Department has played an active role in the development of a new code of practice, which is expected to be launched across Government later this year.

**11.99** The Department undertook 38 public consultations in the year from 1 April 2007, of which 34 (89 per cent) met the 12-week minimum period. Of the five consultations that did not meet the 12-week minimum, all were either technical consultations with an extremely limited audience or short consultations within a policy process, which had previously included significant stakeholder engagement activities. These had all been subject to ministerial sign-off.

**11.100** The Department has continued to promote active engagement in consultations, being inclusive and adopting innovative methods, contributing to consultation on policy development and service design being an important part of a representative democracy. Much of the Department's public-facing work has built on a range of different approaches to stakeholder engagement, including qualitative interviews and discussion groups, quantitative surveys and making use of electronic templates for responses, and a number of consultations have made provision for direct on-line responses and discussion forums.

## Equality and human rights

### NHS Equality Guides

**11.101** During 2006-07, the Equality and Human Rights Group (EHRG) published two guides to help NHS organisations comply with new legislation, which places a positive duty on public organisations to promote disability and gender equality and to provide evidence within their scheme of how this is being met:

- *Creating a Disability Equality Scheme: A Practical Guide for the NHS*, published in October 2006, provides best practice advice on producing a disability equality scheme as required by the disability equality duty which came into effect on 4 December 2006.
- *Creating a Gender Equality Scheme: A Practical Guide for the NHS*, published in February 2007,

provides best practice advice on how NHS organisations might produce a gender equality scheme as required by the gender equality duty which came into effect in April 2007.

**11.102** Further equality guides on transgender issues, age, sexual orientation and religion or belief are currently being developed.

### Department Single Equality Scheme

**11.103** The Department, as part of meeting its obligations under the public sector equality duties (i.e. race, disability and gender), has produced a scheme that sets out how it will progress action on discrimination. As a matter of policy, the Department has included actions on discrimination with regard to sexual orientation, religion and belief, and age. The scheme is being revised in response to a Compliance Notice served on the Department in September 2007 by the then Commission for Racial Equality. In revising the scheme, the Department's aim is to link it to the strategic objectives in the Departmental business plan and its timetable, and the *NHS Operating Framework for 2008-09* priorities.

**11.104** The Department has commissioned research to investigate the different ways men and women access health services. This work will form an evidence base to inform the Department's Single Equality Scheme action plan.

### NHS Single Equality Scheme Learning Site Project

**11.105** In order to support NHS organisations deliver the equalities agenda and comply with current and imminent public sector duties, the EHRG is providing support and guidance for SHA equality leads and selected learning sites (NHS organisations) across the service.

**11.106** Most organisations should have developed their own race, disability and gender schemes. In consideration of this and in anticipation of further

duties in relation to age, religion and belief, and sexual orientation, the project aims to support the equalities agenda in a coherent and cross-cutting way, without diluting any of the individual equality strands, through the development of single equality schemes.

**11.107** The learning and development outcomes from the learning sites are shared and disseminated throughout the NHS principally via the '10 Steps to Developing Your SES' webpage on the Department's website.

**11.108** The selected sites reflect a diverse range of NHS organisations including:

- a good geographical spread mirroring the new SHA and PCT configurations and complementary to existing equalities programmes. So far, the sites are drawn from London, the North and South, and urban and rural locations;
- learning sites, which are broadly representative of the different types of NHS organisation, i.e. NHS foundation trusts, PCTs, ambulance service, acute and mental health trusts;
- learning sites reflecting a broad spectrum of progress and approaches to the Single Equality Scheme; and
- 'buddying up' to engage a wider audience, spread the learning and increase the capacity of the project.

### Department of Health and Disability Rights Commission Partnership Framework

**11.109** From 2003 until October 2007 (when the Disability Rights Commission's (DRC's) functions were subsumed within the Equality and Human Rights Commission), the Department worked in partnership with the DRC to improve the responsiveness of health services for disabled people. The resulting partnership pursued several important areas of joint work, including the publication of *You can make a difference* leaflets for both primary and secondary care settings.

**11.110** In March 2007, the Department and the DRC organised a joint conference to take stock of the work to date, spotlighting examples of disability equality in health that meet the aspirations of the partnership, and to launch the *Disability Equality and Etiquette Learning Framework for Health and Social Care in England*.

### **Pacesetters Programme**

**11.111** The Pacesetters Programme is the Department's flagship programme for equality, diversity and human rights. It is a three-year programme running from 2007-08 to 2009-10 which aims to deliver equality and diversity improvements resulting in:

- patient and service user involvement in design and delivery of services;
- reduced health inequalities for patients and service users; and
- working environments that are fair and free of discrimination.

**11.112** The programme expanded during 2007 and now comprises six SHAs (West Midlands, Yorkshire and the Humber, East Midlands, South West, London and South East Coast), and 18 trusts.

**11.113** During 2007, each SHA and its three participating trusts have been working to develop a range of local interventions or 'change ideas' to tackle longstanding health inequalities that have arisen through discrimination. Each trust will work on three local change ideas with a patient focus and covering a different strand of equality. Therefore, in each SHA area, the three participating trusts will cover all strands of equality – age, disability, race, gender, religion and belief, sexual orientation and gender identity.

**11.114** The NHS Change Programme Team is working with the participating SHAs and their respective trusts to apply service improvement methods; to test and implement learning and

evidenced good practice; and to evaluate which change ideas and learning can be applied to other settings and locations. The long-term aim is to embed improvements in core business and spread learning and evidenced good practice across the NHS. To date, 54 local interventions are being tested and some are already beginning to make an impact. For example, in Walsall the Integrated Learning Disabilities Service has achieved a significant increase in uptake of breast screening by women with learning disabilities. This improved practice is easily transferable to other settings and other disease prevention programmes.

**11.115** During 2008, a further wave of trusts will be recruited to work on a new range of local change ideas with a clinical focus.

### **NHS SHA equality leads**

**11.116** The Department continues to support SHAs and their local NHS organisations in promoting the equality and human rights agenda across the NHS, by bringing together SHA equality leads to discuss and consult and involve them in all equality issues.

**11.117** SHAs will be supported by the EHRG to develop support and performance management frameworks to ensure that local NHS organisations comply with equality legislation and develop single equality schemes in a cross-cutting and coherent way.

### **Race for Health**

**11.118** The Race for Health Programme enables PCTs to make the health service in their areas significantly fairer for black and minority ethnic (BME) communities. The programme supports a growing network of 20 PCTs around the country, working in partnership with local BME communities to improve health, modernise services, increase choice and create greater diversity within the NHS workforce. Through community engagement and leadership, it aims to make

significant improvements in delivering race equality in:

- the workforce, from recruitment to retention and promotion, tackling ‘snow-capping’;
- commissioning, including the planning, designing and buying in of services and products; and
- service improvements, making significant progress in tackling real inequalities in the access, experience and health outcomes experienced by BME people.

**11.119** Building on the work of previous years, in 2007 the Race for Health Programme developed a series of pledges for member PCTs, designed to produce tangible and measurable outcomes. These pledges were to:

- achieve 100 per cent compliance with the *Race Relations (Amendment) Act 2000* with regard to:
  - producing and publishing an effective and comprehensive race equality scheme;
  - collecting, analysing and publishing workforce data and ethnicity relating to selection, access to training, career progression, grievances and disciplinary procedures; and
  - undertaking race equality impact assessments and publishing the results and related activities;
- undertake and publish the results of race equality impact assessments of the:
  - Local Delivery Plan;
  - commissioning strategy; and
  - workforce strategy;
- demonstrate that race equality is effectively addressed at board level through the PCT’s Board Development Programme; and
- develop detailed plans for activity and improvement on:
  - diabetes;
  - perinatal mortality;
  - coronary heart disease and stroke; and
  - mental health.

**11.120** They are expected to use the Race for Health template, or an adaptation that will deliver the same measurable outcomes, and include appropriate mechanisms for capturing and reporting on patient experience.

**11.121** This work will be reported on in spring 2008, and the condition-focused plans will form the basis of the core work of the programme over 2008-09.

**11.122** Race for Health began with an initial cohort of 13 PCTs. Over the past 18 months this has grown to 20. It is anticipated that this number will continue to grow and consideration is being given to opening membership to all NHS trusts. Such growth will require careful handling to ensure that the expansion is not at the expense of sustainability. However, if Race for Health is to truly drive forward race equality in the NHS, then its membership must spread beyond the current core group.

**11.123** The programme remains committed to sharing the learning from the journey to race equality widely across all stakeholders. The learning programme built around peer reviews remains a central component of the programme, with the resulting reports being published on the Race for Health website ([www.raceforhealth.org](http://www.raceforhealth.org)). Other publications include the *Recipes for Success* calendar and progress report (December 2007), guidance on translation and interpreting services (April 2008) and guidance on service improvement (May 2008). In December, a national conference was held in conjunction with the Health Service Journal. Many of the member PCTs discussed local developments that are furthering Race for Health’s vision of an NHS in which the health needs of BME people drive the services that they receive.

### Community cohesion

**11.124** Community cohesion plays a significant role in promoting equality and reducing health inequalities. The Department contributed to the

work of the independent Commission on Integration and Cohesion in 2007 and also worked in partnership with the Institute of Community Cohesion to consider the challenges and rewards for the NHS in promoting community cohesion.

**11.125** As part of the Department's wider work on cohesion, it commemorated the bicentenary of the abolition of the slave trade. In April 2007, the Department launched *Many Rivers to Cross – The History of the Caribbean Contribution to the NHS*. This book tells the stories of people from the Caribbean who mainly joined the NHS between 1948 and 1969. In October 2007, the Department held a national conference of over 300 delegates to look at tackling health inequalities within black communities.

### Engaging with faith communities

**11.126** The Department is aware of the diverse health needs within communities and the key role played by faith organisations in supporting the NHS and social care organisations to improve the health and well-being of local people. The Department maintains close contact with a multi-faith group, which was independently formed by, and comprises, representatives of a wide range of faith communities as part of its commitment to a multi-faith approach to NHS chaplaincy.

**11.127** The Department continues to engage faith communities in public health campaigns. For example, recognising that Ramadan provides a key opportunity for culturally specific promotion of the Department's public health agenda among a key target group, it commissioned a *Ramadan Health Guide* which was independently produced by Communities in Action and was launched at Ealing PCT in September 2007.

### Mosaic

**11.128** The Mosaic project (details available at: [www.mosaic.nhs.uk](http://www.mosaic.nhs.uk)) is sponsored by the Department and hosted by Guy's and St Thomas'

NHS Foundation Trust. The project emerged in response to the *Race Relations (Amendment) Act 2000* and works with key stakeholders in the NHS supply chain to promote equality in and through procurement and to align equality and efficiency goals in the NHS. In June 2007, the project published *Beyond Procurement: Connecting Procurement Practice to Patients* and held a national conference to consider policy issues and practically focused steps to ensure that the NHS meets its equality duties while ensuring effective procurement and commissioning.

### Sexual Orientation and Gender Identity Advisory Group

**11.129** The Department has continued to work with external stakeholders on the development and delivery of a programme of work to promote equality and eliminate discrimination for lesbian, gay, bisexual and transgender (LGBT) people in health and social care (as both service users and employees). In August 2007, the Department launched a number of resources (available at: [www.dh.gov.uk/EqualityAndHumanRights](http://www.dh.gov.uk/EqualityAndHumanRights)) to support the strategy, *Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People: Briefings for Health and Social Care Staff* (DH, September 2007).

**11.130** The Department was also a sponsor of the National LGBT Health Summit. The summit, held in Manchester on 20 and 21 August 2007, with some 300 delegates from across the UK, highlighted key health issues and inequalities facing LGBT communities.

### Human rights

**11.131** In March 2007, the Department launched *Human Rights in Healthcare – A Framework for Local Action*. The framework provides NHS organisations with guidance on how to apply human rights-based approaches to improve service planning and delivery.

**11.132** The Department is continuing to work with several pilot trusts including Southwark Health and Social Care, Heart of Birmingham Teaching PCT, Mersey Care NHS Trust, Tees, Esk and Wear Valleys NHS Trust and Surrey and Borders Partnership NHS Trust to further develop the framework into a series of practical human rights tools. These tools will assist NHS organisations in taking a practical approach to human rights in health and social care.

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**Figure A.1: Department of Health public spending (core table 1)**

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
	outturn	outturn	outturn	outturn	outturn	estimated	plan	plan	plan
<b>£ million</b>									
<b>Consumption of resources</b>									
NHS	55,405	61,865	66,873	74,168	78,468	87,133	92,475	98,263	104,603
Personal social services	1,590	1,617	2,110	2,070	1,817	1,869	1,384	1,510	1,605
NHS pensions <sup>(1)(2)</sup>	4,569	6,194	6,396	9,281	10,226	14,022	14,071	14,993	15,958
NHS (AME)	57	60	30	74	139	458	433	505	577
Credit guarantee finance (AME) <sup>(3)</sup>	39	40	24	54	84	72	93	109	127
<b>Total Department of Health resource budget</b>	<b>61,660</b>	<b>69,776</b>	<b>75,434</b>	<b>85,647</b>	<b>90,734</b>	<b>103,555</b>	<b>108,456</b>	<b>115,379</b>	<b>122,870</b>
<i>Of which:</i>									
Department of Health Departmental Expenditure Limit (DEL)	56,995	63,481	68,983	76,238	80,285	89,003	93,859	99,773	106,208
<i>of which:</i>									
Near cash	54,295	61,030	68,591	74,295	77,290	83,851	90,680	96,321	102,511
Non-cash	2,700	2,451	391	1,943	2,995	5,151	3,179	3,451	3,697
<b>Capital spending</b>									
NHS <sup>(4)</sup>	2,073	2,602	2,624	2,151	3,069	3,316	4,567	5,328	6,059
Personal social services	72	84	83	92	124	255	143	146	148
NHS (AME)	0	0	229	292	0	0	0	0	0
Credit guarantee finance (AME) <sup>(3)</sup>	0	0	0	357	89	43	10	0	0
<b>Total Department of Health capital budget</b>	<b>2,145</b>	<b>2,686</b>	<b>2,937</b>	<b>2,893</b>	<b>3,282</b>	<b>3,614</b>	<b>4,721</b>	<b>5,474</b>	<b>6,207</b>
<i>Of which:</i>									
Department of Health Departmental Expenditure Limit (DEL)	2,145	2,686	2,707	2,244	3,193	3,571	4,711	5,474	6,207
<b>Total public spending in Department of Health<sup>(5)</sup></b>	<b>63,272</b>	<b>72,061</b>	<b>77,860</b>	<b>87,909</b>	<b>92,794</b>	<b>105,745</b>	<b>111,801</b>	<b>119,271</b>	<b>127,262</b>
<i>Of which:</i>									
NHS <sup>(6)(7)</sup>	57,049	64,173	69,051	75,822	80,561	89,568	96,213	102,642	109,568
Personal social services <sup>(8)</sup>	1,653	1,693	2,182	2,153	1,927	2,111	1,512	1,642	1,739
NHS pensions	4,569	6,194	6,396	9,281	10,226	14,022	14,071	14,993	15,958
NHS (AME) <sup>(9)</sup>	0	0	228	292	0	9	0	0	0
Credit guarantee finance (AME) <sup>(3) (10)</sup>	0	0	3	362	80	35	5	-5	-3
<b>Spending by local authorities on functions relevant to the Department</b>									
<b>Current</b>	<b>12,931</b>	<b>14,748</b>	<b>16,121</b>	<b>17,243</b>	<b>17,874</b>	<b>18,326</b>	<b>0</b>	<b>0</b>	<b>0</b>
<i>Of which:</i>									
Funded by grants from the Department of Health	1,881	1,816	2,148	2,141	1,772	1,832	0	0	0
<b>Capital</b>	<b>125</b>	<b>186</b>	<b>209</b>	<b>300</b>	<b>278</b>	<b>358</b>	<b>0</b>	<b>0</b>	<b>0</b>
<i>Of which:</i>									
Financed by grants from the Department of Health	72	132	140	122	181	165	0	0	0

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) NHS Pensions is the resource budget of the pension scheme, and it is included in core table 1 because it is part of the Department of Health resource budget. Figures reflect the requirement specified by Financial Reporting Standard 17 – Retirement Benefits.

