The National Health Service and Public Health Service in England:

Secretary of State's Annual Report 2011/2012

HM Government

The National Health Service and Public Health Service in England: Secretary of State's Annual Report 2011/2012

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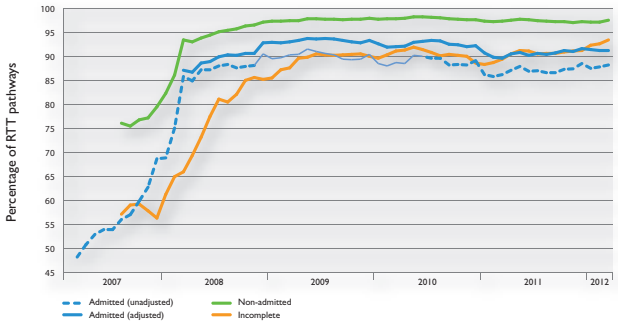
A: Summary – Performance at a Glance

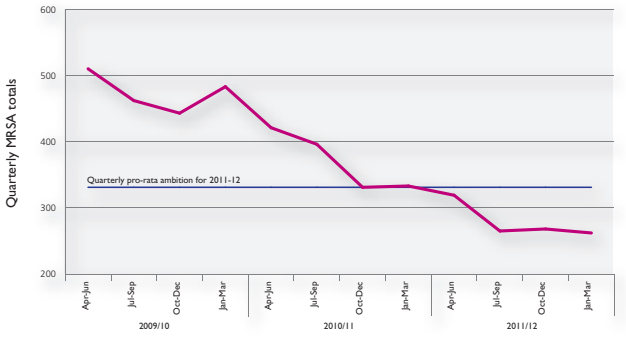
The health service has performed well during 2011/12. It has maintained or improved performance against a range of quality indicators set out in the NHS Operating Framework, while meeting the financial challenge.

Percentage of referral to treatment pathways completed within 18 weeks, England

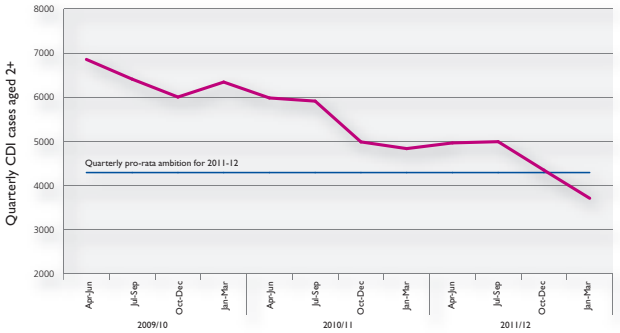


Access to services continues to be maintained, and referral to treatment consultant-led **waiting times remained low and stable in 2011/12**. Over 90% of admitted and 95% of non admitted patients were treated within 18 weeks of referral. **On infection control, the NHS has made significant improvements over the past year**, with MRSA bloodstream infections and *C. difficile* infections at the lowest levels since mandatory surveillance for each was introduced.

MRSA Bacteraemia: quarterly totals between April 2009 and March 2012

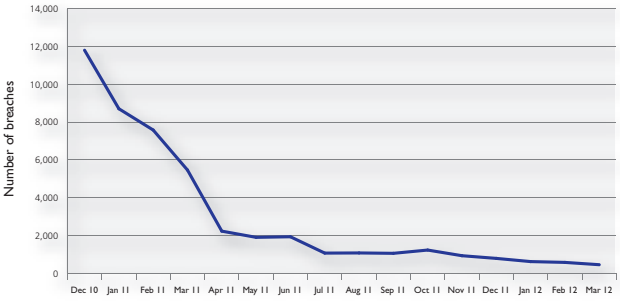


C. difficile cases in patients (aged two or more): quarterly totals between April 2009 and March 2012



The compulsory reporting of breaches of mixed-sex accommodation guidance has resulted in **a fall of over 96% in just 16 months** and single-sex accommodation is now the norm for almost all patients.

Number of breaches of mixed sex accommodation December 2010 – March 2012



We have also had some significant successes with the Responsibility Deal and Change4life in promoting better health. **Change4Life** continues to enjoy very high levels of trust and engagement amongst its target audience – **Awareness is over 85%, and more than 570,000 families have joined the movement.** The momentum of the Responsibility Deal continues to build, with over **390 partners** signed up. Through working in partnership with business, the Department has delivered far more action, more quickly than we could have done through regulation. For example, **over 70% of high street fast food and takeaway chains** by the end of 2012 will have calories on menus.

B: Foreword from the Secretary of State

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1. In the 64 years since the NHS was created, our nation's health and wellbeing has been transformed. In 1948, life expectancy in England was just over 66 for men and 71[1] years for women, and one of every twenty-nine children died before they reached their first birthday. Today that figure is just one of every 235 children,[2] and life expectancy has risen to more than 78 years for men and 82 years for women. The performance of the health service has increased steadily over time, and 2011/12 has been no exception.

2. I would like to thank all of the staff across the health service who have achieved this. I appreciate this has been a challenging year for the NHS but staff have risen admirably to the task. Across the country, they have maintained or improved quality while making significant cost savings and preparing for the transition to the new system. This is a huge testament to their hard work and dedication.

3. I have been responsible for health for over 8 years, in Opposition and now in Government, and have met with countless staff, patients, carers, professional groups and members of the public. It is abundantly clear from these conversations that the health service and those who work in it are held in the highest regard. Its core principle of providing comprehensive healthcare free at the point of use is at the root of this and is as critical now as it was at the conception of the NHS. The reforms set out in the 2012 Health and Social Care Act[3] further embed this principle and give those responsible for patient care the freedom and powers to lead and improve the quality of patient care in a health service that continuously improves.

4. From 1 April 2013, the Secretary of State for Health will have to produce an annual report for Parliament, setting out how the NHS in England has performed that year. This will be the first time that there has been a specific legal requirement for a report of this kind, and it will ensure that the performance of the health service is subject to appropriate Parliamentary scrutiny. The report will cover the health service in its widest sense and will include health services commissioned by the NHS Commissioning Board and Clinical Commissioning Groups, public health services, education and training, and research. Future Secretaries of State will be required by law to comment on how effectively they have discharged their duties in relation to securing continuous improvement in the quality of services and to reducing health inequalities.

5. I am publishing this report, a year earlier than is required, to enable Parliament and the public to see the direction the health service is heading and to support our intention to reflect new beginnings in the health service. The future of the NHS depends on shared objectives and ambitions; open reporting

is central to that. This report therefore highlights the key achievements of 2011/12, as demonstrated by NHS performance data and public health initiatives such as the Responsibility Deal. In future years, the report will focus increasingly on outcomes reflecting how measuring performance of the health service will evolve over time. This will include the changes in my role as the Secretary of State, as set out in the Health and Social Care Act 2012.

6. Whilst the 2011/12 performance data has undoubtedly been positive, we face a number of significant challenges. Compared to other countries we continue to lag on performance on some key outcomes including life expectancy for women, cancer survival, and conditions related to obesity. Looking forward, there will be continued pressure on budgets across the health and care system, so there will need to be sustained efforts to ensure that every penny of public money is spent as effectively as possible, delivering the best possible outcomes for patients. To do this, we must embrace innovation across the service, recognising the opportunity we have to improve quality, including patients' own experience of care.

7. The diseases that people in the country today suffer from are different from when the NHS began. The health service needs to respond and to evolve to meet these new challenges. For example, obesity and alcohol-related diseases have both increased and are having an increasing effect on the health service and the public's health. Prevalence of mental health conditions is also continuing to rise. Tackling these challenges will require a different approach, changing people's lifestyles and their behaviour rather than reliance just on hospital-based services. This makes clear the need for a greater focus on public health and for joint working across services.

8. There is also more we can do to tackle health inequalities. Life expectancy in England can differ by as much as 11 years depending on where you live. While there has been some progress, these differences are deeply embedded and will be difficult to overcome. Addressing these challenges will require coordinated action between all aspects of health, public health and care services.