(2) Employers' National Insurance Contributions increased from 7% to 14% from 1 April 2004.

(3) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury. This line also includes some funding for PCT impairments.

(4) Includes funding available to NHS foundation trusts from 2004-05.

(5) Total public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £437/301/458/507/990/895/845/963/1,108 million (this excludes impairments funded in AME which is outside the DEL).

(6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £428/293/446/497/975/882/830/950/1,095 million (this excludes impairments funded in AME which is outside the DEL).

(7) For a more detailed breakdown of NHS expenditure in England see Figure 9.2.

(8) Personal social services public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £9/8/12/10/14/13/15/13/13 million.

(9) Total NHS (AME) is calculated as the total of the resource budget plus the capital budget, less impairments of £57/60/32/74/139/449/433/505/577 million.

(10) Total credit guarantee finance is calculated as the total of the resource budget plus the capital budget less impairments of £38/40/21/50/93/80/98/114/130 million.

(11) Figures may not sum due to rounding.

**Figure A.2: Department of Health resource budget (core table 2)**

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
	outturn	outturn	outturn	outturn	outturn	estimated	plan	plan	plan
						outturn			
<b>£ million</b>									
<b>Consumption of resources by activity</b>									
<b>National Health Service (NHS)</b>	55,405	61,865	66,873	74,168	78,468	87,133	92,475	98,263	104,603
<i>Of which:</i>									
<b>Hospital and community health services</b>	52,448	58,412	63,373	70,757	76,011	84,458	89,779	95,154	101,315
<i>of which:</i>									
Health authorities unified budget and central allocations and grants to local authorities	52,448	58,412	63,373	70,757	76,011	84,458	89,779	95,154	101,315
<b>Family health services</b>	2,024	2,141	2,129	2,131	1,021	1,064	1,093	1,223	1,277
<i>of which:</i>									
General dental services <sup>(1)</sup>	1,221	1,283	1,246	1,038	19	0	0	0	0
General ophthalmic services	304	322	341	358	381	410	427	449	474
Pharmaceutical services	919	962	966	1,162	1,033	1,075	1,110	1,242	1,302
Prescription charges income	-421	-426	-422	-427	-412	-421	-444	-468	-500
<b>Central health and miscellaneous services</b>	600	993	1,062	979	1,157	1,327	1,327	1,614	1,745
<i>of which:</i>									
Welfare foods DEL	102	138	119	104	110	125	118	125	128
EEA medical costs	251	390	429	517	598	695	749	885	981
Other central health and miscellaneous services	246	465	514	359	449	507	461	604	636
<b>Departmental administration including agencies</b>	333	320	309	300	278	284	276	271	267
<b>Personal social services (PSS)</b>	1,590	1,617	2,110	2,070	1,817	1,869	1,384	1,510	1,605
<i>Of which:</i>									
<b>Personal social services</b>	158	192	240	191	239	259	323	307	312
<b>Local authority personal social services grants</b>	1,432	1,425	1,871	1,880	1,578	1,610	1,061	1,203	1,292
<i>of which:</i>									
Training Support Programme	58	57	55	0	0	0	0	0	0
Specific Grants: AIDS/HIV	17	16	17	17	16	17	20	22	26
Specific Grants: Mentally Ill	133	133	131	133	132	148	0	0	0
Carers' Grant	85	100	125	185	185	185	0	0	0
Promoting Independence Grant	166	0	0	0	0	0	0	0	0
Performance Fund	48	96	0	0	0	0	0	0	0
Deferred Payments Grant	18	23	0	0	0	0	0	0	0
Care Direct	3	2	0	0	0	0	0	0	0
Preserved Rights Grant	614	500	435	340	298	275	0	0	0
Residential Allowance grant	93	182	406	217	0	0	0	0	0
National Training Strategy	0	25	29	92	108	108	0	0	0
Delayed Discharge	0	51	100	100	100	100	0	0	0
Access and Systems Capacity Grant	0	170	484	643	546	546	0	0	0
Human Resources Development Strategy	0	10	24	63	50	50	0	0	0
Social Services Projects – ISB	2	0	0	0	0	0	0	0	0
Assistive Technology	0	0	0	0	30	50	0	0	0
Prevention Service	0	0	0	0	20	40	0	0	0
Individual Budget Pilots	0	0	0	0	3	3	0	0	0
Area Based Grant	0	0	0	0	0	0	942	958	979
Learning Disabilities: closure of campuses	0	0	0	0	0	0	14	31	51
Transforming Personalisation, Prevention and Well-being	0	0	0	0	0	0	85	192	237
Grants for children	194	60	65	91	90	89	0	0	0
<b>NHS – superannuations – England and Wales</b>	4,569	6,194	6,396	9,281	10,226	14,022	14,071	14,993	15,958
<b>NHS (AME)</b>	57	60	30	74	139	458	433	505	577
<b>Credit guarantee finance<sup>(2)</sup></b>	39	40	24	54	84	72	93	109	127
<b>Total Department of Health resource budget</b>	<b>61,660</b>	<b>69,776</b>	<b>75,434</b>	<b>85,647</b>	<b>90,734</b>	<b>103,555</b>	<b>108,456</b>	<b>115,379</b>	<b>122,870</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) General dental services (GDS) data represents the net cost, after taking account of patient charge income, for non-discretionary services only. Outturn trends are affected by the progressive movement of dental practices into personal dental service pilots. From April 2006, provision for GDS is included within the general HCFHS resources as dental care is now commissioned from funds devolved to PCTs. The GDS provision identified for 2006-07 represents the costs of completing payments in respect of GDS services delivered up to March 2006.

(2) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury.

(3) Figures may not sum due to rounding.

**Figure A.3: Department of Health capital budget (core table 3)**

	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 estimated outturn	2008-09 plan	2009-10 plan	2010-11 plan	£ million
<b>National Health Service (NHS)</b>	2,073	2,602	2,624	2,151	3,069	3,316	4,567	5,328	6,059	
<i>Of which:</i>										
<b>Hospital and community health services<sup>(1)</sup></b>	2,043	2,566	2,592	2,111	3,033	3,266	4,527	5,288	6,017	
<i>of which:</i>										
Health authorities unified budget and central allocations and grants to local authorities	2,043	2,566	2,592	2,111	3,033	3,266	4,527	5,288	6,017	
<b>Central health and miscellaneous services</b>	20	13	16	22	20	28	20	19	20	
<b>Departmental administration including agencies</b>	10	23	16	19	17	22	21	22	23	
<b>Personal social services (PSS)</b>	72	84	83	92	124	255	143	146	148	
<i>Of which:</i>										
<b>Personal social services (including Credit Approvals)</b>	47	59	58	67	77	187	24	25	26	
<b>Local authority PSS grants</b>	25	25	25	25	47	68	119	120	121	
<i>of which:</i>										
AIDS/HIV Capital grants	0	0	0	0	2	3	3	3	3	
Improving Information Management	25	25	25	25	25	25	0	0	0	
Learning Disabilities	0	0	0	0	0	0	11	11	11	
Transforming Personalisation, Prevention and Well-being	0	0	0	0	0	0	15	16	17	
Mental Health Capital Grant	0	0	0	0	0	0	23	23	23	
Social Care Capital Grant	0	0	0	0	0	0	28	28	28	
Extra Care Housing Grant	0	0	0	0	20	40	40	40	40	
<b>NHS (AME)</b>	0	0	229	292	0	0	0	0	0	
<b>Credit guarantee finance (AME)<sup>(2)</sup></b>	0	0	0	357	89	43	10	0	0	
<b>Total Department of Health capital budget</b>	2,145	2,686	2,937	2,893	3,282	3,614	4,721	5,474	6,207	

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) Includes funding available to NHS foundation trusts from 2004-05.

(2) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury.

(3) Figures may not sum due to rounding.

**Figure A.4: Total capital employed by the Department of Health (core table 4)**

	£ million								
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
	outturn	outturn	outturn	outturn	outturn	estimated	plan	plan	plan
	outturn	outturn	outturn	outturn	outturn	outturn	plan	plan	plan
Within the Departmental account <sup>(1)(2)</sup>	12,290	11,597	14,333	14,551	14,950	15,436	15,899	16,337	16,786
Investment outside accounting boundary <sup>(3)(4)(5)(6)</sup>	24,860	27,468	32,693	33,597	35,502	36,656	37,756	38,794	39,861
<b>Total capital employed</b>	<b>37,150</b>	<b>39,065</b>	<b>47,026</b>	<b>48,148</b>	<b>50,453</b>	<b>52,093</b>	<b>53,655</b>	<b>55,131</b>	<b>56,647</b>

Source: Department of Health

Notes:

(1) This includes all entities within the DH resource accounting boundary, such as the central DH, SHAs and PCTs.

(2) Source: DH consolidated resource accounts.

(3) Includes the NHS Litigation Authority which moved inside the accounting boundary in 2000-01.

(4) Includes the Health Development Agency which moved inside the accounting boundary in 2002-03.

(5) This includes, for example, NHS trusts and the National Blood Authority.

(6) In 2000-01, part of NHS supplies (the Purchasing and Supply Agency) moved inside the boundary and, from 2001-02, Rampton, Broadmoor and Ashworth Special Health Authorities moved outside the accounting boundary.

**Figure A.5: Department of Health administration costs (core table 5)**

	£ million								
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
	outturn	outturn	outturn	outturn	outturn	estimated	plan <sup>(1)</sup>	plan <sup>(1)</sup>	plan <sup>(1)</sup>
<b>Administration expenditure</b>									
Paybill	142	140	113	114	118	117	n/a	n/a	n/a
Other	162	156	164	140	116	115	n/a	n/a	n/a
<b>Total administration expenditure</b>	<b>304</b>	<b>296</b>	<b>277</b>	<b>254</b>	<b>234</b>	<b>232</b>	<b>223</b>	<b>218</b>	<b>213</b>
Administration income	-8	-11	-9	-9	-5	-6	-4	-4	-4
<b>Total administration budget</b>	<b>296</b>	<b>284</b>	<b>268</b>	<b>246</b>	<b>228</b>	<b>226</b>	<b>219</b>	<b>214</b>	<b>209</b>
<b>Analysis by activity:</b>									
Central Department	296	284	268	246	228	226	219	214	209
Other	0	0	0	0	0	0	0	0	0
<b>Total administration budget</b>	<b>296</b>	<b>284</b>	<b>268</b>	<b>246</b>	<b>228</b>	<b>226</b>	<b>219</b>	<b>214</b>	<b>209</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) A break down between paybill and other for years 2008-09 to 2010-11 is not available.

**Figure A.6: Department of Health staff numbers (core table 6)**

	Financial year average									
	2002-03 actual	2003-04 actual	2004-05 actual	2005-06 actual	2006-07 actual	2007-08 plan	2007-08 estimated outturn	2008-09 plan	2009-10 plan	2010-11 plan
<b>Department of Health (gross control area)<sup>(1)(7)</sup></b>										
Core Department of Health (full time equivalents)	3,390	2,964	2,050	2,245	2,250	2,195	2,178	2,221	2,245	2,245
Other	0	0	0	0	0	0	0	0	0	0
Designated to transfer from the Department (full time equivalents)	0	0	139	119	65	50	50	24	0	0
<b>Agencies</b>										
NHS Pensions Agency (full time equivalents) <sup>(2)</sup>	268	258	0	0	0	0	0	0	0	0
Medicine and Healthcare products Regulatory Agency (full time equivalents) <sup>(3)</sup>	0	747	781	819	854	891	909	927	939	951
Medical Devices Agency <sup>(3)</sup>	156	0	0	0	0	0	0	0	0	0
Medicines Control Agency <sup>(3)</sup>	519	0	0	0	0	0	0	0	0	0
NHS Purchasing and Supply Agency (full time equivalents) <sup>(4)</sup>	309	318	332	350	321	331	282	314	314	314
NHS Estates <sup>(5)</sup>	390	375	314	0	0	0	0	0	0	0
<b>Total Department of Health</b>	<b>5,032</b>	<b>4,662</b>	<b>3,616</b>	<b>3,533</b>	<b>3,490</b>	<b>3,467</b>	<b>3,419</b>	<b>3,486</b>	<b>3,498</b>	<b>3,510</b>

Source: Department of Health (core) – Personnel and Related Information System (PARIS).

Notes:

(1) Actual figures are an average across the financial year and are compiled on the same basis as in Departmental Resource Accounts. In particular they include ministers and special advisers.

(2) The NHS Pensions Agency became a special health authority (part of the NHS) in April 2004.

(3) The Medicines Control Agency and Medical Devices Agency merged with effect from 1 April 2003 to become the Medicines and Healthcare products Regulatory Agency (MHRA). The variance between the 2007-08 plan and estimated outturn is due to the MHRA managed policy on staff headcount numbers.

(4) NHS Purchasing and Supply Agency (PASA) has revised its 2003-04 staff number following an internal review of records. The Procurement Policy Advisory Unit and the Centre for Evidence Based Purchasing joined PASA from the core Department from 2004-05 following an organisational review. The variance between the 2007-08 plan and estimated outturn is following the outsourcing of activities and associated staffing to DHL/NHS Supply Chain during 2006-07 and the subsequent reduction in overall staffing for NHS PASA.

(5) NHS Estates became a Trading Fund on 1 April 1999. Figures from 2003-04 include staff in Inventures. NHS Estates was abolished on 31 March 2005.

(6) Future planned staff numbers are subject to change.

(7) The Department announced a major change programme in March 2003, under which it committed to reduce its workforce from 3,645 full-time equivalent posts to 2,245. The reduction of 1,400 was to consist of 680 transfers to other organisations and the removal of 720 posts. This change programme predated the 2004 Spending Review, but it was agreed that the Department could adopt the change programme target reduction as its Spending Review (Gershon) target. By the end of December 2007, the Department's full-time equivalent staffing was 2,189 (excluding ministers and special advisers), representing a reduction of 1,456 from March 2003. This consisted of 637 transfers and 819 posts removed.

**Figure A.7: Department of Health identifiable expenditure on services, by country and region (core table 7)**

	£ million								
	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 plan	2008-09 plan	2009-10 plan	2010-11 plan
North East	2,996.5	3,193.2	3,574.7	3,868.5	4,144.8	4,646.4	4,945.2	5,279.2	5,616.4
North West	7,883.9	8,734.9	9,484.7	10,217.2	10,923.0	12,292.8	13,005.1	13,884.0	14,770.5
Yorkshire and Humberside	5,335.5	5,929.5	6,645.7	7,244.8	7,616.8	8,493.9	8,993.9	9,602.9	10,217.4
East Midlands	3,936.1	4,431.0	4,975.7	5,415.2	5,829.8	6,791.8	7,073.9	7,552.9	8,036.3
West Midlands	5,506.4	6,002.8	6,716.8	7,222.0	7,961.0	8,711.9	9,400.1	10,034.6	10,675.6
Eastern	5,275.8	5,723.9	6,441.6	6,846.1	7,374.0	7,954.7	8,960.2	9,568.6	10,182.3
London	9,152.6	10,116.8	11,370.7	11,918.4	12,143.9	13,896.1	14,550.1	15,523.9	16,508.8
South East	7,914.9	8,606.5	9,601.3	10,015.6	11,012.3	11,896.8	13,151.7	14,048.3	14,951.0
South West	4,864.7	5,366.6	6,049.1	6,590.1	6,902.0	7,810.5	8,328.3	8,900.0	9,474.5
<b>Total England</b>	<b>52,866.2</b>	<b>58,105.3</b>	<b>64,860.2</b>	<b>69,337.8</b>	<b>73,907.5</b>	<b>82,494.8</b>	<b>88,408.7</b>	<b>94,394.3</b>	<b>100,432.7</b>
Scotland	35.6	34.9	37.5	40.8	45.3	49.2	55.3	59.3	64.1
Wales	-2.2	-147.8	-161.4	-181.3	-179.0	-185.1	-158.1	-144.7	-137.4
Northern Ireland	24.2	22.2	23.9	25.5	26.3	28.0	33.4	36.1	39.0
<b>Total UK identifiable expenditure</b>	<b>52,923.9</b>	<b>58,014.5</b>	<b>64,760.2</b>	<b>69,222.7</b>	<b>73,800.2</b>	<b>82,386.9</b>	<b>88,339.3</b>	<b>94,345.0</b>	<b>100,398.5</b>
Outside UK	363.4	380.7	563.4	475.2	671.5	754.5	827.5	908.4	998.7
<b>Total identifiable expenditure</b>	<b>53,287.3</b>	<b>58,395.2</b>	<b>65,323.5</b>	<b>69,697.9</b>	<b>74,471.7</b>	<b>83,141.3</b>	<b>89,166.8</b>	<b>95,253.4</b>	<b>101,397.2</b>
Non-identifiable expenditure	0.0	0.0	0.0	0.0	0.0	337.0	714.0	1,074.0	1,738.0
<b>Total expenditure on services</b>	<b>53,287.3</b>	<b>58,395.2</b>	<b>65,323.5</b>	<b>69,697.9</b>	<b>74,471.7</b>	<b>83,478.3</b>	<b>89,880.8</b>	<b>96,327.4</b>	<b>103,135.2</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in Departmental budgets. They do include pay, procurement, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.

(2) The figures were taken from the HM Treasury Public Expenditure database in December 2007 and the regional distributions were completed in January/February 2008. Therefore, the tables may not show the latest position and are not consistent with other tables in the Departmental report.

**Figure A.8: Department of Health identifiable expenditure on services, by country and region, per head (core table 8)**

	£ per head								
	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 plan	2008-09 plan	2009-10 plan	2010-11 plan
North East	1,179.3	1,256.5	1,406.1	1,517.2	1,621.8	1,823.2	1,934.8	2,059.3	2,183.9
North West	1,163.1	1,284.5	1,390.8	1,493.8	1,593.9	1,782.0	1,874.8	1,990.2	2,105.0
Yorkshire and Humberside	1,066.7	1,179.4	1,312.3	1,418.5	1,481.2	1,644.6	1,727.5	1,829.7	1,931.0
East Midlands	932.4	1,041.6	1,159.5	1,251.3	1,335.8	1,545.8	1,595.1	1,687.4	1,778.8
West Midlands	1,039.9	1,130.1	1,261.0	1,349.7	1,483.4	1,616.3	1,734.3	1,840.8	1,947.1
Eastern	971.1	1,045.5	1,168.9	1,230.6	1,315.2	1,405.6	1,567.5	1,657.2	1,745.9
London	1,243.3	1,373.8	1,538.9	1,598.5	1,616.5	1,834.2	1,905.1	2,015.8	2,125.6
South East	983.6	1,064.2	1,181.7	1,223.7	1,336.8	1,434.7	1,573.7	1,667.7	1,760.7
South West	978.1	1,072.3	1,199.8	1,295.5	1,347.0	1,510.3	1,594.8	1,687.7	1,779.1
<b>Total England</b>	<b>1,064.7</b>	<b>1,165.2</b>	<b>1,294.3</b>	<b>1,374.0</b>	<b>1,455.9</b>	<b>1,614.6</b>	<b>1,717.1</b>	<b>1,819.2</b>	<b>1,920.4</b>
Scotland	7.0	6.9	7.4	8.0	8.9	9.6	10.7	11.5	12.3
Wales	-0.7	-50.4	-54.8	-61.4	-60.4	-62.1	-52.8	-48.1	-45.4
Northern Ireland	14.2	13.1	14.0	14.8	15.1	15.9	18.8	20.2	21.7
<b>Total UK identifiable expenditure</b>	<b>892.1</b>	<b>974.1</b>	<b>1,082.1</b>	<b>1,149.1</b>	<b>1,218.1</b>	<b>1,351.2</b>	<b>1,438.5</b>	<b>1,525.2</b>	<b>1,611.3</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in Departmental budgets. They do include pay, procurement, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.

(2) The figures were taken from the HM Treasury Public Expenditure database in December 2007 and the regional distributions were completed in January/February 2008. Therefore, the tables may not show the latest position and are not consistent with other tables in the Departmental report.

**Figure A.9: Department of Health identifiable expenditure on services by function, by country and region, 2006-07 (core table 9)**

	£ million							Grand total
	Health			Social protection				
	Central and other health services	Medical services	Total health	Sickness and disability	Old age	Survivors	Total social protection	
North East	46.6	4,214.8	4,261.4	14.2	-147.9	17.2	-116.6	4,144.8
North West	123.6	11,142.8	11,266.4	37.5	-402.2	21.4	-343.3	10,923.1
Yorkshire and Humberside	85.4	7,760.9	7,846.3	25.9	-278.6	23.2	-229.5	7,616.8
East Midlands	64.9	5,933.5	5,998.4	19.7	-217.1	28.8	-168.6	5,829.8
West Midlands	88.4	8,078.0	8,166.4	26.9	-269.7	37.4	-205.5	7,961.0
Eastern	82.8	7,531.9	7,614.7	25.1	-292.5	26.7	-240.7	7,373.9
London	136.7	12,312.9	12,449.5	41.5	-363.9	16.7	-305.7	12,143.9
South East	120.4	11,326.1	11,446.4	36.6	-472.7	2.0	-434.2	11,012.3
South West	77.5	7,137.3	7,214.8	23.5	-336.6	0.3	-312.8	6,902.0
<b>Total England</b>	<b>826.2</b>	<b>75,438.1</b>	<b>76,264.3</b>	<b>250.9</b>	<b>-2,781.2</b>	<b>173.5</b>	<b>-2,356.8</b>	<b>73,907.5</b>
Scotland	0.0	0.1	0.1	0.0	33.6	11.7	45.3	45.3
Wales	0.0	0.0	0.0	0.0	-210.9	31.9	-179.0	-179.0
Northern Ireland	0.0	0.0	0.0	0.0	4.3	22.1	26.3	26.3
<b>UK identifiable expenditure</b>	<b>826.2</b>	<b>75,438.1</b>	<b>76,264.3</b>	<b>250.9</b>	<b>-2,954.2</b>	<b>239.2</b>	<b>-2,464.1</b>	<b>73,800.2</b>
Outside UK	538.5	0.0	538.5	0.0	125.6	7.4	133.0	671.5
<b>Total identifiable expenditure</b>	<b>1,364.7</b>	<b>75,438.1</b>	<b>76,802.9</b>	<b>250.9</b>	<b>-2,828.6</b>	<b>246.5</b>	<b>-2,331.2</b>	<b>74,471.7</b>
Not identifiable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>1,364.7</b>	<b>75,438.1</b>	<b>76,802.9</b>	<b>250.9</b>	<b>-2,828.6</b>	<b>246.5</b>	<b>-2,331.2</b>	<b>74,471.7</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(1) The functional categories used are the standard United Nations Classifications of the Functions of Government (COFOG) categories. This is not the same as the strategic priorities used elsewhere in the report.

## B Public Service Agreement and Operating Standards

Targets are intended to be outcome focused, delivering further improvements in key areas of public service delivery and capturing the outcomes that matter to people, and this inevitably means that measurement may be complex in some cases. The Department is committed to ensuring that the data used in monitoring and reporting on Public Service Agreements (PSAs) is robust and reliable. The data systems underpinning PSA targets are subject to validation by the National Audit Office (NAO). The NAO report on the quality of the data systems underlying PSAs, the *Fourth Validation Compendium Report* (NAO, December 2007), examines the data systems used by 11 departments to monitor and report progress against their 2005 to 2008 PSA targets. See **figure B.1** for an explanation of the ratings used. Each of the Department's SR 2004 targets shows its rating.

The Department accepts that there are some areas where data collection needs to improve, and work is in place to ensure that this is happening. The Department works closely with HM Treasury, the Prime Minister's Delivery Unit and analytical experts to ensure improvements to data relating to all target areas.

**Figure B.1: National Audit Office ratings on PSA data systems**

Rating	Meaning
Green (fit for purpose)	The data system is fit for the purpose of measuring and reporting performance against the target.
Green (disclosure)	The data system is appropriate for the target and the Department has fully explained the implications of limitations that cannot be cost-effectively controlled.
Amber (systems)	The data system is broadly fit for purpose, but needs strengthening to ensure that remaining risks are adequately controlled.
Amber (disclosure)	The data system is broadly appropriate, but includes limitations that cannot be cost-effectively controlled; the Department should explain the implications of these.
Red	The data system is not fit for the purpose of measuring and reporting performance against the target or will not be put in place within the PSA 2005 to 2008 period.
White (not established)	The Department has not yet put in place a system to measure performance against the target.
White (too early to form a view)	The Department has established a system but it is too early to form a view on its fitness for purpose.

## Departmental PSA targets (SR 2004) analysis

Further to the 1998, 2000 and 2002 Spending Reviews, the 2004 Review continued the process of delivering improvements in services, through the innovation of PSA targets. The targets from that review are laid out below, with updates on progress.

### Objective I: Health of the population

#### Target 1

**A.** Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.

#### Measure

Life expectancy at birth for men and women in England.

#### Progress

##### Overall life expectancy – encouraging progress.

In the period 2004 to 2006, the life expectancy in England at birth was as follows:

Male – 77.2 years

Female – 81.5 years

These have risen from a baseline of 75.0 years for males and 79.9 years for females for the period 1997 to 1999.

#### Data quality

No rating applied.

## Figure B.2: Overall life expectancy at birth of men and women in England

Period	Life expectancy at birth (male)	Life expectancy at birth (female)
1997-1999	75.0	79.9
1998-2000	75.3	80.1
1999-2001	75.7	80.4
2000-2002	76.0	80.6
2001-2003	76.3	80.7
2002-2004	76.6	80.9
2003-2005	76.9	81.1
2004-2006	77.2	81.5

Source: Office for National Statistics.

Notes:

(1) These data differ slightly from those used for the health inequalities target. This is because the Government Actuary's Department estimates are produced using a different methodology from the Office for National Statistics estimates.

**B.** Substantially reduce mortality rates by 2010 from heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a 40 per cent reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

#### Measure

Death rate from heart disease, stroke and related illnesses among people aged under 75.

#### Progress

**Overall mortality – met early.** The 1995 to 1997 baseline figure for overall mortality for heart disease in people aged under 75 in England was 141.0 deaths per 100,000 population. In the period 2004 to 2006, the rate had fallen to 84.2 deaths per 100,000 – a fall of 40.3 per cent.

**Inequality dimension – on course.** Three-year average rates have fallen in the spearhead group and England as a whole for each period since the baseline. During this period, the inequality gap has reduced from a baseline absolute gap of 36.7 deaths per 100,000 population in the period 1995 to 1997 to 24.9 deaths per 100,000 population in the period 2004 to 2006 (the target for 2010 is to reduce the absolute gap to 22.0 deaths or less per 100,000 population). The gap has therefore reduced by 32.2 per cent since the baseline, compared with

the required target reduction of at least 40 per cent by the period 2009 to 2011.

## Data quality

Green (fit for purpose).

**Figure B.3: Mortality rate from all circulatory diseases**

Period	Mortality rate per 100,000 (under-75s)	% Change from baseline
1995-1997	141.0	
1996-1998	135.1	-4.2%
1997-1999	128.3	-9.0%
1998-2000	121.6	-13.8%
1999-2001	114.5	-18.8%
2000-2002	108.1	-23.3%
2001-2003	102.8	-27.1%
2002-2004	96.7	-31.4%
2003-2005	90.5	-35.9%
2004-2006	84.2	-40.3%

Source: Office for National Statistics Mortality Data.

**Figure B.4: All circulatory diseases, inequality dimension**

Period	Absolute gap between England and spearhead group (rate per 100,000 under-75s)	% Change from baseline
1995-1997	36.7	
1996-1998	36.4	-0.8%
1997-1999	35.2	-4.0%
1998-2000	32.7	-10.8%
1999-2001	30.8	-16.0%
2000-2002	29.0	-20.8%
2001-2003	28.7	-21.8%
2002-2004	27.6	-24.7%
2003-2005	26.4	-27.9%
2004-2006	24.9	-32.2%

Source: Office for National Statistics Mortality Data.

**C.** Substantially reduce mortality rates by 2010 from cancer by at least 20 per cent in people under 75 with a reduction in the inequalities gap of at least 6 per cent between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

## Measure

Death rate from cancer among people aged under 75.

## Progress

**Overall mortality – on course.** The 1995 to 1997 baseline figure for overall mortality for cancer in people aged under 75 in England was 141.2 deaths per 100,000 population. In the period 2004 to 2006, the rate had fallen to 117.0 deaths per 100,000 – a fall of 17.1 per cent. Three-year average rates have fallen for each period since the baseline. If the trend of the last 10 years were to continue, the target would be met.