9. The three Outcomes Frameworks (NHS[4], Public Health[5] and Adult Social Care[6]) will focus on what matters for patients, and will help drive change across the system. The increased focus on outcomes, supported by the Health and Social Care Act 2012, will give the health service the long-term stability and focus it needs to meet the challenges of the future.

C: The Comprehensive Health Service in England

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1. The health service belongs to the people. It touches our lives at times of need, when care and compassion are what matters most. The health service is built upon a common set of values and principles, that comprehensive healthcare should be free to all at the point of use, regardless of ability to pay, and funded from general taxation. These rights are enshrined within the NHS Constitution[7], which protects and promotes these enduring principles.

2. Ever since the National Health Service Act 1946, the Secretary of State, and before him the Minister of Health, have had a duty to promote a comprehensive health service. The Parliamentary debates on the original NHS Act 1946 indicate that the intention behind the idea of a "comprehensive" health service was that no particular illnesses or services should be excluded from its remit, and that no groups of individuals should be excluded because of, for example, their ability to pay.

3. The Health and Social Care Act 2012 strengthens the focus on improving the health of the whole population and improving the quality of the health service. In this report, references to health services or the comprehensive health service therefore reflect the same original purpose, and include the provision of NHS and public health services. Key aspects of the comprehensive health service include:

   - **The direct provision of services to patients and the public** to support us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.
   - Services and interventions to **prevent ill health, improve our health and to reduce health inequalities.**
   - **The promotion of research,** and the dissemination and adoption of innovations and evidence-based interventions across the health system.
   - Support to staff to continue delivering excellent care through **education and training.**

4. Alongside this report, the Secretary of State has published a review examining the effect of the NHS Constitution over the past three years. The Department and the Secretary of State will also be working with the NHS Future Forum, staff, patients and the public to review and revise the rights and pledges in the Constitution to strengthen and reinforce these fundamental principles.

Principles that guide the Health Service

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. NHS services must reflect the needs and preferences of patients, their families and their carers.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

5. The NHS will remain true to its defining principles. It will do more to support the population to stay healthy as well as to get better when illness occurs. It will embrace the latest evidence of what works and it will ensure that the workforce has the training and support they need to provide excellent care.

Strategic challenges

6. Over the past 30 years, huge improvements have been made in the health and wellbeing of the population. As a nation, people are living longer, and there have been significant increases in life expectancy and reduced premature mortality from the main diseases. However, international benchmarking and variation between parts of this country demonstrate that more can be done.

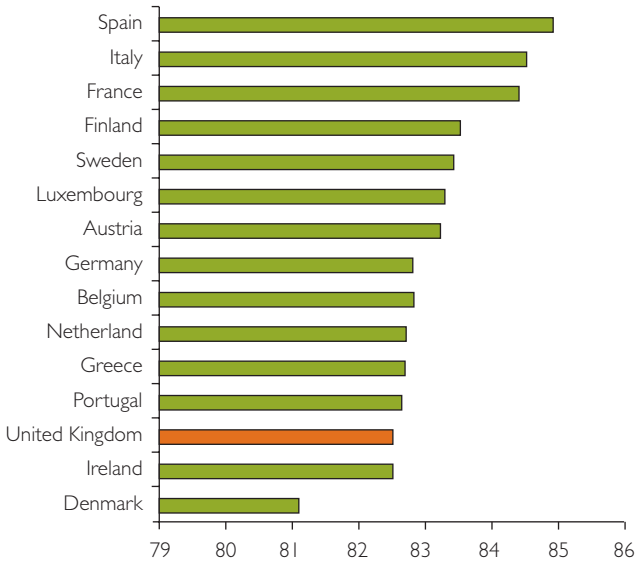
7. Compared to other countries, performance lags in some key areas, including premature mortality for women, the treatment of some cancers, and conditions related to obesity. Although life expectancy overall has been improving, women in particular have lower life expectancy in the UK than in comparable countries (see Diagram 1). Cancer outcomes remain poor when compared to the best in Europe, with a significant gap in both survival and mortality rates. Around 10,000 lives every year could be saved if cancer survival rates matched the best in Europe.[8] There are also persistent inequalities in life expectancy and healthy life expectancy between communities, a challenge that is common to all countries.

Diagram 1: Life Expectancy in the EU15 European Countries (2009)

Male life expectancy at birth

Source: OECD Health Data, 2011

Female life expectancy at birth



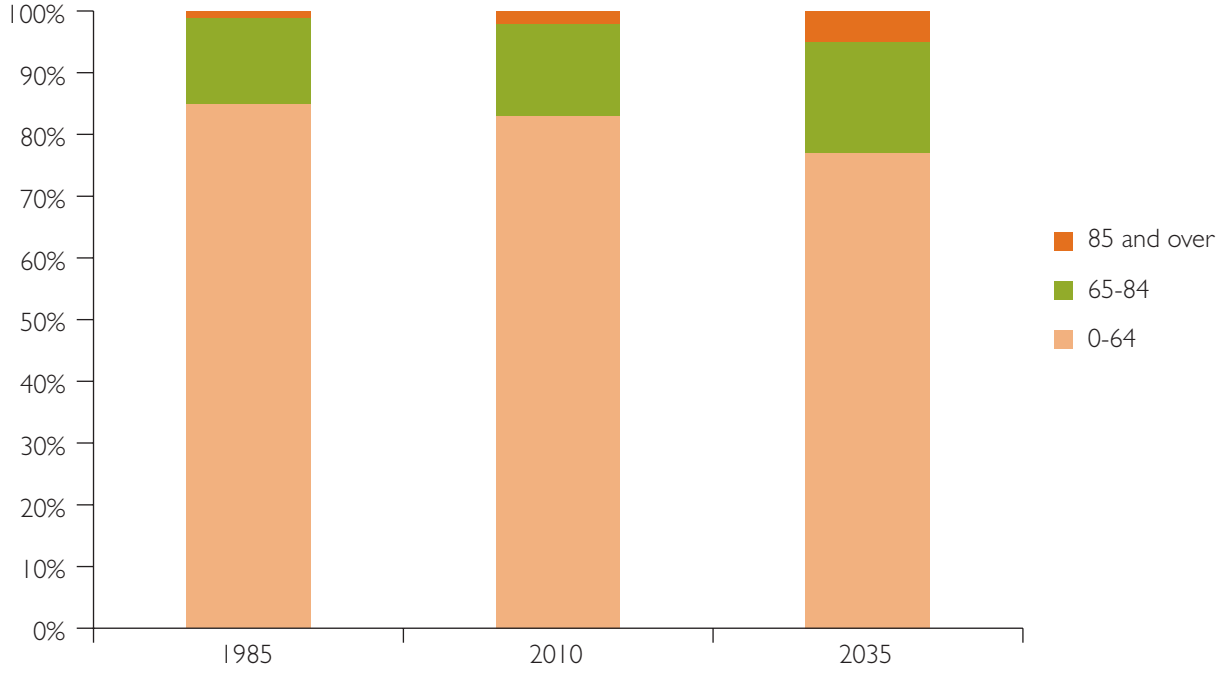
Source: OECD Health Data, 2011

8. Looking to the future, demographic pressures and changes in disease patterns will continue to increase demands on the future health and care system. The population is ageing, with the number of people aged over 85 set to more than double by 2035, resulting in rising numbers of frail older people, of people with dementia and of people with multiple long-term conditions (see Diagram 2).[9] The number of people with dementia is expected to double over the next 30 years and costs are expected to treble.[10] The number of people with three or more long term conditions is set to increase from 1.9 million in 2008 to 2.9 million in 2018.[11]

9. In recent years, several major diseases have become more common, partly reflecting modern lifestyles. Obesity has been increasing steadily for both men and women (see Diagram 3).[12] Higher rates of obesity and higher levels of excessive alcohol consumption have resulted in higher incidence of diabetes, arthritis and chronic liver disease, all of which are preventable. Estimates suggest that the number of people with diabetes in England could rise from 3.1 million in 2009 to 4.6 million by 2030.[13] Prevalence of gastrointestinal diseases has also risen rapidly: for example, there was a 25% increase in liver disease deaths between 2001 and 2009.[14]

10. Poor mental health makes up a high and growing proportion of ill health. Almost 1 in 5 of the adult population experience mental ill health at any one time and the number of people with significant neurotic symptoms