**Inequality dimension – ahead.** Three-year average rates have fallen in the spearhead group and England as a whole for each period since the baseline. Following a small increase in the inequality gap in the first monitoring period, the gap has reduced slightly from a baseline absolute gap of 20.7 deaths per 100,000 population in the period 1995 to 1997 to 18.1 deaths per 100,000 population in the period 2003 to 2005. Although mortality rates continue to fall, for the period 2004 to 2006 there has been a small increase in the inequality gap to 18.4 deaths per 100,000 population (the target for 2010 is to reduce the absolute gap to 19.5 deaths or less per 100,000 population). The gap has therefore reduced by 11.3 per cent since the baseline, compared with the required target reduction of at least 6 per cent by the period 2009 to 2011.

## Data quality

Green (fit for purpose).

**Figure B.5: Mortality rate from cancer in people aged under 75**

Period	Mortality rate per 100,000 (under-75s)	% Change from baseline
1995-1997	141.2	
1996-1998	138.4	-1.9%
1997-1999	134.9	-4.5%
1998-2000	132.0	-6.5%
1999-2001	128.7	-8.8%
2000-2002	126.5	-10.4%
2001-2003	124.1	-12.1%
2002-2004	121.6	-13.9%
2003-2005	119.0	-15.7%
2004-2006	117.0	-17.1%

Source: Office for National Statistics Mortality Data.

**Figure B.6: Cancer, inequality dimension**

Period	Absolute gap between England and spearhead group (rate per 100,000 under-75s)	% Change from baseline
1995-1997	20.7	
1996-1998	21.0	1.2%
1997-1999	20.8	0.1%
1998-2000	20.3	-2.2%
1999-2001	19.9	-4.2%
2000-2002	19.6	-5.5%
2001-2003	19.1	-8.1%
2002-2004	18.8	-9.4%
2003-2005	18.1	-12.7%
2004-2006	18.4	-11.3%

Source: Office for National Statistics Mortality Data.

**D.** Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20 per cent.

### Measure

Death rate from intentional self-harm and undetermined injury among people of all ages. Baseline is average of 1995, 1996 and 1997 (all using Office for National Statistics mortality statistics, age standardised to allow for changes in the age structure of the population).

### Progress

**Suicide and injury of undetermined intent – encouraging progress.** The three-year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen and is now 10 per cent below the baseline. The three-year average rate for the period 2004 to 2006 fell to the lowest recorded rate of 8.3 deaths per 100,000 population. If current trends continue, the target for 2010 would not be met, though there are signs that the rate of decline may once again be increasing. An increased rate of decline must be sustained if the target is to be met.

### Data quality

Green (fit for purpose).

**Figure B.7: Mortality rate from intentional self-harm and injury of undetermined intent (excluding verdict pending)**

Period	Mortality rate per 100,000	% Change from baseline
1995-1997	9.2	
1996-1998	9.3	1.7%
1997-1999	9.6	4.4%
1998-2000	9.7	5.5%
1999-2001	9.3	1.5%
2000-2002	8.9	-2.9%
2001-2003	8.6	-5.6%
2002-2004	8.6	-6.6%
2003-2005	8.5	-7.5%
2004-2006	8.3	-10.0%

Source: Office for National Statistics Mortality Data.

### Target 2

Reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.

### Measure

Mortality in infancy by social class – the gap in infant mortality between routine and manual groups and the population as a whole. Baseline is average of 1997, 1998 and 1999.

Life expectancy by local authority – the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole. Baseline is the average of 1995, 1996 and 1997.

### Progress

**Infant mortality – slippage.** Data for the period 2004 to 2006 (3-year average) shows a further slight narrowing in the gap between the ‘routine and manual’ groups and the population as a whole, compared with data for 2003 to 2005 and 2002 to 2004. However, over the period since the target baseline, the gap has widened, and the infant mortality rate among the ‘routine and manual’ group is now 17 per cent higher than in the total population. This compares with 13 per cent higher in the baseline period of 1997 to 1999, although there have been year-on-year fluctuations in intervening years.

The target is measured using an indicator of socio-economic groups defined only through the father's occupation because there is limited occupational data associated with sole registration by mothers. The current approach has remained consistent since the target was set.

**Life expectancy at birth – slippage.** For men, in the period 2004 to 2006 the relative gap in life expectancy between England and the spearhead group was 2 per cent wider than at the baseline period 1995 to 1997, the same as in the period 2003 to 2005.

For women, in the period 2004 to 2006 the relative gap in life expectancy between England and the spearhead group was 11 per cent wider than at the baseline period 1995 to 1997, compared with 8 per cent wider in the period 2003 to 2005.

In the period 2004 to 2006, data shows that 41 per cent of spearhead areas are on track to narrow their own life expectancy gap with England by 10 per cent by 2010 compared with baseline for either men or women, or both. Some 17 per cent are on track for men only, with a further 13 per cent on track for women and 11 per cent on track for both.

## Data quality

Green (fit for purpose).

**Figure B.8: Inequalities in infant mortality, England and Wales**

Period	Infant deaths per 1,000 live births – population as a whole	Infant deaths per 1,000 live births – routine and manual group	Relative gap (% difference) between routine and manual group and population as a whole	% change in relative gap from baseline
1997-1999	5.6	6.3	13%	
1998-2000	5.4	6.2	14%	10%
1999-2001	5.3	6.2	17%	30%
2000-2002	5.2	6.0	16%	23%
2001-2003	5.0	6.0	19%	45%
2002-2004	4.9	5.9	19%	47%
2003-2005	4.8	5.7	18%	39%
2004-2006	4.8	5.6	17%	27%

Source: Office for National Statistics.

Notes:

(1) Figures relate to infants born inside marriage or outside marriage jointly registered by both parents. Births registered by the mother alone are not included.

## Target 3

**A.** Tackle the underlying determinants of health and health inequalities by reducing adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less.

## Measure

Smoking – reduction in numbers of adult and routine/manual groups of smokers. Prevalence from General Household Survey.

**Figure B.9: Inequalities in life expectancy at birth, England**

Period	Male life expectancy at birth – England average	Male life expectancy at birth – spearhead group average	Relative gap (% difference) between spearhead group and England (males)	% change in relative gap from baseline (males)	Female life expectancy at birth – England average	Female life expectancy at birth – spearhead group average	Relative gap (% difference) between spearhead group and England (females)	% change in relative gap from baseline (females)
1995-1997	74.6	72.7	2.57%		79.7	78.3	1.77%	
1996-1998	74.8	72.9	2.59%	1%	79.8	78.4	1.83%	3%
1997-1999	75.1	73.1	2.66%	4%	80.0	78.5	1.85%	5%
1998-2000	75.4	73.4	2.63%	2%	80.2	78.7	1.87%	6%
1999-2001	75.7	73.7	2.62%	2%	80.4	78.9	1.85%	5%
2000-2002	76.0	74.1	2.55%	-1%	80.7	79.2	1.85%	4%
2001-2003	76.2	74.2	2.61%	1%	80.7	79.2	1.87%	6%
2002-2004	76.5	74.6	2.59%	1%	80.9	79.4	1.90%	8%
2003-2005	76.9	74.9	2.61%	2%	81.1	79.6	1.91%	8%
2004-2006	77.3	75.3	2.63%	2%	81.6	80.0	1.96%	11%

Source: Office for National Statistics.

## Progress

**Adult smoking rates – on course.** The percentage of adults smoking has fallen by 5 percentage points since 2001. While 27 per cent of the whole population smoked in 2001, this figure had fallen to 22 per cent in 2006. The fall of 2 percentage points from 24 per cent to 22 per cent is statistically significant, and it occurred among both men and women.

**Reduction in prevalence among routine and manual groups – encouraging progress.** The routine and manual figures were 33 per cent in 2001 and 29 per cent in 2006, a fall of 4 percentage points over the period 2001 to 2006.

## Data quality

Green (disclosure).

**Figure B.10: Adult smoking rates**

Period	All adults	Routine and manual groups
1998	28%	–
1999	–	–
2000	27%	–
2001	27%	33%
2002	26%	31%
2003	25%	32%
2004	25%	31%
2005	24%	31%
2006	22%	29%

Source: Office for National Statistics General Household Survey 2006.

**B.** Tackle the underlying determinants of health and health inequalities by halting the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole (joint target with the Department for Children, Schools and Families and the Department for Culture, Media and Sport).

## Measure

Obesity data system – the Health Survey for England (HSE), which comprises a series of annual surveys beginning in 1991. The series is part of an overall programme of surveys commissioned by the Department of Health which are designed to

provide regular information on various aspects of the nation's health.

As set out in the Technical Note for this PSA target, levels of childhood obesity are measured by aggregate trend data available every three years.

## Progress

**Obesity – not yet assessed.** Annual performance on tackling obesity is measured by comparing HSE figures for aggregate three-year periods. Halting the increase in obesity would mean no statistically significant change in prevalence between the three-year periods 2005 to 2007 and 2008 to 2010.

Non-aggregated data from the 2006 HSE recorded that 15.2 per cent of children aged 2 to 10 years in England were obese. Figures from the 2007 HSE are not yet available. The delay between the end of the collecting period and when the data are published is around 12 to 15 months.

The Government Office of Science Foresight project, *Tackling Obesities: Future Choices*, provided a clearer understanding of the complexity and scale of the obesity problem. This means moving away from a focus solely on obesity to one of promoting healthy weight, healthy lives and recognising that weight is a problem that affects adults as well as children. A shift in approach means the numbers of overweight and obese people must be reversed if severe consequences to individual health are to be avoided.

## Data quality

White (too early to form a view).

The three-year aggregate data for 2002 to 2004 showed that the prevalence of obesity among children aged 2–10 was 14.9 per cent. Equivalent aggregate data for 2003 to 2005 (published by the National Centre for Social Research) also indicated a figure of 14.9 per cent.

While aggregate estimates for the level of obesity for the period 2003 to 2005 were the same as for the period 2002 to 2004 these results should be treated with caution due to the overlapping periods used in the estimates and because the estimates are subject to sampling error. The 2004 to 2006 results will also include overlapping data and therefore more meaningful comparisons will not be possible until the 2005 to 2007 data is available, which will not include overlapping data from 2002 to 2004. HSE estimates these data will be available by early 2009.

**C. Tackle the underlying determinants of health and health inequalities by reducing the under-18 conception rate by 50 per cent by 2010, as part of a broader strategy to improve sexual health (joint target with the Department for Children, Schools and Families).**

### Measure

Teenage conceptions – the under-18 conception rate is the number of conceptions to under-18-year-olds per thousand females aged 15 to 17. Baseline year is 1998. Office for National Statistics conception statistics.

### Progress

**Teenage conceptions – slippage.** The under-18 conception target is one of the five lead indicators used to measure progress on the new ‘Youth’ PSA. A cross-government delivery agreement sets out the contribution that each department – including the Department of Health – will make towards the achievement of the PSA target ‘To increase the number of young people on the path to success’.

Teenage pregnancy rates are falling. Between the 1998 baseline year and 2006, the under-18 conception rate has fallen by 13.3 per cent. The rate is at the lowest level for 22 years; however, progress needs to accelerate for the target to be met. The under-16 conception rate has fallen by 13 per cent between 1998 and 2006.

### Data quality

Green (fit for purpose).

**Figure B.11: Under-18 conception rate**

Period	Under-18 conception rate per 1,000 females aged 15-17	% Change from baseline
1998	46.6	
1999	44.8	-3.9%
2000	43.6	-6.4%
2001	42.5	-8.8%
2002	42.7	-8.4%
2003	42.2	-9.4%
2004	41.6	-10.7%
2005	41.3	-11.4%
2006	40.4	-13.3%

Source: Office for National Statistics.

Note:

Data is compiled by adding together birth registration and abortion notification data.

## Objective II: Long-term conditions

### Target 4

To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at-risk; and to reduce emergency bed days by 5 per cent by 2008, through improved care in primary care and community settings for people with long-term conditions.

### Measure

Reduction in number of emergency bed days as measured through Hospital Episode Statistics. Reduction in number of very high intensive uses of care.

### Progress

Reduction in number of emergency bed days – met early. Between 2003-04 and 2006-07, the number of emergency bed days decreased by 10.1 per cent, from 32,457,517 to 29,183,638.

### Data quality

Red (not fit for purpose) – offering a personalised care plan for vulnerable people most at-risk.

Amber (disclosure) – reducing emergency bed days by 5 per cent by 2008.

**Figure B.12: Emergency bed-days**

Period	Number of emergency bed days	% Change from baseline
2003-04	32,457,517	
2004-05	31,902,650	-1.7%
2005-06	30,699,595	-5.4%
2006-07	29,183,638	-10.1%

Source: The Information Centre Hospital Episode Statistics.

## Objective III: Access to services

### Target 5

By December 2008, ensure that no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks).

### Measure

By the end of March 2008, the NHS is aiming to have achieved milestones of 85 per cent of patients admitted for hospital treatment and 90 per cent of patients who are not admitted receiving their treatment within a maximum of 18 weeks.

In December 2007, the Department of Health published operational standards of delivery of 18 weeks for the NHS in December 2008. After adjustments to allow for patient choice along the admitted part of admitted pathways, these standards are:

- 90 per cent of pathways where patients are admitted for hospital treatment should be completed within a maximum of 18 weeks.
- 95 per cent of pathways that do not result in an admission should be completed within a maximum of 18 weeks.

### Progress

**18 weeks – on course.** The NHS has made good progress. Referral to treatment data for January 2008 shows:

- 69 per cent of admitted patients waited 18 weeks or less in January 2008 compared with 47 per cent in January 2007.

- 82 per cent of non-admitted patients waited 18 weeks or less in January 2008 compared with 73 per cent in April 2007.

18 weeks referral to treatment can only be delivered if the NHS can reduce waits for all diagnostic tests, and in particular the 15 key monthly tests. Access to the 15 key diagnostic tests continues to improve:

- The number of waits over 13 weeks fell by 142,362 (84.4 per cent) from 167,826 at the end of January 2008 to 25,464 at the end of December 2007.
- The number of over 6-week waits fell by 264,637 (75.4 per cent) from 350,822 over the same period.
- The median waiting time now stands at 3 weeks compared with 6.1 weeks in April 2006. The number of waits over 6 weeks continues to fall.

### Data quality

Amber (systems).

### Target 6

Increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

### Measure

Annual returns from the National Drug Treatment Monitoring Service (NDTMS), which provides details on the number of drug misusers entering into, successfully completing and sustaining treatment.

### Progress

#### Participation in drug treatment – met early.

The results from the NDTMS reveal that there were over 195,000 people receiving structured drug treatment in England during 2006-07, an increase of 130 per cent on the 1998-99 baseline of 85,000.