Diagram 2: Projected age distribution, UK population



Source: ONS, Population Ageing in the United Kingdom its constituent countries and the European Union, March 2012

has increased since 1993.[15] The economic and social costs of mental health problems in England have recently been estimated at £105 billion, and treatment costs are expected to double in the next 20 years.[16] Mental health problems also add considerably to the costs of the education and criminal justice systems, and homelessness services. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity.[17] Mental illness is also the most common reason for incapacity benefits claims. Around 43% of the 2.6 million people on long term health-related benefits have a mental or behavioural disorder as their primary condition.[18]

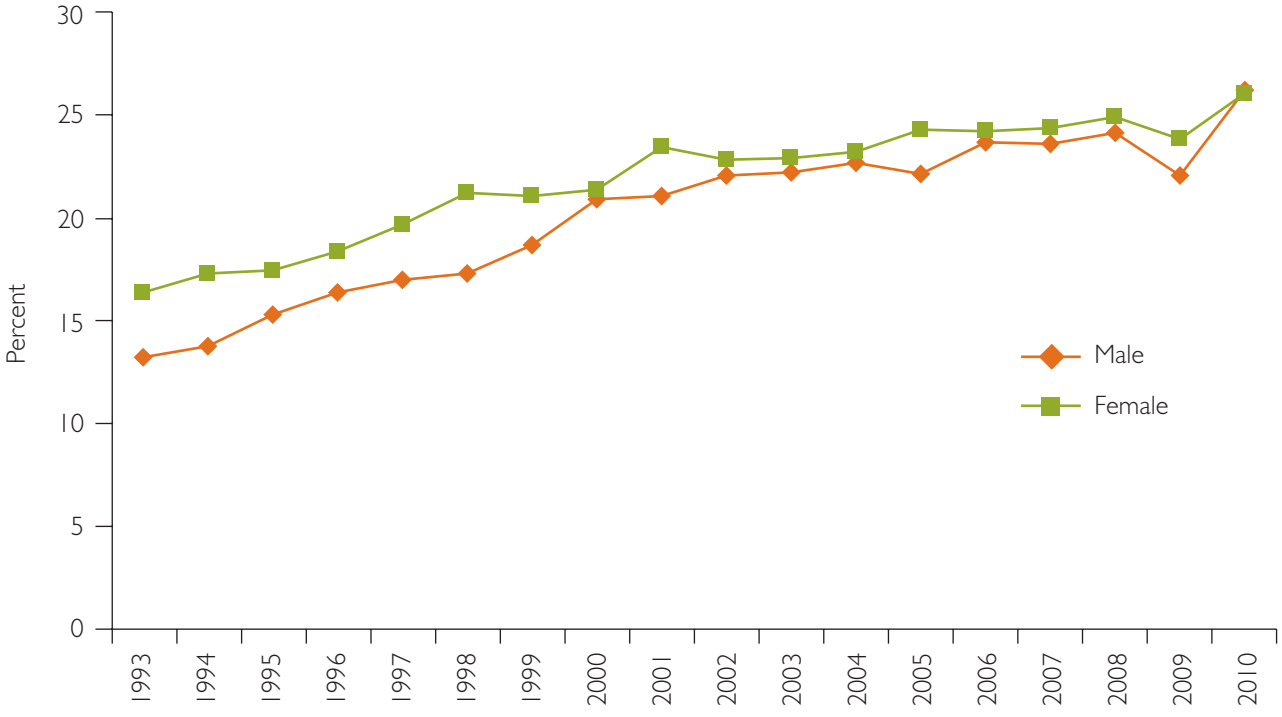
11. In addition to changes in demography and disease patterns, expectations are increasing. As a country's wealth grows, people expect increases in the quality of health and care services. At the same time, medical advances and improvements in technology enable more people to be treated safely and effectively. This expansion of treatment extends lives and improves quality of life, but also has the potential to increase costs.

12. This is all contributing to increasing demand for health and care services. Historically, increases in demand have been managed by spending more on treating people when they get ill. Total hospital admissions have nearly doubled since 1990 and increased by around a third in the last decade.[19] The average number of prescriptions per head has increased by around a third over the last ten years.[20] These increases in treatment have been possible over the last decade because of the amounts of additional funding that went into the NHS, increases that are unsustainable in the longer term.

13. Looking forward, health and care services need to respond flexibly and innovatively to continue to deliver safe, effective and compassionate care that meets people's expectations and provides better value from public spending. There will be more focus on preventing ill health and on reducing deterioration in health.

14. Health services are already responding in new and innovative ways. For example, early diagnosis is improving, assisted by new

Diagram 3: Prevalence of obesity, adults aged over 16



Source: Health Survey for England

technology and increased awareness. Access to diagnostic testing for cancer has been widened, and investment in public awareness has increased.

15. People are also increasingly engaged in their own care, with the potential for further progress due to the use of new technologies and support. Around a third of people are now actively involved in their own care, and self-care has the potential to further empower people and improve outcomes. People with long-term conditions are often experts in managing their own health, and understand better than anyone else how they are affected. Supporting self-care has the potential to improve quality, but also reduce the demand for health and care services. Similarly, rehabilitation and reablement services have the potential to significantly improve quality, by easing the transition from acute treatment to home or community health services.

16. The system also needs to be alert to new challenges, ensuring the population's health is protected from major incidents and is resilient to future economic uncertainty. To do so will require closer working across the boundaries of public health, the NHS and social care.

System change

17. The White Paper, *Equity and Excellence: Liberating the NHS*[21], set out a vision for a revised health system to help meet the strategic challenges. The new system will help deliver better health, better care and better value for money, encouraging greater focus on preventing ill health and empowering local communities to plan services according to local priorities. The modernisation will help the health service to develop from a system of management control to a system where power and decision-making is devolved to the most appropriate level. Change will be led by clinicians and local service providers, working with local authorities, in response to the needs of their patients, people using care services, carers and communities.

18. To enable the health system to meet the challenge of more people developing and living with long-term conditions, it will be important to rethink how care is provided. Rather than treating people when things go wrong, there needs to be a greater focus on prevention. The White Paper, *'Healthy Lives, Healthy People: Our Strategy for Public Health in England'*, set out a plan for a reformed public health system in England. Giving local authorities new responsibilities for public health opens up new opportunities to develop far more holistic solutions, embracing the full range of local services such as health, housing, leisure, planning, transport, employment and social care to improve people's health and wellbeing. Local authorities will be supported by a new integrated public health service, **Public Health England**, which will drive the delivery of improved outcomes in health and wellbeing and will protect the population from threats to its health.

19. The changes to public health will help prevent the initial onset of long-term conditions and to tackle the major challenges around obesity and alcohol. Linked to this, the health service will need to improve the management and treatment of such conditions when people do develop them.

20. If managed well, people with long-term conditions may not need to be treated within secondary care but, too often, care is uncoordinated and does not fit in with the individual's life, leading to a crisis point and a hospital admission. Instead, **personalisation, empowerment and shared decision-making, for example through expanding patient choice, personalised care planning and personal health budgets**, will help people to have far greater input into decisions about their care, and more control over the care they receive including where and when they receive it. This also offers greater potential for **self-management and self-care**, where the person is empowered to manage their condition.

21. Alongside this, the changes in the commissioning system will help to meet the coming challenges, by strengthening the role of clinicians and involving patients in decisions about services they receive. *Equity and Excellence* devolved financial responsibility for commissioning to **Clinical Commissioning Groups (CCGs)**, led by local doctors and other health professionals, supported by the **NHS Commissioning Board**. This means that decisions about local services will now be made by those who have the most contact with patients, and who therefore have the clearest understanding of the needs and preferences of their local community. GPs are already responsible for much of the commissioning of the care that is provided by prescribing and referring as they see fit. By devolving budget responsibility to CCGs, this gives a real incentive for GPs and other primary care professionals to meet the needs of their population as efficiently as possible.