### Effectiveness of drug treatment – on course.

In addition, in 2006-07, 80 per cent of those in drug treatment either successfully completed their programme or were retained in treatment for at least 12 weeks (measure of effectiveness). This is an increase from 76 per cent in 2005-06 and means that the Department remains on track to meet the target to increase year-on-year the proportion of drug misusers in treatment who either are being retained or successfully complete their treatment programme.

A second indicator, which measured solely the proportion of those retained in structured treatment for at least 12 weeks following triage assessment, stood still between 2005-06 and 2006-07.

These figures are based on a new method of counting introduced for 2006-07 to align the national PSA with the method used to judge local PCT performance against their local delivery plans. The new method focuses exclusively on new entrants to the treatment system who are retained for 12 weeks or more. The previous method included all those retained in treatment on 31 March 2007 and those successfully completing their treatment plan (including those completing treatment plans of less than 12 weeks).

### Data quality

Amber (systems).

### Figure B.13: Numbers of clients receiving structured treatment

Period	Drug user numbers	% Change from baseline
1998-99	85,000	
1999-2000	91,000	7.1%
2000-01	99,000	16.5%
2001-02	116,000	36.5%
2002-03	115,500	35.9%
2003-04	125,545	47.7%
2004-05	160,453	88.8%
2005-06	177,055	108.3%
2006-07	195,464	130.0%

Source: National Treatment Agency National Drug Treatment Monitoring System.

## Objective IV: Patient and user experience

### Target 7

Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

### Measure

The national survey programme (under the administration of the Healthcare Commission) will gather feedback from patients on different aspects of their experience of care in NHS trusts.

### Progress

#### Improving the patient experience – on course.

Since the first survey was conducted in 2001-02, well over 1.7 million patients have taken part in 18 surveys across five different NHS care settings.

PSA scores are an average score out of 100 calculated by aggregating scores from five domains of patient experience:

- Improving access and waiting.
- Building closer relationships.
- Better information, more choice.
- Safe, high-quality, coordinated care.
- Clean, friendly, comfortable place to be.

Scores are calculated in each of five different service settings (adult in-patient, outpatients, emergency services, community mental health services and primary care). To date figures for three of the five service areas covered by the PSA suggest small improvements. These improvements have been recorded in the service areas:

- Adult In-patient Survey (75.7 in 2003-04 to 76.4 in 2005-06);
- Primary Care Survey (76.9 in 2003-04 to 77.0 in 2005-06. Results for 2005-06 are obtained from a national survey conducted by the Department,

and are marginally lower than the 77.4 recorded in the Healthcare Commission primary care trust (PCT) survey administered in 2004-05); and

- Community Mental Health Services Survey (74.5 in 2005-06 to 75.2 in 2006-07. Results for earlier years cannot be compared due to changes in question wording).

Surveys are carried out on a rolling programme, and the latest surveys for outpatients and for emergency services were carried out in 2004-05. The results then showed a small decline in the outpatient survey (76.9 in 2002-03 to 76.7 in 2004-05). Results from the emergency care survey could not be compared with earlier results due to changes to survey questions.

In addition to these overall results, latest published figures also include scores for 'involvement in decisions about healthcare' as well as a baseline score for 'choice of provider'. The latter represents the position in the final year before the 'choice of four providers' policy was introduced. Results in these tables represent a baseline against which future progress can be measured.

Full details of progress against the improving patient experience PSA target is available on the Department website at: [www.dh.gov.uk](http://www.dh.gov.uk)

### 2006-07 and future surveys

In 2006-07, the Healthcare Commission conducted:

- An Adult In-patient Survey (results published in May 2007) and a Community Mental Health Services Survey (published in September 2007). The results for each NHS organisation participating in these surveys – and nationally aggregated data – are available on the Healthcare Commission website.
- A new trust-based survey among women who had recently used maternity services. Local and national results were published by the Healthcare Commission in November 2007.

Results from each of these 2006-07 surveys and confirmation of the 2007-08 survey programme are available at: [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

### Data quality

Amber (disclosure).

### Target 8

**A.** Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by increasing the proportion of older people being supported to live in their own home by 1 per cent annually in 2007 and 2008.

### Measure

Those being helped to live at home are those who receive community-based services but are not in residential or nursing care. Only those who are care managed by social services, i.e. are assessed by social services and have a care plan, will be included in the target.

### Progress

**Older people supported to live at home – slippage.** The number of older people helped to live at home as at 31 March per 1,000 people has decreased from 81 in 2005-06 to 80 in 2006-07. This represents a decrease of 1.3 per cent (calculated from unrounded figures), reflecting the trend towards providing more intensive services to a smaller number of households and clients.

### Data quality

Amber (systems).

**B.** Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by increasing by 2008 the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care.

## Measure

Those people receiving more than 10 contact hours of home care and 6 or more visits per week divided by the population of people supported by councils in residential care and nursing homes.

## Progress

**Older people supported intensively to live at home – met. This is final reporting for this target.** In England, the number of older people supported intensively to live at home in 2006-07 continues its strong upward trend, increasing to 35.1 per cent of the total supported by councils in residential care and in their own homes, 1.1 percentage points above the target of 34 per cent by March 2008.

The continual rise in the PSA value is due in part to the increasing number of households receiving intensive home care (ie the target has not been met simply by reducing numbers of care home residents). In September 2007, 103,100 households received intensive home care, a 2 per cent increase from the 2006 figure of 100,700 households and a rise of 18 per cent since 2003.

See *Community Care Statistics 2007. Home Care Services for Adults, England* (The Information Centre, March 2008).

## Data quality

Green (disclosure).

## Departmental PSA targets (SR 2002) analysis

Targets 2, 3, 4 and part of 7 have been adopted into the SR 2004 standards. Targets 5, 6, 8, 9, 10 and parts of 7 and 11 have been subsumed into SR 2004 targets. Final reporting on target 12 took place in the 2007 *Autumn Performance Report*. Information on the remaining targets 1 and part of 11 is provided below.

## Objective I: Improve service standards

### Target 1

Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for in-patient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum in-patient and day case waiting time to 3 months by 2008.

## Measure

Number of patients waiting.

## Progress

**Outpatient waiting times – met. This is final reporting for this target.**

Number waiting more than 3 months (13 weeks) – quarterly figures:

- December 2002 – 223,575
- December 2003 – 121,908
- December 2004 – 62,752
- February 2005 – 56,202
- December 2005 – 198
- February 2006 – 198
- February 2007 – 159<sup>(1)</sup>
- February 2008 – 113<sup>(2)</sup>

**In-patient waiting times – met. This is final reporting for this target.**

Number waiting more than 6 months – monthly figures:

- February 2001 – 251,474
- February 2002 – 242,900
- February 2003 – 207,271
- February 2004 – 113,485
- February 2005 – 60,493
- February 2006 – 165

- February 2007 – 429<sup>(3)</sup>
- February 2008 – 74<sup>(4)</sup>

(1) Figures revised since publication of the Departmental report 2007.  
 (2) Of the 113, forty-six were English residents waiting in Welsh hospitals.  
 (3) Figures revised since publication of the Departmental report 2007.  
 (4) Of the 74, four were English residents waiting in Welsh hospitals.

The extension of the in-patient stage of treatment target to a maximum of three months has been overtaken and rendered irrelevant by the referral-to-treatment target of 18 weeks.

## Objective II: Improve health and social care outcomes for everyone

### Target 11

By 2010, reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

#### Measure

Mortality in infancy by social class – the gap in infant mortality between ‘routine and manual’ groups and the population as a whole (see SR 2004 PSA target 2).

Life expectancy by local authority – the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. Baseline year is average of 1997, 1998 and 1999.

#### Progress

**Life expectancy at birth – slippage.** For men, in the period 2004 to 2006 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 1 per cent higher than at the baseline period 1997 to 1999, compared with 1 per cent lower than at the baseline on revised data for the period 2003 to 2005.

For women, in the period 2004 to 2006 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 11 per cent higher than at the baseline period

1997 to 1999, compared with 7 per cent higher on revised data for the period 2003 to 2005.

(Figures for the period 2003 to 2005 were revised to take into account revised population estimates for 2002 to 2005 published by the Office for National Statistics in August 2007.)

In addition, for health inequalities in life expectancy please see progress report under SR 2004 PSA target 2.

## Departmental PSA targets (SR 2000) analysis

The majority of SR 2000 targets were subsumed within the SR 2002 targets and details were given in previous performance reports. For the three targets that were not carried forward, final reporting took place in the *Autumn Performance Report 2003* and *Departmental Report 2007*. Responsibility for target 7 now lies with the Department for Children, Schools and Families.

## Departmental PSA targets (CSR 1998) analysis

Targets 1, 2, 5, 13 and 20 were subsumed into SR 2002 targets. Final reporting took place in the *Autumn Performance Report 2003* and Departmental Reports 2004 and 2007 with regard to the majority of the other targets. Information on those that remain live, targets 3 and 4, is given below.

## Objective I: To reduce the incidence of avoidable illness, disease and injury in the population

### Target 3

Reduction in the death rate from accidents by at least 20 per cent by 2010, from a baseline of 15.8 per 100,000 population for the three years 1995 to 1997.

## Measure

Death rate from accidents.

## Progress

**Death rate from accidents – slippage.** Data for the period 2004 to 2006 shows a rate of 15.9 deaths per 100,000 population – a rise of 1 per cent from the baseline period 1995 to 1997.

## Target 4

Reduction in the rate of hospital admissions for serious accidental injury by at least 10 per cent by 2010, from a baseline estimate of 315.9 admissions per 100,000 population for the financial year 1995-96.

## Measure

Rate of hospital admissions for serious accidental injury requiring a hospital stay of four or more days.

## Progress

**Rate of hospital admissions for serious accidental injury – slippage.** This data is single financial year figures, available annually. Single year data for 2006-07 shows a rate of 325.8 admissions per 100,000 population – 3.1 per cent higher than the 1995-96 baseline estimate.

## Departmental operating standards

### Standard 1

Reduce to 4 hours the maximum wait in A&E from arrival to admission, transfer or discharge.

Note: Following discussions with clinicians' representatives, a 2 per cent tolerance was introduced during 2003 for the minority of patients who clinically require more than four hours in A&E. This meant that providers were performance managed to ensure that 98 per cent of patients were seen, diagnosed and treated within four hours of their arrival at A&E.

## Measure

Total time patients spend in A&E from arrival to admission, transfer or discharge. This includes major A&E departments, walk-in centres and minor injury units.

## Progress

**A&E total time** – since 2005 performance against the operational standard has been maintained – 98.2 per cent of patients were seen, diagnosed and treated within four hours of their arrival at A&E in both 2005-06 and 2006-07. Early published information for the 2007-08 financial year has shown continued commitment by the NHS to delivering the standard – 98 per cent of patients have been seen, diagnosed and treated within four hours of arrival across the first three quarters of the 2007-08 financial year (98.2 per cent in quarter 1 (April – June); 98.3 per cent in quarter 2 (July – September); and 97.3 per cent in quarter 3 (October – December)). NHS organisations will continue to work hard to ensure that they maintain performance.

## Standard 2

Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.

## Measure

The Department's main measure for 48-hour GP access is now the national GP Patient Survey.

PCT performance on both the 24-hour and 48-hour targets continues to be measured through the now quarterly Primary Care Access Survey (PCAS).

## Progress

**Primary care access** – the 2007 GP Patient Survey results indicated that 86 per cent of patients are satisfied with the ability to get an appointment with a GP within the next two days that the surgery is open.

Since December 2004, PCTs have reported through PCAS each month that over 99 per cent of patients could be offered an appointment within two working days to see a GP. Since April 2007, PCAS is now conducted quarterly and quarter 3 of 2007-08 indicates a performance rate of 99.6 per cent.

PCAS remains the only mechanism for reporting the 24-hour target. PCTs report that 99.4 per cent of patients can be offered an appointment with a primary care professional within 24 hours.

### **Standard 3**

Ensure every hospital appointment is booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.

#### **Measure**

The Department of Health monthly central data collection measures the percentage of patients given the opportunity to choose the most convenient date from a range of dates. The booking data collection ceased at the end of March 2007 as the service is moving towards electronic booking through Choose and Book.

#### **Progress**

##### **Booking**

Number of day cases booked – final figure:

- March 2007 – 99.6 per cent

The number of in-patients appointments booked (day cases and ordinary admissions) – final figure:

- March 2007 – 99.6 per cent

Outpatient booking – final figure:

- March 2007 – 98.9 per cent

##### **Electronic booking**

The Choose and Book system was launched in summer 2004, and enables patients to book initial

hospital appointments at a time and place of their choice while in the GP surgery, or later either on the Internet or on the telephone through the Choose and Book Appointments Line.

#### **Choice**

To monitor implementation of choice at referral, the Department is carrying out bi-monthly patient surveys to measure whether patients recall being offered a choice when their GP referred them to see a hospital specialist, and whether they were aware that they were entitled to choose. Latest figures for January 2008 indicate that around 46 per cent of patients who are eligible recall being offered choice. This is a slight decrease on end-of-year figures for March 2007, though the percentage of patients reporting awareness of choice has continued to rise and now stands at 42 per cent for January 2008.

### **Standard 4**

Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and child and adolescent mental health services (CAMHS).

#### **Measure**

Annual mapping of CAMHS to monitor success.

For crisis services there are two main forms of measurement:

- Number of patients who are subject to at least one consultant episode (acute home-based) per annum is measured.
- Number of crisis resolution teams established.

#### **Progress**

**Access to CAMHS.** Progress towards this standard is being measured by the percentage of PCTs that have care pathways to three essential elements of comprehensive CAMHS. In December 2007 all PCTs were compliant with this requirement. The three elements which form this standard are:

- 24-hour emergency assessment;

- CAMHS for children and young people with a learning disability; and
- age-appropriate CAMHS for 16- and 17-year-olds.

**Access to crisis services.** The key enabler for improving access to crisis services is the implementation of sufficient numbers of crisis resolution teams and their achieving the full caseload.

Number of crisis resolution teams in place:

- September 2002 – 62
- March 2003 – 101
- September 2003 – 137
- March 2004 – 179
- September 2004 – 198
- March 2005 – 343
- January 2006 – 343
- March 2007 – 343

Number of people receiving crisis resolution services:

- 2002-03 – 28,500
- 2003-04 – 45,800
- 2004-05 – 68,800
- 2005-06 – 83,800<sup>(1)</sup>
- 2006-07 – 95,400

In 2006-07, 95 per cent of the national target (100,000 home treatment episodes) was achieved.

*(1) In quarter 3 of 2005-06, the guidance was revised to record the number of home treatment episodes. Figures from 2005-06 are not comparable with previous years.*

## C Executive agencies of the Department of Health and other bodies

### **Medicines and Healthcare products Regulatory Agency (MHRA)**

The Medicines and Healthcare products Regulatory Agency (MHRA) helps safeguard public health through the regulation of medicines and medical devices. It does this by ensuring that they meet the standards of safety, quality, performance and effectiveness and are used safely. Its main sources of funding are from fees from the pharmaceutical industry for the licensing of medicines and funding from the Department of Health for the regulation of medical devices.

The main tasks carried out by the MHRA are to assess medicines before they can be used in the UK and to ensure compliance with statutory requirements for the manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices.

The agency also operates systems for recording, monitoring and investigating adverse reports and incidents, and taking enforcement action to safeguard public health. The agency provides advice and support to the Department of Health ministers on policy issues and represents the UK in European and other international areas concerning the regulation of medicines and medical devices.

The MHRA has also recently taken on the authorising and inspecting of blood establishments, monitoring compliance of hospital blood banks and the assessment of serious adverse events and reactions associated with blood and blood components (haemovigilance).

For further information visit the website at: [www.mhra.gov.uk](http://www.mhra.gov.uk)

### **NHS Purchasing and Supply Agency (NHS PASA)**

The NHS Purchasing and Supply Agency (NHS PASA) was established in April 2000. NHS PASA works to ensure that the NHS in England makes the most effective use of its resources by getting the best possible value for money when purchasing goods and services. Its prime target is to release money that could be better spent on patient care by achieving purchasing savings and improving supply performance across the NHS.

For further information visit the website at: [www.pasa.nhs.uk](http://www.pasa.nhs.uk)

## **Other bodies (including executive non-departmental public bodies and special health authorities)**

### **Executive non-departmental public bodies**

Appointments Commission (AC)  
[www.appointments.org.uk](http://www.appointments.org.uk)

Commission for Patient and Public Involvement in Health (CPPIH) (closed on 31 March 2008)

Commission for Social Care Inspection (CSCI)  
[www.csci.org.uk](http://www.csci.org.uk)

Council for Healthcare Regulatory Excellence (CHRE)  
[www.chre.org.uk](http://www.chre.org.uk)

General Social Care Council (GSCC)  
[www.gsc.org.uk](http://www.gsc.org.uk)

Healthcare Commission (HC)  
[www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

Health Protection Agency (HPA)  
[www.hpa.org.uk](http://www.hpa.org.uk)

Human Fertilisation and Embryology Authority (HFEA)  
[www.hfea.gov.uk](http://www.hfea.gov.uk)

Human Tissue Authority (HTA)  
[www.hta.gov.uk](http://www.hta.gov.uk)

Independent Regulator of NHS Foundation Trusts (MONITOR)  
[www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

National Institute for Biological Standards and Control (NIBSC)  
[www.nibsc.ac.uk](http://www.nibsc.ac.uk)

Postgraduate Medical Education and Training Board (PMETB)  
[www.pmetb.org.uk](http://www.pmetb.org.uk)

### **Special health authorities**

Information Centre for Health and Social Care (HSCIC)  
[www.ic.nhs.uk](http://www.ic.nhs.uk)

Mental Health Act Commission (MHAC)  
[www.mhac.org.uk](http://www.mhac.org.uk)

National Institute for Health and Clinical Excellence (NICE)  
[www.nice.org.uk](http://www.nice.org.uk)

National Patient Safety Agency (NPSA)  
[www.npsa.nhs.uk](http://www.npsa.nhs.uk)

National Treatment Agency for Substance Misuse (NTA)  
[www.nta-nhs.org.uk](http://www.nta-nhs.org.uk)

NHS Blood and Transplant (NHS BT)  
[www.nhsbt.nhs.uk](http://www.nhsbt.nhs.uk)

NHS Business Services Authority (NHS BSA)  
[www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk)

NHS Institute for Innovation and Improvement (NHSi)  
[www.institute.nhs.uk](http://www.institute.nhs.uk)

NHS Litigation Authority (NHS LA)  
[www.nhs.com](http://www.nhs.com)

NHS Professionals (NHS P)  
[www.nhsprofessionals.nhs.uk](http://www.nhsprofessionals.nhs.uk)

For a full listing of public bodies that exist to support the Department's business, please go to:  
[www.appointments.org.uk/docs/public\\_bodies\\_2007.pdf](http://www.appointments.org.uk/docs/public_bodies_2007.pdf)

## D Public Accounts Committee: reports published in 2007

Eleven Public Accounts Committee (PAC) reports were published in the calendar year of 2007 and for each an HM Treasury Minute response has been published (an HM Treasury Minute is the Government's formal and considered response to a PAC report).

The list of PAC reports, with date of publication, is as follows:

1. *Tackling Childhood Obesity – First Steps* – **25 January 2007**
2. *The Paddington Health Campus Scheme* – **30 January 2007**
3. *Smarter Food Procurement in the Public Sector* – **6 March 2007**
4. *The Provision of Out-of-Hours Care in England* – **14 March 2007**
5. *Financial Management in the NHS* – **20 March 2007**
6. *The National Programme for IT in the NHS* – **17 April 2007**
7. *Improving the Use of Temporary Nursing Staff in NHS Acute and Foundation Trusts* – **7 June 2007**
8. *Sure Start Children's Centres* – **17 July 2007**
9. *Dr Foster Intelligence: A Joint Venture between The Information Centre and Dr Foster LLP* – **18 July 2007**
10. *Clinical Governance in Primary Care Trusts* – **13 September 2007**
11. *Pay Modernisation: A New Contract for NHS Consultants in England* – **22 November 2007**

### Tackling Childhood Obesity – First Steps

The Committee concluded that obesity is a serious health condition and its rising prevalence added a significant financial burden to the NHS. It noted that the delivery chain to tackle child obesity is complex and that departments (Department of Health, the Department for Children, Schools and Families and the Department for Culture, Media and Sport) have found it difficult to communicate across the network of organisations involved. It recommended that departments needed to improve leadership and galvanise activity; clarify responsibilities and introduce measures to judge performance of the respective parties; inform and engage parents; and influence the food industry to reduce fat and sugar content in foods targeted at children while encouraging a more responsible approach in their marketing.

Action taken on PAC conclusions and recommendations includes:

- to provide leadership across Whitehall the Government has established a new Cabinet Committee on Health and Well-being. Its remit includes tackling obesity and promoting healthy weight, and the membership includes all of the lead departments. The Cabinet Committee on Families, Children and Young People will also monitor progress with respect to child weight problems;

- all parents of children in Reception and Year 6 who take part in the National Child Measurement Programme will routinely receive their child's results, regardless of their weight, from their primary care trust (PCT), unless the parent or the child withdraws from the exercise or the parent requests not to receive the results. Depending on the parliamentary timetable, it is hoped this will be introduced from September 2008; and
- the new cross-government strategy (see below) to promote healthy weight set out plans to work with the food industry to finalise a Healthy Food Code of Good Practice to challenge the industry as a whole to adopt practices to reduce the consumption of saturated fat, sugar and salt among other measures.

More broadly, *Healthy Weight, Healthy Lives: A Cross-government Strategy for England*, published on 23 January 2008, set the first steps in a sustained programme of both prevention and treatment, to help everyone to maintain a healthy weight.

## The Paddington Health Campus Scheme

The Committee concluded that, after five years and £15 million spent trying to develop a robust business case, the scheme simply collapsed. The scheme had been too ambitious and an earlier opportunity to stop it had been missed. It recommended: incomplete or inadequate business cases should not be approved until all material issues have been addressed; capital schemes in the NHS should have a single sponsor; Strategic health authorities (SHAs) should establish clear criteria for monitoring schemes; and the Department should maintain scrutiny of large projects (over £200 million) so that NHS trusts procure assets within shorter timeframes and with improved value for money.

Action taken on PAC conclusions and recommendations includes:

- since Paddington, the procurement process has focused on ensuring that more work is done at the

earlier outline business case (OBC) stage to ensure that any scheme which goes out to tender (private finance initiative or public capital route) has undertaken the appropriate design briefing, design studies and cost planning to establish a robust and affordable preferred option;

- the Gateway Review process introduced into the NHS in 2002 now provides a rigorous and independent assessment of project risks and leadership arrangements, including governance and project management. In NHS project management guidance the 'project sponsor' is the project director, and the Department has always ensured that all schemes which have been or are being jointly procured have a single project director;
- since 2005, the Department's approval of the initial business case stage – strategic outline case – has ceased. Instead, its main approval point has been moved back from full business case to the OBC stage for cases in excess of £75 million, a task previously performed only by the local SHA; and
- OBC approval by the Department now sets firm affordability and value for money parameters that schemes will have to stay within; these also provide clear criteria by which SHAs can monitor them.

## Smarter Food Procurement in the Public Sector

The Committee concluded that there are a range of initiatives to improve standards in public food and catering services (it had focused on schools, hospitals and armed forces bases) but noted that more cooperative procurement of food can achieve greater value for the public sector. It made a number of recommendations that applied to the three major departments considered, including: working in partnership to provide healthier food; benchmarking surveys; encouraging greater use of e-procurement methods; the use of collective purchasing power; greater use of local produce; and sustainable food procurement.

Action taken on PAC conclusions and recommendations includes:

- NHS Supply Chain operates and maintains the NHS Nutritional Database on behalf of the NHS. This database provides NHS staff with information on all products supplied through NHS Supply Chain and uses a traffic light system to identify the nutritional information;
- use of e-tendering is fully embedded within national NHS procurement and use of e-auctions is considered for all procurements but only employed when an e-auction is likely to deliver additional savings;
- the Food Procurement Group was set up with representation from schools, health, prisons, the Ministry of Defence and the Department for Environment, Food and Rural Affairs, ultimately meaning that all the main stakeholders in food procurement in the public sector have input into the group to lead work on a range of strategic food procurement issues; and
- NHS procurement policy recognises that aggregating demand can provide better pricing and reducing costs through fewer deliveries. NHS trusts are encouraged to utilise the benefits and economies of scale provided by NHS Supply Chain contracts. Work is continuing to extend this and allow other public sector bodies to participate.

## The Provision of Out-of-Hours Care in England

The Committee was very critical of preparations for the new service both at national and local level. It recommended that the Department needed to: decide what kind of service it wanted PCTs to plan for; be a principal in future contract negotiations, not an observer, rigorously evaluating the financial impacts of proposed initiatives in advance; make clear to PCTs whether 95 per cent or 100 per cent compliance with quality requirements is necessary; and set a timetable for PCTs to benchmark their services against their peers.

Action taken on PAC conclusions and recommendations includes:

- the Department commissioned the Royal College of General Practitioners to develop a Clinical Audit Toolkit, which will help PCTs, and providers to monitor their performance against the out-of-hours quality requirements. The toolkit was published on 14 March 2007;
- the Department worked with the Audit Commission to develop the benchmarking tool, used for the original National Audit Office report, into an effective interactive tool which commissioners and providers will be able to use regularly to benchmark their services, and has let a contract to promote and embed the use of this tool in the NHS; and
- the Department published an *Urgent Care Update* paper on 15 November 2007. It provides a summary of the findings of the *Direction of Travel for Urgent Care* consultation, a short review of the evidence base that has been built up, and plans for further work to support good practice along with the outcome of the workshops, in-depth work and research evidence. In light of the announcement of the NHS Next Stage Review by Lord Darzi, it was decided that the wider issues raised by that consultation should be taken forward as part of this review.

## Financial Management in the NHS

The Committee concluded that, although the standard of financial management varied across the NHS, there was no single reason why NHS bodies were in deficit. It noted that the NHS was aiming to return to financial balance in 2006-07 and to produce a £250 million surplus in 2007-08. It recommended that the Department should: require NHS bodies to produce and interpret balance sheet information regularly in-year; identify models of successful joint working between financial and clinical management; set up a formal process for sharing turnaround reports; and maintain an overall

picture of the impact of deficits on the NHS's capacity to deliver services.

Action taken on PAC conclusions and recommendations includes:

- throughout 2007-08, the Department has been working with the NHS to bring together in-year monitoring and accounting information into its data collection. This collection is entirely consistent with standard accounting rules as contained within UK GAAP and there is a clear emphasis on year-to-date performance. The Department has significantly reduced the in-year reporting burden on the NHS, with the aim of achieving a more efficient system that supports improved data quality and more accurate accounts;
- the Department is ensuring that issues, strategies, learning points and knowledge are shared across the turnaround organisations and, additionally, the whole of the NHS;
- the NHS ended 2005-06 with a £547 million deficit, so ministers made financial recovery throughout the NHS a key priority for 2006-07. Audited results for 2006-07 show that the NHS as a whole reported a net surplus of £515 million. At the end of the third quarter of 2007-08, the level of surplus has risen to £1,789 million. In achieving this significant improvement, the NHS did not expect any one sector to contribute more in financial savings than any other part of the health system; and
- the number of NHS organisations in deficit has fallen from 33 per cent at the end of 2005-06, to 22 per cent at the end of 2006-07 and just 5 per cent at quarter 3 of 2007-08.

## The National Programme for IT in the NHS

The Committee concluded that the Department has much to do to win the hearts and minds of the NHS, that there was uncertainty about costs for the local NHS with suppliers struggling to deliver

and that the shared electronic patient clinical record is running two years behind schedule. It recommended that the Department should: develop a robust timetable with suppliers; provide an annual statement of total costs and benefits; review the extent of clinical involvement in the specification; and clarify responsibilities and accountabilities for the local implementation of the programme.

Action taken on PAC conclusions and recommendations includes:

- SHA chief executives have been appointed senior responsible owners for both implementation of the programme and the realisation of benefits for their part of the NHS;
- through SHAs, responsibility for the development and execution of implementation plans has transferred to local NHS organisations working directly with suppliers. This transfer of responsibility, with associated resources, provides the means for greater accountability, control and engagement of clinical staff at a local level;
- the NHS Summary Care Record (the shared electronic patient clinical record) is now live in the first early-adopter sites. The early-adopter phase will provide evidence and experience to inform the future implementation of the Summary Care Record;
- the costs of the programme remain under firm control. Local NHS organisations are benefiting from the many systems that have now been deployed and steps are in hand to report the benefits systematically as implementations increase; and
- following the appointment of the programme's chief clinical officer, clinical involvement and leadership has been strengthened through the appointment of both clinical directors and further national clinical leads.

## Improving the Use of Temporary Nursing Staff in NHS Acute and Foundation Trusts

The Committee concluded that, despite a significant increase in the number of nurses in the NHS, the amount spent on temporary nurses as a proportion of total expenditure on nursing has stayed around the same level and that there is poor information on the drivers of demand for or use of temporary nurses across the NHS. It recommended that the Department outline its strategy for the use of temporary nursing staff as part of wider workforce planning and expedite implementation of the electronic staff record so it can monitor the hours worked by temporary staff. Trusts need arrangements in place to obtain temporary staff at best value.