22. To help CCGs perform this function, and to ensure that they have the information about the needs of their local population, **health and wellbeing boards** will bring together local health and care organisations with local authorities and others to ensure strategic planning is based on local health needs. This reflects the need for the integration of services and the coordination of organisations, recognising the growing number of people who access health and care services from a wide variety of providers. Health and wellbeing boards will provide a forum to share information, particularly the **joint health and wellbeing strategy** and the **Joint Strategic Needs Assessment (JSNA)**, which will mean that all of the key participants are aware of the needs of the population they serve.

23. The new vision will mean changes in the provision of health services as well. Therefore, the changes in *Equity and Excellence* will **liberate providers** and simplify the regulatory regime, enabling them to respond to the wishes and preferences of commissioners and the population that they serve. This will give providers of NHS services more freedom to innovate, and to make changes to services, to improve quality and efficiency, free from political interference. **Monitor**, the regulator of health and care providers, will license providers and ensure they act in patients' interests. **Monitor's** main duty, as the sector regulator, will be to protect and promote patients' interests. This will be done through the licensing of providers. Monitor will focus on enabling different parts of the health and care sector to deliver the best possible outcomes for patients today and into the future, by creating incentives, providing information and enforcing rules where necessary.

24. The changes to the commissioning system, combined with the expansion of patient choice and empowerment, will further encourage providers to respond to patient preferences. Stronger incentives will mean that providers will need to ensure that they deliver services that are beneficial to patients and treat them with dignity and respect; otherwise commissioners will act upon patients' feedback and preferences and patients themselves may choose to go elsewhere.

25. All of the changes are underpinned by the role of **information**, which will aid transparency and the development of a system that is locally-owned, locally-led and better able to meet the needs of the population. This is set out in more detail in the Government's information strategy *'The Power of information: putting all of us in control of the health and care information we need'*,[22] published on 21 May 2012. It sets out the vision and steps needed to harness information and new technologies to achieve high quality care and to improve outcomes.

26. The role of information will be bolstered by the introduction of **Healthwatch England**, which will represent the views of people using health and social care services, members of the public and Local Healthwatch organisations. This will give

people a strong voice in the new system. The NHS Commissioning Board, CCGs, Monitor and health and wellbeing boards will all have duties to involve patients, carers and the public in the decisions they make.

27. To ensure that the health system continues to progress high quality research and development, and training, will be vitally important. Therefore, the **Health Research Authority (HRA)** will promote and protect the interests of patients and the public in health research. The Secretary of State, the NHS Commissioning Board and CCGs will all have a duty to promote research and the use of evidence. **Health Education England** and **Local Educational and Training Boards** will ensure that all staff delivering NHS services have the right education and skills they need to deliver high quality services.

28. The Secretary of State, accountable to Parliament for the effectiveness of the system as a whole, will have responsibility for ensuring the entire system works together to respond to the priorities of communities and to meet the needs of patients. He will set the strategic direction and regulatory framework for health and care services and, if necessary, use his powers of oversight and intervention to ensure that services are provided in accordance with legislation. Diagram 4 overleaf gives a developing overview of the health and social care structures arising from the Health and Social Care Act 2012.

29. The Secretary of State continues to have responsibility for the promotion of a comprehensive health service designed to prevent, diagnose and treat physical and mental illness, and to improve the physical and mental health of the people of England. The Secretary of State will also have legal responsibilities to:

    - secure **improvement in the quality** of services;
    - have regard to the need to **reduce health inequalities;**
    - **promote research** in areas relevant to the health service and the use of evidence within the health service; and
    - ensure that there is an effective system for the planning and delivery of **education and training.**

A new focus on outcomes

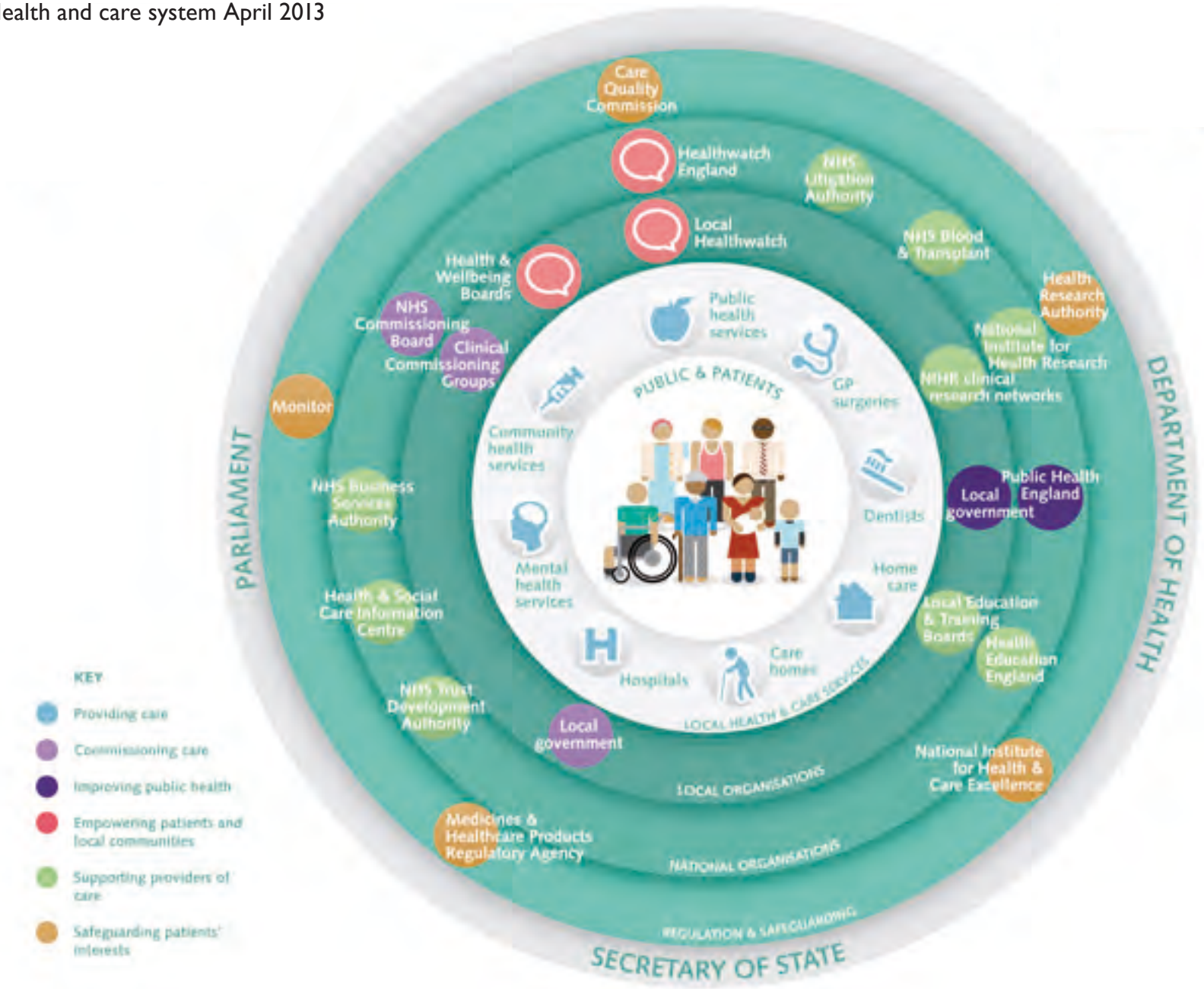
30. *Equity and Excellence: Liberating the NHS* set out how improving people's health and wellbeing will be the primary purpose of the health system. Modernisation will refocus the system on improving health outcomes for the whole population and reducing inequalities in health, rather than only achieving narrow process targets. The new focus on outcomes across health and social care will ensure that the system will address what matters most to the public, users of services, patients and professionals.

31. This new focus is reflected in the outcomes frameworks for the NHS, public health and adult social care. Together, the combined frameworks will set the direction for the health and social care system. This will increase accountability and transparency for the outcomes delivered, and will provide flexibility in how they are delivered.

32. The three interlinked outcomes frameworks reflect the different delivery and accountability mechanisms for public health, the NHS and social care. Each framework operates differently. The NHS Outcomes Framework will be used to strengthen the accountability of the NHS Commissioning Board. The Adult Social Care Outcomes Framework will support local transparency and benchmarking between local authorities, and support the accountability of the Secretary of State to the public and Parliament for the adult social care system. The Public Health Outcomes Framework will hold national systems to account for public health outcomes, whilst supporting local transparency.