Action taken on PAC conclusions and recommendations includes:

- progress in reducing the unit cost of employing temporary nursing staff continues;
- the NHS is spending less on agency workers year-on-year and will continue to do so. Reducing agency spend is part of the Department's contribution to the £6.5 billion Gershon efficiency target and the 10 HR High Impact Changes as highlighted in *A Workforce Response to Local Delivery Plans: A Challenge for NHS Boards*;
- the Department supports and works with a number of initiatives to help trusts reduce spending on temporary staffing. These include the National Agency Staffing Project and NHS Employers' Making Effective Use of Temporary Staff Programme; and
- NHS Purchasing and Supply Agency (PASA) plays an active role in driving costs down and quality upwards through development of Agency Framework Agreements and regular audits. PASA uses the NHS's buying power to negotiate lower pay rates with agencies.

## Sure Start Children's Centres

The Committee concluded that the Sure Start children's centres (led by the Department for Children, Schools and Families (DCSF)) brings together early education, childcare health and family support services in a way that has not been done before. It recommended action on three fronts: a commitment from all partners to play their part; effective management to build sustainable services that families want to use; and a focus so that the services really do reach the most disadvantaged families.

Action taken on PAC conclusions and recommendations includes:

- improving access and connecting families with the services of the Sure Start children's centres;
- delivering the Child Health Promotion Programme, which is a schedule of screening and surveillance, immunisations, health reviews, health promotion and parenting support, led by the health visitor. It begins antenatally and includes progressive services, ie more intensive and tailored support for families according to level of risks and protective factors to reduce inequalities in outcomes;
- increasing the number of PCT and local authority sites and families offered the Family Nurse Partnership (FNP) Programme. The FNP Programme provides a preventive intervention for first-time parents whose children are at greatest risk. It is a licensed model providing an intensive, nurse-led home visiting programme; and
- establishing the new Child Health Promotion and First Years of Life Board. This is one of the joint DH and DCSF boards which has been established as part of the new DH/DCSF governance arrangements. The board will oversee the joint DH/DCSF work programme for the promotion of child health and well-being in pregnancy and the first years of life to support the new Public Service Agreement 12 and will, in turn, report to the Child Health and Well-being Board.

## Dr Foster Intelligence: A Joint Venture between The Information Centre and Dr Foster LLP

The Committee concluded that the Department and Information Centre (IC) failed to advertise the deal or hold a competition and let it appear that they offered an advantage to one company. Also, without an open competition the Department could not demonstrate that it had paid best price for its 50 per cent share. It recommended that an independent valuation be obtained and the Department follow HM Treasury and public sector guidelines on procurement and joint ventures. The IC needed to clarify the benefits it expected from the joint venture. The Department did not accept several of the Committee's conclusions, responding that:

- the Department and the IC followed the advice of their commercial, legal and professional advisers throughout the deal;
- an independent report by PricewaterhouseCoopers suggests that the price negotiated to establish Dr Foster Intelligence was a reasonable one; and
- Dr Foster Intelligence has no preferential relationship with the IC. There is equal and fair access to data for all and the procurement of services is subject to competition.

Action taken on PAC conclusions and recommendations includes:

- continued improvement of measurement of operational and internal performance information on the joint venture through the development of future business plans; and
- on-going IC participation in discussion of financial performance, through its representatives on the board of Dr Foster Intelligence, to ensure a full return on the Department's investment.

## Clinical Governance in Primary Care Trusts

The Committee concluded that clinical governance is not as well established in primary care as in secondary care, largely because of the complexity of PCTs' roles in both commissioning and providing care. It recommended that: the Department in developing its guidance for PCT commissioning should include clear outcome measures on quality and safety in their contracts so that performance of healthcare providers can be monitored and evaluated; PCTs engage more effectively with their client groups; and PCTs include in their contracts a requirement that all providers have an active incident reporting system that links to the national reporting system.

Action taken on PAC conclusions and recommendations includes:

- publication of a new NHS and social care commissioning framework for 2008-09, *Commissioning for Health and Well-being*, which focuses on outcomes tailored to the needs of individuals;
- publication of *Fit for the Future*, guidance to PCTs on establishing new professional executive committees (PECs), which emphasises the importance of identifying clinical professionals with leadership potential and providing support for their development;
- consultation on *Making Experiences Count* (DH, June 2007), an integrated health and social care complaints system that aims to make the experience of making a complaint easier, more user-friendly, cooperative and responsive to people's needs. New approaches will be implemented by early-adopter sites in 2008; and
- working with the National Patient Safety Agency (NPSA) on projects to improve reporting and learning from patient safety incidents in general practice and any other primary care settings.

## Pay Modernisation: A New Contract for NHS Consultants in England

The Committee concluded that, although a new contract was needed, the implementation was rushed, the cost underestimated by around £150 million and some intended benefits have not been realised. It recommended that the Department should: use sufficient, relevant and reliable data to cost new policies; pilot major human resource policies before implementation; and, in conjunction with NHS Employers, develop training aids and tools to help managers improve their capability and capacity to carry out effective job planning with an understanding of what work the trust needs doing and what it can afford.

Action taken on PAC conclusions and recommendations includes:

- establishing a Revenue and Investment Branch within the Department to improve the quality of forecasting of the financial impact of policies;
- introducing the Electronic Staff Record system which will provide much more extensive data to inform the modelling and costing of new workforce policies;
- undertaking thorough cost modelling and piloting for reforms to non-medical pay;
- introducing tools to allow trusts to benchmark the clinical activity of consultants and to identify the areas that provide the greatest opportunity for delivering efficiency and productivity gains through service improvements; and
- commissioning a Large Scale Workforce Change Programme focused on sharing good practice in implementation of the consultant contract to deliver benefits to patients, staff and employers; and considering how the NHS is using IT applications to manage and update consultant job plans, building on the *Job Planning Toolkit* published in 2005.

# E Spending on publicity and advertising and income from sponsorship 2007-08

## Sponsorship guidelines

Under guidelines published by the Cabinet Office in July 2000, government departments are required to disclose sponsorship amounts of more than £5,000 in their departmental annual reports. For these purposes, 'sponsorship' is defined as:

- the payment of a fee or payment in kind by a company in return for the rights to a public association with an activity, item, person or property for mutual commercial benefit.

**Figure E.1: Departmental spending on publicity and advertising and sponsorship, 2007-08**

Campaigns run by the Department	£ million Amount
Tobacco control	19.0
Tobacco legislation	8.7
Sexual health (including DH's contribution to joint campaign with Department for Children, Schools & Families)	6.9
Drugs prevention (DH's contribution to joint campaign with Home Office and Department for Children, Schools & Families)	2.0
Alcohol (DH's contribution to joint campaign with Home Office)	1.3
Hepatitis C	2.1
Flu immunisation	1.4
Social work/care	3.1
Keep warm, keep well (DH's contribution to cross-government campaign)	0.5
Maternal and infant nutrition	1.2
Respiratory and hand hygiene	0.8
NHS Direct	1.0
Antibiotics	0.6
5 A Day	1.3
NHS Injury Benefits Scheme	0.4
<b>Total</b>	<b>50.3</b>

Source: Communications Directorate, DH

**Figure E.2: Sponsorship received by the Department of Health from other organisations, 2007-08**

Sponsor/Partner	£s	
	Amount received	Support received
ASDA FM	5,868	Stop smoking messaging in 315 stores broadcast by ASDA's instore radio ASDA FM
ASDA	273,881	Print and exposure within stores for stop smoking campaign
NicAid (Tesco NRT)	38,500	In pack stop smoking messaging
Football clubs – Tottenham Hotspur, Chelsea, Watford, Norwich City, Wolverhampton Wanderers, Manchester City	16,200	Media space around stadiums for stop smoking campaign
Alliance	551,000	Print and exposure within stores for stop smoking marketing
Chupa Chups	8,000	On pack exposure of NHS Smoking Helpline for stop smoking campaign
Greene King	230,064	Stop smoking messaging to staff and customers throughout their pub estate
Grosvenor Casinos	9,250	Stop smoking messaging to staff and customers throughout their casino estate
Mecca Bingo	31,945	Stop smoking messaging to staff and customers throughout their bingo club estate
Regent Inns	15,000	Stop smoking messaging to staff and customers throughout their pub estate
Shepherd Neame	20,000	Stop smoking messaging to staff and customers throughout their pub estate
Tesco	570,000	Print and exposure within stores for stop smoking campaign
Virgin Trains	6,000	Stop smoking messaging to drivers in staff areas
Clubs for Young People	480,630	Poster space, e-zine feature and online presence to support drugs initiative
Club 18-30	13,252	Resort support, Summer 07 brochure advertisement, e-flyers
Habbo Hotel	35,325	Home page, dedicated FRANK page messaging, weekly online advice and Habbo credits
Live Nation	30,600	FRANK adverts screened during 'down time' between bands at the Download Festival
Addictive Interactive	5,166	Supporting FRANK via 21 clubbing/music websites
Kleenex	9,800	Supply of 20,000 branded packets of tissues for Respiratory & Hand Hygiene Campaign
Alliance Pharmacy	623,000	Print and exposure within 964 Alliance Pharmacies for sexual health
Club 18-30	477,833	Advertising on ticketbook, brochure advertisement, collateral distribution, posters in-resort and free condoms, web promotion for sexual health
2wentys	438,333	Brochure advertisement, collateral distribution, posters in-resort and free condoms, web promotion for sexual health
Radio 1	1,608,922	Themed radio shows, DJ features, hourly mentions, online exposure and giveaways for sexual health
MTV	548,544	News broadcasts on daytime shows, across MTV networks for sexual health
Addictive Interactive	25,574	Profile and free survey for sexual health
Co-Op	127,606	Print and exposure within Co-Op stores around Valentines Day for sexual health
Kangol	107,248	Print and exposure within 82 stores around Christmas and January for sexual health
Lloyds	194,642	100,000 leaflets distributed in-store. University sampling for sexual health
National Union of Students	112,500	Display of posters in universities, and free media space for sexual health
Luminar Leisure	46,900	E-newsletter, plasma screen messaging and poster display for sexual health

Source: Communications Directorate, DH

**Figure E.3: Sponsorship paid by the Department of Health to other organisations, 2007-08**

Recipient	£	
	Amount sponsored	Support donated
Fresh 40 Chart Show	329,000 <sup>(1)</sup>	Sponsorship of Fresh 40 radio chart show by FRANK. Additional media value of FRANK messaging generated independently audited at £687,610.

Source: Communications Directorate, DH

Notes:

(1) This represents the rights fee only for the period July 2007 to March 2008 (nine month extension).

## F Glossary

### **A&E (Accident & Emergency)**

The emergency departments of hospitals that deal with people who need emergency treatment because of sudden illness or injury. Sometimes called casualty departments.

### **Accruals accounting**

Accruals accounting recognises assets or liabilities when goods or services are provided or received – whether or not cash changes hands at the same time. Also known as the ‘matching concept’, this form of accounting ensures that income and expenditure are scored in the accounting period when the ‘benefit’ derived from services is received or when supplied goods are ‘consumed’, rather than when payment is made.

### **Acute services**

Medical and surgical interventions usually provided in hospital. Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

### **Alternative Provider of Medical Services (APMS)**

Under the new general medical services (GMS) contract arrangements, APMS is intended to cover all primary care medical services commissioned from non-GMS and non-PMS providers, e.g. from the voluntary sector, commercial sector, other NHS trusts or PCTs.

### **Annually Managed Expenditure (AME)**

Totally Managed Expenditure (TME) is divided into Annually Managed Expenditure (AME) and Departmental Expenditure Limits (DEL). AME is public expenditure for which multi-year spending limits are not seen as appropriate, and which is instead subject to annual review.

### **Arm’s length bodies (ALBs)**

Government funded organisations which work closely with local services, and other ALBs. In the Department of Health they regulate the system, improve standards, protect public

welfare, and support local services. The Department has three main types of ALB: executive agencies, executive non-departmental public bodies; and special health authorities.

### **Atkinson Review**

Review of the measurement of government output and productivity.

### **Capital**

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if it is in excess of £5,000.

### **Capital charges**

Capital charges are a way of recognising the costs of ownership and use of capital assets and comprise depreciation and interest/target return on capital. Capital charges are funded through a circular flow of money between HM Treasury, the Department of Health, primary care trusts and NHS trusts.

### **Central health and miscellaneous services**

These are a wide range of activities funded from the Department of Health’s spending programmes whose only common feature is that they receive funding direct from the Department, and not via primary care trusts. Some of these services are managed directly by departmental staff, others are run by non-departmental public bodies, or other separate executive organisations.

### **Community care**

Care, particularly for elderly people or people with learning or physical disabilities or a mental illness, which is provided outside a hospital setting, ie in the community.

## **Consolidated Fund**

The Government's general account at the Bank of England. Tax revenues and other current receipts are paid into this fund. Parliament gives statutory authority for funds to be drawn from the Consolidated Fund to meet most expenditure by the Government.

## **Corporate governance**

System by which organisations are directed and controlled.

## **Cost of capital**

A charge on the value of assets tied up in an organisation, as a measure of the cost to the economy.

## **Credit approvals**

Central government permission for individual local authorities to borrow or raise other forms of credit for capital purposes.

## **Departmental Expenditure Limit (DEL)**

Totally Managed Expenditure (TME) is divided into Annually Managed Expenditure (AME) and Departmental Expenditure Limits. The Departmental Expenditure Limit (DEL) is made up of departmental budgets for which there are multi-year spending limits. Almost all the Department of Health's budget, including allocations to the NHS, is within the DEL.

## **Departmental Strategic Objectives (DSOs)**

The core purpose of the Department of Health – what it is here for – is enshrined in the Department's Strategic Objectives so that its individual and team objectives and its departmental targets can all connect directly to them.

## **Depreciation**

The measure of the wearing out, consumption or other loss of value of a fixed asset whether arising from use, passage of time or obsolescence through technology and market changes.

## **Distance from target**

The difference between a primary care trust's allocation and its target fair share of resources informed by the weighted capitation formula.

## **Drugs bill**

Drugs bill gross expenditure is the amount paid to contractors (ie pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs medicines and certain listed appliances which have been prescribed by NHS practitioners. Net drugs bill expenditure is less Pharmaceutical Price

Regulation Scheme (PPRS) receipts. Funding is subject to local resource limits and forms part of primary care trusts' discretionary allocations.

## **e-GIF**

The e-GIF defines the technical policies and specifications governing information flows across government and the public sector. They cover interconnectivity, data integration, e-services access and content management.

## **Estimated outturn**

The expected level of spending or income for a budget, which will be recorded in the Department's accounts.

## **Estimates**

See 'Supply Estimate'.

## **European Economic Area (EEA)**

The European Community countries plus Norway, Iceland and Liechtenstein.

## **Executive agencies**

A discrete unit set up to undertake an executive function of government. The Department of Health has two executive agencies; the Medicines and Healthcare products Regulatory Agency and the NHS Purchasing and Supply Agency.

## **Family Health Services (FHS)**

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, most of whom are independent contractors.

## **General Dental Services (GDS)**

The GDS offers patients personal dental care via general dental practitioners (GDPs), most of whom work as independent contractors from high street and local surgeries. Since April 2006, PCTs have been responsible for the local commissioning of general dental and other primary dental care services. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

## **General medical services (GMS)**

These are services covered by contract arrangements agreed at national level by GPs to provide one-to-one medical services, for example: giving appropriate health promotion advice, offering consultations and physical examinations, offering appropriate examinations and immunisations.

The introduction of the new General Medical Services (nGMS) contract represents a fundamental change in the way in which practices are incentivised to deliver patient care. While it retains the independent contractor status for GPs, it moves away from remunerating individual doctors to a practice-based contract funded within primary care trusts' discretionary allocations.

The new contract provides a range of new mechanisms allowing practices greater flexibility in determining the range of services they wish to provide, including rewards for delivering clinical and organisational quality, modernisation of GP infrastructure including premises and IT, and unprecedented levels of investment through the Gross Investment Guarantee. All these mechanisms are designed to deliver a wider range of quality services for patients and to empower patients to make best use of primary care services.

See also 'Alternative provider of medical services (APMS)' and 'Personal Medical Services (PMS)'.

### **General Ophthalmic Services (GOS)**

The GOS offers priority groups of patients free NHS sight tests or vouchers to help with the purchase of glasses. NHS sight tests are mainly available to children, people aged 60 or over, adults on low income, or people suffering from or predisposed to eye disease. NHS optical vouchers are mainly available for children, adults on low incomes and those who need certain complex lenses. Services are provided by optometrists and ophthalmic medical practitioners who work as independent contractors from high street opticians. Although the GOS is administered by primary care trusts (PCTs) as part of the family health services, optical contractors are engaged under a uniform national contract. Funding is provided from the national demand-led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's discretionary allocation.

### **Gershon Review**

Efficiency review of Whitehall departments looking at common core functions.

### **Green Paper**

Green Papers are consultation documents produced by the Government. Often when a government department is considering introducing a new law or other major policy change, it will put together a discussion document called a Green Paper. The aim of this document is to allow people both inside and outside Parliament to debate the subject and give feedback on the proposals.

### **Gross Domestic Product (GDP) deflator**

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms. The series is produced by HM Treasury.

### **Gross/net**

Gross expenditure is the total expenditure on health services, part of which is funded from other income sources, such as charges for services, receipts from land sales and income generation schemes. Net expenditure (gross minus income) is the definition of 'public expenditure' most commonly used in this report, since it is the part of the total expenditure funded by the Exchequer.

### **H5N1**

Commonly known as 'avian influenza' or 'bird flu'.

### **Health Improvement Programmes**

An action programme to improve health and healthcare locally and led by the primary care trust. It will involve NHS trusts and other primary care professionals, working in partnership with the local authority and engaging other local interests.

### **Healthcare Resource Groups (HRGs)**

Groupings of similar clinical procedures that require approximately similar levels of resource input. They provide a way of categorising the treatment of patients in order to monitor and evaluate the use of resources.

### **Hospital and community health services (HCHS)**

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by primary care trusts and provided by NHS trusts or NHS foundation trusts. HCHS provision is discretionary and also includes funding for those elements of family health services spending that are discretionary (GMS discretionary expenditure). It also covers related activities such as research and development and education and training purchased centrally from central budgets.

### **Independent sector treatment centre (ISTC)**

Private sector treatment centres that offer pre-booked day and short stay surgery, and diagnostic procedures.

### **In-patient**

A person admitted on to a hospital ward for treatment.

## Lean

A system to improve productivity and reduce costs, and to shorten the time to deliver a product or service.

## Local Exercise Action Pilots (LEAPs)

Local Exercise Action Pilots (LEAPs) are locally run pilot programmes to test and evaluate new ways of encouraging people to take up more physical activity.

## MRSA

MRSA (sometimes referred to as the superbug) stands for methicillin-resistant *Staphylococcus aureus*. It is a bacterium from the *S. aureus* family.

## Near cash

Transactions that have an impact on cash flow in the short term e.g. pay and pension costs, revenue expenditure on goods and services, or cash payments for the release of provisions.

## NHS Bundle

The NHS Bundle is a collection of former DH Central Programme budgets where expenditure will be incurred by the NHS. It is intended to give early notification of funding for those activities that the Department needs the NHS to carry out on its behalf. Bundle allocations are made to each of the ten strategic health authorities (SHAs). The SHAs are then able to develop comprehensive business and financial plans, and have flexibility to allocate resources as they see fit in the light of local priorities.

## NHS foundation trusts

NHS hospitals that are run as independent, public benefit corporations, which are both controlled and run locally.

## NHS LIFT

NHS LIFT stands for NHS Local Improvement Finance Trust. A local LIFT will build and refurbish primary care premises which it will own. It will rent accommodation to GPs on a lease basis (as well as other parties such as chemists, opticians, dentists etc).

## NHS trusts

NHS trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as represented by primary care trusts and GPs.

## National Insurance Fund

The statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid, and from which expenditure on most contributory social security benefits is met. The NHS also receives an element of funding from this.

## National Service Framework (NSFs)

NSFs are long-term strategies for improving specific areas of care. They set measurable goals within set timeframes. Each NSF is developed with the assistance of external stakeholders in groups that usually contain health professionals, service users and carers, health service managers, partner agencies and other advocates, adopting an inclusive process to engage the full range of views.

## Non-cash

Items that will either never require a cash payment (e.g. the cost of using capital assets, depreciation, bad debts) or other items classified as non-cash that may require cash payments but in the longer term (e.g. provisions).

## Non-discretionary

Expenditure that is not subject to a cash limit, mainly applying to certain 'demand-led' family health services, such as the general ophthalmic services, dispensing remuneration for pharmacists and income from prescription charges.

## Operational capital

Operational capital (previously known as 'block capital') is used to maintain NHS organisations' capital stock to a minimum standard, as well as for minor developments and equipment replacement. The allocation uses a formula that is depreciation based and takes into account the levels of building and equipment stock.

## Outpatient

A person treated in a hospital but not admitted on to a ward.

## Outturn

The actual year end position in cash terms.

## Overage

Overage (also called 'claw back') is a term to describe a sum of money in addition to the original sale price which a seller of land may be entitled to receive following completion if and when the buyer complies with agreed conditions.

## **Payment by Results (PbR)**

Transparent rules based system that sets fixed prices (a tariff) for clinical procedures and activity in the NHS, enabling all trusts to be paid the same for equivalent work.

## **Performance indicator**

Measures of achievement in particular areas used to assess the performance of an organisation.

## **Personal dental services (PDS)**

PDS schemes initially started as pilots where dentists offered patients personal dental care equivalent to that provided within the general dental services (GDS), but within a more flexible framework of local commissioning arrangements and alternative payment systems to item of service fees. From April 2006 most former PDS pilots switched to the new GDS contract terms. PDS agreements are now generally reserved for the commissioning of specialist care within the community, for example from practices offering orthodontic services only. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

## **Personal medical services (PMS)**

A PMS contract is agreed locally between the commissioner and the provider. This means that primary care service provision is responsive to the local needs of the population. As a result, PMS has been successful in reaching deprived and under-doctored areas. Many PMS pilots focus on the care of vulnerable groups, including the homeless, ethnic minorities and mentally ill patients. Funding for PMS contracts is within primary care trusts' discretionary allocations.

## **Personal Social Services (PSS)**

These are care and support services for people, who may require them as a result of old age, mental or other ill health, substance misuse, physical or learning disability and children in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and social workers who provide help and support for a wide range of people.

## **Pharmaceutical Services (PhS)**

NHS pharmaceutical services cover the supply of drugs, medicines and appliances prescribed by NHS practitioners. Gross PhS expenditure includes total drugs bill costs (see 'Drugs bill') and dispensing costs which are the remuneration paid to contractors (community pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in

respect of personally administered items) for dispensing NHS prescriptions. Net PhS expenditure is the gross expenditure less income from prescription charges.

Funding for the total drugs bill is subject to local resource limits and forms part of primary care trusts' (PCTs') hospital and community health services discretionary allocations. However, funding for dispensing costs is currently provided from the national demand-led or non-discretionary budget, and is not subject to local resource limits and is not included in a PCT's discretionary allocation.

## **Primary care**

The initial contact for many people when they develop a health problem is a member of the primary care team. The term primary care covers family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners. NHS Direct and NHS walk-in centres are also primary care services.

## **Primary care trust (PCT)**

Primary care trusts are responsible for identifying from within their available resources the healthcare needs of their relevant population, and for securing through their contracts with providers a package of hospital and community health services to reflect those needs. PCTs have a responsibility to ensure satisfactory collaboration and joint planning with local authorities and other agencies.

## **Primary care trust medical services (PCTMS)**

Primary medical services provided directly by the PCT e.g. through directly employing a GP.

## **Private finance initiative (PFI)**

An initiative aimed at securing private sector money and management expertise for the provision of services which have traditionally been undertaken by the public sector. It was introduced as a means by which private funds can be used to supplement public investment in capital projects such as hospitals. The aim is to transfer risks of cost overruns, design faults, servicing and maintaining over lifetime of the contract onto private sector.

## **Provisions**

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, e.g. estimates for clinical negligence liabilities. Provisions are included in the accounts to comply with the accounting principle of prudence. An estimate of the likely expense is charged to the income and expenditure account

(for the Department, to the Operating Cost Statement) as soon as the issue comes to light, although actual cash payment may not be made for many years, or in some cases never. The expense is matched by a balance sheet provision entry showing the potential liability of the organisation.

### **Public Accounts Committee (PAC)**

The PAC is a Committee of the House of Commons that examines the regularity and propriety of government expenditure and how it is accounted for. It also examines the economy, efficiency and effectiveness of public expenditure.

### **Public Service Agreement (PSA)**

PSAs accompany the Spending Review and set out output targets agreed with HM Treasury detailing the exact outcomes departments have committed to deliver with the money provided.

### **Real terms**

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

### **Reference costs**

Reference Costs are the average cost to the NHS of providing a defined service in a given financial year. Reference Cost data allows NHS trusts to compare their costs to the NHS average and therefore benchmark their relative efficiency.

### **Regulatory impact assessment**

A regulatory impact assessment (RIA) is a short, structured document which is published with regulatory proposals and new legislation. It briefly describes the issue that has given rise to a need for regulation and compares various possible options for dealing with that issue.

### **Resource accounting and budgeting (RAB)**

Introduced in full on 1 April 2001, RAB is a Whitehall-wide programme to improve the management of resources across Government. The concept deals with the wider issue of the resources available to government departments and includes consideration of all of their assets and liabilities and not just the level of cash financing which was the principal measure used historically.

Resource accounting comprises:

- accruals accounting to report the expenditure, income and assets of a department;
- matching expenditure, income and assets (resource consumption) to the aims and objectives of a department of

the appropriate financial year determined by accruals accounting; and

- reporting on outputs and performance.

Resource budgeting is the extension of resource accounting principles and represents the spending plans of the Department's programmes and operations measured in resource terms (resource consumed in the financial year rather than just cash spent/received) to reflect the full costs of its activities.

### **Revenue**

Revenue is expenditure other than capital, for example, staff salaries and drug budgets. Also known as current expenditure.

### **Secondary care**

Specialised medical services and commonplace hospital care, including outpatient and in-patient services. Access is often via referral from primary care services.

### **SNOMED**

Systematised Nomenclature of Medicine. It is a common computerised language that will be used by all computers in the NHS to facilitate communications between healthcare professionals in clear and unambiguous terms.

### **Social Services**

These are local authority departments that provide direct services in the community to clients.

### **Special health authority**

Independent health authorities that provide a service to the public and/or the NHS. They generally provide a service to the whole population of England and not just to a particular local community. Examples include, NHS Direct and the National Patient Safety Agency.

### **Specific grants**

These are grants (usually for current expenditure) allocated by central government to local authorities for expenditure on specified services, reflecting ministerial priorities.

### **Spending Review**

HM Treasury-led review of public funding across all Government departments, leading to publication of Public Service Agreements and the budgets departments will receive to fulfil those agreements.

## Strategic capital

Strategic capital (previously known as ‘discretionary capital’) is allocated to support larger capital projects that primary care trusts (PCTs) cannot afford to fund from operational capital. The formula is capitation based and, in the main, follows the revenue resource allocation formula.

## Strategic health authority (SHA)

The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans, and that primary care trusts (PCTs) are performing well. There are ten in England, largely coterminous with Government Offices of the Regions.

## Supply Estimate

The term is loosely used for the Main Estimates, a request by the Department of Health to Parliament for funds required in the coming financial year. There are also Supplementary Estimates. Supply Estimates are subdivided into groups (Classes) which contain provision (usually by a single department) covering services of a broadly similar nature. A subdivision of a Class is known as a Vote and covers a narrower range of services. The Department of Health has three Votes which form Class II. Vote 1 covers the Department of Health and contains two requests for resources – the first covering expenditure on the NHS, the second other departmental services and programmes. A Supply Estimate does not of itself authorise expenditure of the sums requested. This comes through an Appropriation Act passed by Parliament.

## Telecare

The use of information and communications technology systems to provide diagnosis, advice, treatment and monitoring to patients remotely. It is being used in both primary and hospital settings.

## Third sector

Non-governmental organisations that are run on a not-for-profit basis and are not part of the public sector. They are motivated primarily by a desire to further social, environmental or cultural objectives rather than to make a profit for its own sake and any surpluses they make are reinvested to further these objectives. This includes the voluntary and community sector as well as co-operatives and social enterprises, trade unions, not-for-profit trade associations etc.

## Trading fund

Trading funds are government departments or accountable units within government departments set up under the Government Trading Funds Act 1973, as amended by the Government Trading Act 1990. The Acts enable the responsible minister to set up as a trading fund a body which is performing a statutory and monopoly service and whose fees are fixed by or under statute. A trading fund provides a financing framework within which outgoings can be met without detailed cash flows passing through vote accounting arrangements.

## Unified allocation

Before April 1999, commissioners received separate revenue funding streams for hospital and community health services, discretionary funding for GP practice staff, premises and computers, and family health services prescribing. The White Paper, *The New NHS: Modern, Dependable* proposed unifying these funding streams. Since April 1999, commissioners have received a single unified allocation.

## Virement

The agreed transfer of money from one budget head – income or expenditure – to another, within a financial year. Virement is a measure of flexibility that allows budget-holding managers to reflect budget variances within a year.

## Voluntary and community sector (VCS)

Groups set up for public or community benefit such as registered charities, and non-charitable non-profit organisations and associations.

## Vote

See ‘Supply estimate’.

## Walk-in centre

Centres staffed by nurses that offer patients fast and convenient access to treatment and information without an appointment.

## Weighted capitation formula

This determines PCTs’ target share of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare need. It is a formula that uses PCT populations, which are then weighted for (i) the cost of care by age group; (ii) for relative need over and above that accounted for by age; and (iii) for unavoidable geographical variations in the cost of providing services (the market forces factor).

## **White Paper**

A document produced by the Government setting out details of future policy on a particular subject. A White Paper will often be the basis for a Bill to be put before Parliament. The White Paper allows the Government an opportunity to gather feedback before it formally presents the policies as a Bill.

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