33. The frameworks are at different levels of development, and each will continue to

Diagram 4: Health and care system April 2013



evolve, developing new specific indicators to reflect emerging health and care challenges. They share a common structure, allowing close alignment. Setting out the three frameworks helps to disentangle the specific contribution of the different parts of the system.

The Public Health Outcomes Framework

34. The main purpose of the Public Health Outcomes Framework is to provide a framework for transparency and accountability across the public health system. The two overarching public health aims will be to increase healthy life expectancy, and to reduce differences in life expectancy and healthy life expectancy between communities. These outcomes reflect the focus the Department wishes to take, not only on how long people live, but on how well people live and on reducing health inequalities between people in society.

35. These aims are reflected in Public Health Outcomes Framework domains:

- **improving the wider determinants of health**;
- **health improvement**;
- **health protection**; and
- **healthcare public health and preventing premature mortality**.

36. While information is available on the performance against the two overarching outcomes, the nature of public health is such that improvements may take years or even decades to see a marked change. A set of supporting indicators has therefore been developed to show the progress made year-by-year nationally and locally on the things that will contribute to these longer-term aims.

The NHS Outcomes Framework

37. The Secretary of State will set out a mandate to the NHS Commissioning Board, outlining key objectives for a multi-year period and to be refreshed annually.* The NHS Outcomes Framework will form a central part of the mandate, setting the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account.

38. The NHS Outcomes Framework has five domains for assessing how well the NHS is:

- **preventing people from dying prematurely**;
- **enhancing quality of life** for people with long-term conditions;
- **helping people to recover** from episodes of ill health or following injury;
- ensuring that people have a **positive experience of care**; and
- **treating and caring for people in a safe environment** and protecting them from avoidable harm.

39. These domains reflect the three-part definition of quality (clinical effectiveness, patient experience and safety),[23] which is now enshrined in law via the Health and Social Care Act 2012.

The Adult Social Care Outcomes Framework

40. The overall objective of the Adult Social Care Outcomes Framework is to promote improvement in the quality and outcomes for users of adult social services and carers. The framework itself will encourage a change in focus, away from service activity and towards improving outcomes and addressing the variation in the quality of service providers. Central Government will not have a direct role in holding commissioners and providers to account – instead, Government is working with councils to support the sector to lead its own performance and improvement activity.

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* The draft mandate *'Our NHS care objectives: a draft mandate to the NHS Commissioning Board'* and the accompanying consultation *'Developing our care objectives: a consultation on the draft mandate to the NHS Commissioning Board'* were published on 4 July, and are available at http://mandate.dh.gov.uk

The Adult Social Care Outcomes Framework, as a source of nationally comparable outcomes information, will enable councils to compare their performance to other local authorities, based on the outcomes they deliver for local people. The framework also supports local people to hold their council to account for their performance. For example, the Outcomes Framework will inform the development of local accounts, which councils will use to set out their priorities and progress to their citizens.

41. The four domains of the Adult Social Care Outcomes Framework are:

    - **Enhancing quality of life** for people with care and support needs;
    - Delaying and **reducing the need for care and support**;
    - Ensuring that people have a **positive experience** of care and support; and
    - **Safeguarding people** whose circumstances make them vulnerable and protecting from avoidable harm.

42. Nationally, the Framework provides an indication of the strengths and weaknesses of social care and its success in improving outcomes for people who use services. This will support the Government's role in reporting to the public and Parliament on the overall system, and will influence national policy development.

Aligning the outcomes frameworks

43. Although the three Frameworks focus on the respective roles of Public Health England (PHE), the NHS and local government, delivering health and wellbeing outcomes across the system for the whole population requires a collective effort. To support this collective effort, it is important that the three frameworks are aligned so the whole system works together. For example, the fourth domain of the Public Health Outcomes Framework and the first domain of the NHS Outcomes Framework cover many of the same indicators, which will help to encourage an integrated approach. The three frameworks also provide the opportunity to focus on particular issues. The Department is considering how the frameworks will work together to improve outcomes in specific areas; for example improving the health and wellbeing of children and young people.

44. The focus on the wider determinants of health (for example, indicators focusing on employment, housing and environment) within the Public Health Outcomes Framework offers an opportunity to align this framework with any that may emerge from other Government departments or indeed at a local level across a range of related public services.

45. This clearer focus on alignment, collaboration and integration at a national level is also important at a local level in terms of improving services and outcomes as well as making savings. The Department is currently looking at how the outcomes frameworks can support health and wellbeing boards, both in terms of understanding the needs of the local area and how well services are meeting those needs. including a potential basket of indicators. It will be for health and wellbeing boards to set their own local priorities, in their joint health and wellbeing strategies, capitalising based on evidence from their Joint Strategic Needs Assessments, and use these as a basis for local commissioning services. National outcomes measures and strategies should inform, but not overshadow, these local priorities.

D: Performance Across the Health Service in 2011/12

D: Performance Across the Health Service in 2011/12

This report looks at performance over the 2011/12 financial year. It includes data showing achievements against performance measures set out in '*The Operating Framework for the NHS in England 2011/12*'. To recognise the wider elements of the comprehensive health service, the Secretary of State's report will look at performance, challenges and highlights from the 2011/12 year in the following areas:

- the National Health Service;
- public health;
- promotion of growth, innovation and research; and
- education, training and workforce.

There is also a specific focus on two priority areas - reducing health inequalities, and the delivery of integrated care.

The National Health Service

KEY MESSAGE: The NHS has performed well during 2011/12. It has maintained or improved performance in relation to a range of quality indicators as set out in the NHS Operating Framework, while meeting the first stage of the financial challenge it is facing.

1. *The Quarter Report*: Summary of NHS Financial and Service Performance, Quarter 4 2011/12*,[24] provides a detailed breakdown of end of year performance data and can be found on the Department of Health's website. In the Operating Framework 2012/13, most performance indicators are grouped under the five NHS Outcomes Framework domains and for consistency with future years, this is how the annual report has been structured. The NHS has only previously been performance managed on the indicators within the Operating Framework. In contrast, this report includes references to wider metrics and indicators, to set a clear direction for future annual reports by the Secretary of State. This report is structured to reflect the duties of the Secretary of State after 1 April 2013.

2. The three outcomes frameworks will, in future years, give a clear and far broader picture of the performance of the health and care system. They will give a comprehensive summary of how the health and care service is performing, across a wide range of indicators. They will focus on what matters to patients, service users, professionals and the public, and will indicate the long-term ambitions of the system. This will be in sharp contrast to previous years, when the

* A series of quarterly updates from David Flory, Deputy NHS Chief Executive, that outline the NHS financial position alongside progress made in health and health services

focus has been on a narrow set of quality indicators, such as waiting times, healthcare associated infection rates and delayed discharges. While these indicators, and others, do give an idea of of service quality, they are not comprehensive.

3. Nevertheless, it is not yet possible to give the full picture – the outcomes frameworks are still being developed, and they will improve over the next few years as more data is gathered. Therefore, this year, the report focuses on some of the key achievements of the health service in 2011/12, based on information and indicators that are currently available.

NHS Outcomes Framework Domain 1: Preventing people from dying prematurely

4. High quality care can make the difference between life and death. This domain captures the role of the NHS in reducing the number of avoidable deaths, recognising the complementary role of public health organisations and of individuals in improving their own health.

5. The NHS has continued to sustain performance against the cancer waiting times measures in the Operating Framework for the NHS in England for 2011/12. At a national level, all requirements for maximum waiting times for diagnosed and suspected cancer patients were met.

6. Over the past year, the Cancer Drugs Fund has had a positive impact, building on the additional funding the Government made available to the NHS in October 2010 to give patients better access to cancer drugs that would not otherwise be available from the NHS. **The £600 million Cancer Drugs Fund**, over three years, has been widely welcomed for the freedom it gives clinicians to prescribe the cancer drugs they think are best for their patients, and the real difference this is making to the lives of individual patients and their families. By the end of February 2012, over 12,500 patients had accessed additional cancer drugs that can extend or improve life. This was as a result of the funding that has been made available, and many thousands more will benefit over the life of the Cancer Drugs Fund. The information generated through the Fund will also be invaluable in assessing the benefits that these drugs deliver in real-world clinical practice.

- **Key cancer standards have been achieved across all eight performance measures.** Additionally, the NHS Breast Cancer Screening Programme and the NHS Bowel Cancer Screening Programme are both being extended so that more cases of cancer are detected at an early stage, improving the likelihood of survival.
- **In addition, the National Oesophago-gastric Cancer Audit**[25] **found that** for patients undergoing curative surgery, in-hospital mortality was lower than previously recorded (5.1% vs 8.9%). A greater number of curative procedures are being performed with a minimally invasive approach and the **National Bowel Cancer Audit**[26] found that Laparoscopic procedures are increasing with nearly 30% of surgical cases being completed laparoscopically. The overall 30-day post-operative mortality rate is falling and now stands at 3.7%.

NHS Outcomes Framework Domain 2: Enhancing quality of life for people with long-term conditions

7. A chronic illness or long term condition (LTC) is one that is ongoing, cannot be cured, but can be managed through medication and therapy. This includes physical or mental health conditions, or conditions associated with a disability. **Today there are over 15**

million people in England living with at least one LTC. This will increase to around 18 million in 2025/30. People with LTCs account for 55% of all GP appointments, 68% of all outpatient and A&E appointments, and 77% of all inpatient bed days. In total, around 70% of total health and social care spend is accounted for with caring for people with LTCs.

8. **Telehealth** (measuring vital health signs remotely) and **telecare** (electronic equipment that supports independent living) could make a significant contribution to improving the lives of people with LTCs. In December 2011, the Department published early findings from the Whole System Demonstrator Programme.[27] The early indications show that if used correctly, telehealth can deliver a 15% reduction in A&E visits, a 20% reduction in emergency admissions and more strikingly, they also demonstrate a 45% reduction in mortality rates. In January 2012, Paul Burstow, Minister for Care Services launched a concordat with the four trade associations for the telehealth and telecare industry. This signalled a joint commitment to work together to improve the lives of 3 million people over the next five years using telehealth and telecare, where appropriate, as an integral part of health and care services.

- More people with diabetes are now being offered diabetic retinopathy screening than ever before, and to higher standards. At quarter 4 99.0% of patients with diabetes were offered screening for diabetic retinopathy during the previous 12 months.* In addition, the National Diabetes Audit found that between 2005 and 2010, the percentage of people with diabetes receiving all the NICE recommended care has more than doubled.

9. Through the expansion of the Improving Access to Psychological Therapies (IAPT) Programme, more people are now benefitting from these services with **528,000 people entering treatment in 2011/12** compared to 182,000 in 2009/10, and steady progress is being made towards achieving a 50% recovery rate. More **than £400 million** will be invested over the period of spending review on completing the roll out of the IAPT Programme which delivers NICE-approved talking therapies to those who need them. In February, Ministers agreed significant additional investment of up to £22 million over the next three years for IAPT for children and young people.

Armed Forces Covenant

10. The Department continues to fully support the Armed Forces Covenant, ensuring that those serving in the Armed Forces, their families and veterans receive the best possible healthcare. The Department has put in place initiatives to improve veterans' mental health, including a 24-hour veterans mental health helpline, which was done in partnership with Combat Stress and Rethink. This has increased the number of mental health professionals in the NHS supporting veterans. The Department has also continued with an early intervention service for the Armed Forces community provided by Big White Wall** and launched an e-learning package for GPs.

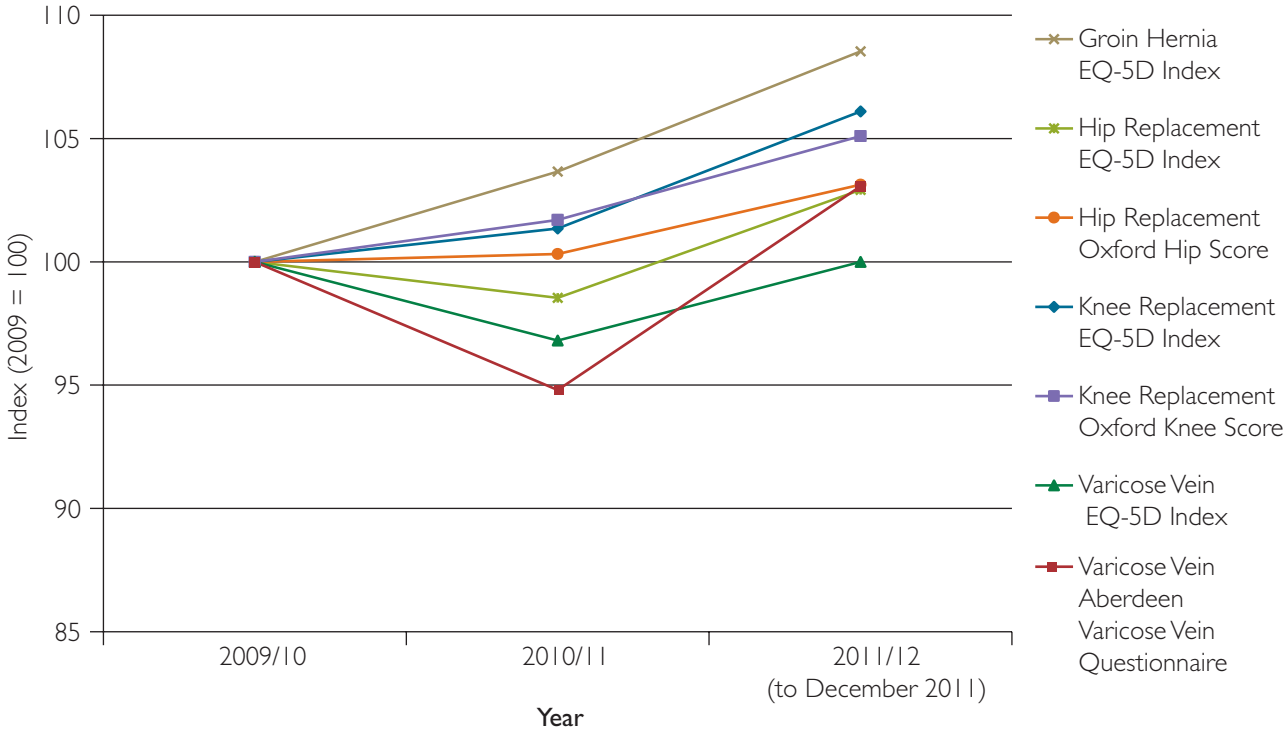
NHS Outcomes Framework Domain 3: Helping people to recover from episodes of ill health or following injury

11. This domain captures the importance of helping people to recover as quickly and as fully as possible from ill health or injury. A fast recovery is beneficial for both patients and the system, and can both improve outcomes and save money.

* The offering of screening and the uptake of screening are different. For quarter 2 of 2011/12, the national uptake of screening was 73%.

** Big White Wall www.bigwhitewall.com is an online early intervention service for people in psychological distress.

Diagram 5: Average adjusted health gain for PROMs procedures



Patient Reported Outcome Measures

12. Patient Reported Outcome Measures (PROMs)[28] are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. On average, patients are reporting greater health improvement for hip and knee replacements and groin hernia surgery in 2011/12 than before as shown in Diagram 5 above.*

13. The PROMs programme is being extended. Pilots are exploring their use for patients undergoing interventions such as angioplasty and coronary artery bypass grafts, and secondary care treatment of depression, reflecting the increasing importance being placed on patients' views of their treatment. Health status questions are also being included within the GP Patient Survey, to help measure outcomes for people with LTCs. This will contribute to Domain 2 of the NHS Outcomes Framework as well as Domain 3.

14. In response to the report produced by Dr Andrew Murrison MP '*A better deal for military amputees*'[29], the **Government committed £15m over three years to ensure that veterans who were injured in the service of their country have access to high quality prosthetics**. Since April 2012, these veterans can access interim funding and by April 2013 will have access to specialist veterans' prosthetics centres in place throughout England.

* This provisional publication of PROMs data includes eligible HES episodes with both an episode start date and pre-operative questionnaires completed between 1 April 2010 and 31 December 2011. The increases in health gain between 2011/12 and 2009/10 are statistically significant for the Groin, Hip and Knee measures, at a 1% level. The increases in health gain for the Aberdeen Varicose Vein score is significant at a 10% level. There is no change in the Varicose Vein EQ-5D Index between 2011/12 and 2009/10 and so is not statistically significant. This is the first time that data of this kind has been routinely collected on a national scale. This means that while the data is informative, it may be too soon to infer that the changes are a result of quality improvements.

NHS Outcomes Framework Domain 4: Ensuring that people have a positive experience of care

15. This domain reflects the importance of providing a positive experience of care for patients, service users and carers. As the NHS

Constitution states, patients have the right to be treated with dignity and respect, with a professional standard of care, and in a safe and clean environment that is fit for purpose.

16. The quality of services needs to be reflected not only in measurable outcomes of recovery but also in the experiences of those being cared for. A greater understanding, and more information, is therefore required about patients' experiences of their treatment and care, and these results can be used to improve services.

- The compulsory reporting of breaches of mixed-sex accommodation guidance has resulted in a fall of over 96% in just 16 months. A dramatic fall in breaches (both absolute number and rates) in the final quarter of 2010-11 has been followed by a steady decline during 2011-12 to a breach rate for England of 0.3 in March, **and single-sex accommodation is now the norm for almost all patients**.
- **Over 80% of stroke patients are now spending 90% or more of their hospital stay in a stroke unit**, and over 70% of transient ischaemic attack (TIA) cases with a higher risk of minor stroke are now treated within 24 hours – both significant improvements since 2009.
- Patients and the public are getting more control over their care and where that care takes place, through offering greater scope for self-directed support and patient choice. This includes choice of treatment, of consultant and of GP as well as choice of provider. This is supported by the proposals set out in the information strategy and the consultation *'No decision about me, without me'*[30] which will help people to be more informed about the care that they receive and the choices they make.

Public perception of the health service

17. Public confidence in the NHS remains high. According to a recent survey of the general public by MORI[31], 70% of people are satisfied with the running of the NHS, **77% agree that their local NHS provides them with a good service, and 73% agree that England has one of the best national health services in the world, the highest level ever recorded in this survey**.

Patients experience of the health service

18. Surveys of patients show positive results. For example, in 2011 **92% of inpatients**[32] **and 95% of outpatients**[33] rated their overall experience as good, very good or excellent. Both the inpatient and outpatient surveys cover around 70,000 patients each.
    - The 2011/12 Adult Inpatient Survey also shows a **clear improvement in the provision of single sex bathroom and shower areas, and patients receiving copies of letters between clinicians**. It does, however, show a reduction in patient reported experience of their waiting times for admission to hospital, the quality of food in hospitals and the provision of help for those who struggle with eating.
    - The 2011/12 National Adult Outpatient Survey also shows **clear improvements in being seen on time for an appointment, cleanliness of wards, being treated with respect and dignity, and with receiving answers that could be understood**. However, there were declining standards in changing appointment dates and in explanation of the process of treatment.

19. In the Report by the Secretary of State for Health on the effect of the NHS Constitution, it is acknowledged that while the NHS is often excellent at providing compassionate care, it sometimes falls short. In future years, more widespread use of patient experience surveys will be encouraged, along with real-

time feedback and other sources of intelligence which, when combined, will give a rounded picture of the quality of services provided. Patients will be enabled to rate services according to the quality of care they received, and hospitals will be required to be open about mistakes and always tell patients if something has gone wrong. Staff will also be required to provide feedback around the quality of the patient care provided in organisations is publicly available.

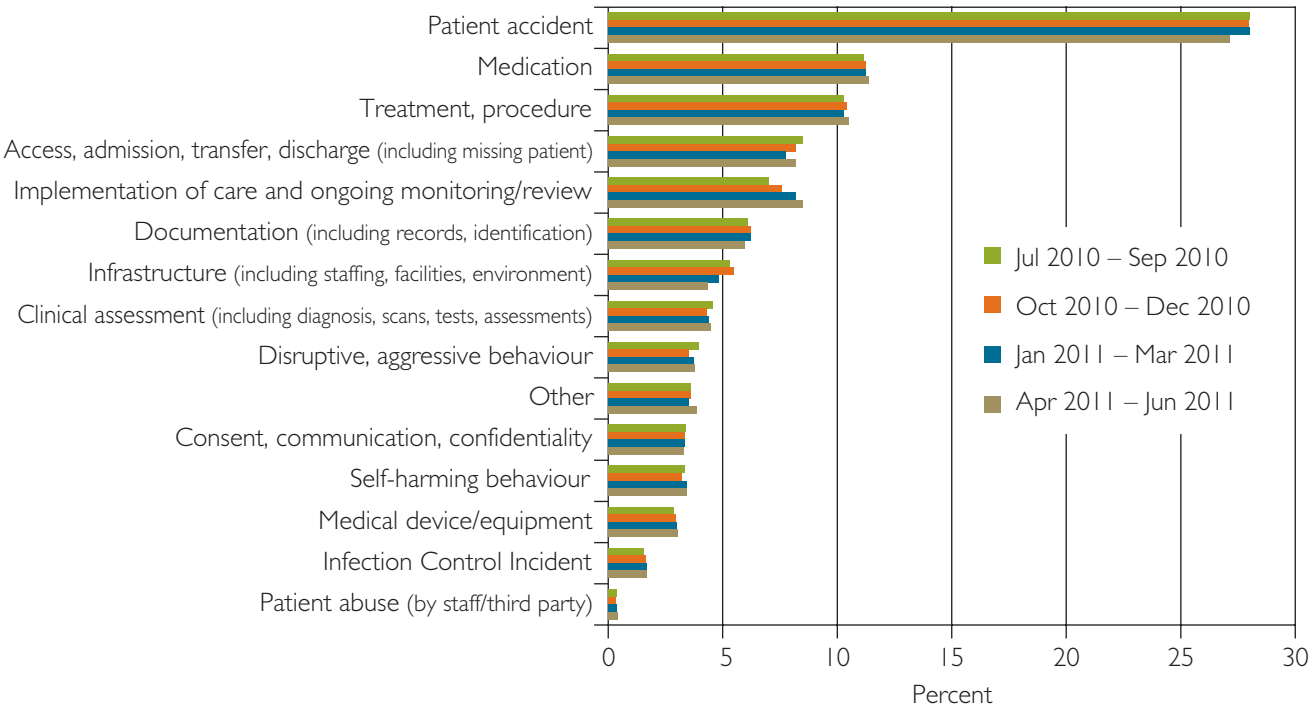
NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

20. This domain recognises that patient safety is of paramount importance in terms of quality of care and delivering better health outcomes, and reflects the commitments in the NHS Constitution. It is about measuring how well the NHS is adopting a safety culture and delivering improvements in safety as a result, rather than ensuring that services or organisations are fit to practise. Experience has shown that the NHS is adept at making real improvements on specific safety issues. This domain also reflects the importance of identifying areas where there are particular patient safety issues or risks that need attention if the NHS is to achieve excellence in patient safety. These include reducing the incidence of key harms such as venous thromboembolism (VTE) and healthcare – associated infections, and improving the safety of maternity services.

- With **25%** fewer MRSA bloodstream infections than in the previous year and **17%** fewer *C. difficile* infections, **these infections are at the lowest levels since mandatory surveillance was introduced**.
- **Over 90% of adult admitted patients are now risk assessed for venous thromboembolism (VTE).** By 31 March 2012 more than 17.7 million NHS patients had been screened since July 2010, 93% of NHS patients in England are now being screened for VTE and around 260,000 NHS patients are currently being screened every week.

21. The National Reporting and Learning System was established in late 2003 and all

Diagram 6: Proportion of incidents by incident type and quarter, July 2010–June 2011



organisations had the ability to report from 2005. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Diagram 6 above shows the proportion of incidents by incident type and quarter between July 2010 and June 2011.

Maintaining performance

22. In addition to the outcome measures outlined above, evidence based on access to services and measures of performance are also integral to quality. For example:

    - Access to NHS dentistry continues to grow quarter on quarter, with more than **one million more people now seeing a dentist through the NHS since May 2010**.
    - **All ambulance trusts met the Category A8* operational standard of 75% for the first year since Call Connect was introduced in 2008**. Nationally, 76.1% of the Category A8 calls (immediately life threatening calls) received a response within 8 minutes meeting the target of 75%. The service has continued to meet the A19 operational standard of 95%, with a national performance of 96.8% for 2011/12. Ambulance clinical quality indicators were introduced on 1 April 2011. The indicators are divided into system measures and outcome measures. System measures look at issues such as response times, call abandonment and re-contact. Outcome measures focus on the clinical outcome for patients who received further care following transport by the ambulance service. Data published so far show variation between regions, and publishing this information will highlight where the NHS can make improvements to patient care.
    - Key cancer standards have been achieved across all eight performance measures.
    - **Access to services continues to be maintained and referral to treatment (RTT) consultant-led waiting times remained low and stable in 2011/12**. Over 90% of patients admitted to hospital and 95% non-admitted patients started treatment within 18 weeks of referral. The number of patients waiting longer than 18 weeks who have yet to start their treatment is also down to its lowest ever level, at 6.6%.
    - A&E performance continues to exceed the national operational standard of 95%, with **96.6% of patients spending less than 4 hours in A&E**. In April 2011, a new set of clinical quality indicators was introduced to replace the previous four-hour waiting time standard, and to measure the quality of care delivered in A&E departments in England. These indicators will continue to be in place for 2012/13 for local use.

Financial Efficiency

23. In order to maintain and improve the quality of services in the NHS in response to rising demand, each local health economy has been required to develop a clear vision for a transformed local health system by 2015. This has included the delivery of in year savings to support quality improvement through quality, innovation, productivity and prevention.

24. The NHS has reported that **£1.9 billion of QIPP savings** were delivered during quarter 4.** Building on the savings of £3.9 billion reported at quarter 3, this gives the annual total for 2011/12 QIPP savings figure of **£5.8 billion**. The first year of QIPP delivery of 2011/12 has marked a strong start to the four-year QIPP challenge, with the NHS reporting the delivery of substantial savings. However, the health system faces ongoing challenges over the remainder of the QIPP

* "A8"–75% of Category A (immediately life-threatening) calls should receive a response within 8 minutes. "A19"–95% of Category A patients requiring transport should receive this within 19 minutes of the request for transport being made; ambulance services also respond to Category C (neither life-threatening nor serious) calls, but performance on these are managed locally.

** QIPP – Quality, Innovation, Productivity and Prevention – is a large scale transformational programme for the NHS.

period to 2014/15. An ageing population will continue to place increased demands on a cost-constrained health system, while economic realities put pressure on the NHS to innovate at scale and pace to meet these new demands.

Managing and Delivering Change

25. While the passage through Parliament of the Health and Social Care Act 2012 was a major event over the last year, the Department has also continued the work to implement the reforms:

- The Department achieved agreement on, and implemented, an HR Transition Framework, setting out the principles, policies and processes, enabling the delivery of a workforce built for future service needs. This impacts 40,000 health and social care employees.
- The Department formed PCT and SHA clusters to provide resilience for managing performance through transition and established the NHS Commissioning Board and Health Research Authority (HRA) as special health authorities.
- Shadow health and wellbeing boards started developing nationwide and close working was established with local government.
- All 212 proposed CCG applicants have now agreed their authorisation wave. Applications for CCG authorisation will take place from July to November 2012 and the NHS Commissioning Board is on schedule to have completed the authorisation process by January 2013.
- Significant progress was made on the set-up of Public Health England, and the Chief Executive Designate was appointed on 5 April 2012.
- As of 1 April 2012, there were 144 Foundation Trusts, with 104 NHS trusts remaining in the Foundation Trust (FT) pipeline. FT status is a measure of the sustained quality and financial performance of the Trust. Tripartite Formal Agreements (TFAs) between NHS trusts, their SHAs and the Department are underpinning progress towards FT status for each organisations still in the FT pipeline. All NHS trusts have completed these agreements. As of the end of June 2012, 86 were making progress in line with their agreements; 18 were not and were in contact with the Department to develop recovery plans and progress towards sustainable, high-quality services.
- The Department has developed proposals for the introduction of 'Any Qualified Provider'* into community services.

* When a service is opened up to choice of 'Any Qualified Provider', patients can choose from a range of providers all of whom meet NHS standards and price.

A Focus on: Inequalities in Health Outcomes

KEY MESSAGE: While there has been progress on tackling health inequalities, significant differences remain, and in some cases these gaps are widening over time.

26. The causes of health inequalities are broad and complex, and they relate to circumstances at and before birth and throughout the life course. All this was set out by Professor Sir Michael Marmot in his report[34] of February 2010 which was accepted by the Government. While a health service cannot solve all the problems associated with health inequalities, it can certainly make a difference where health and care interactions have an impact on people's lives.

27. The latest data shows that while life expectancy is increasing for all, **the difference in life expectancy** at birth between the local authorities in England with the highest and lowest figures was **11.5 years for males and 10.7 years for females**. These are both currently increasing, as set out in Diagram 7.

28. Despite overall differences in life expectancy increasing over time, the health service has made significant progress in reducing inequalities of some of the major killers.

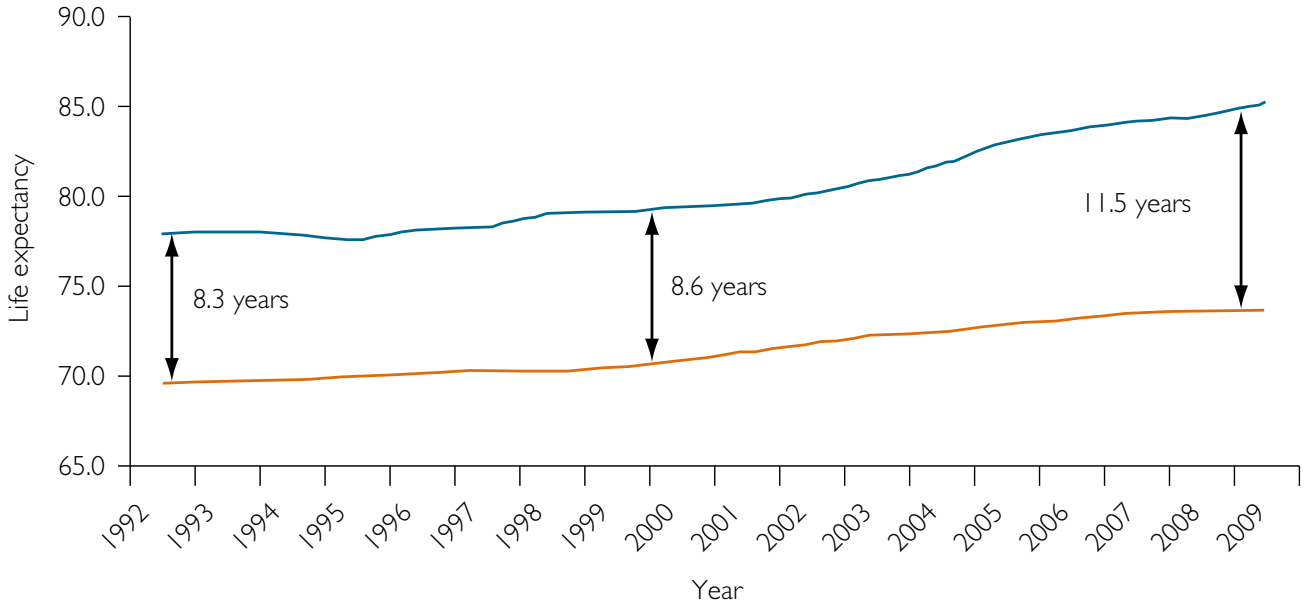
29. Diagrams 8 and 9 overleaf show that not only have death rates from cancer and from circulatory diseases fallen over time, the gap between the national average and disadvantaged areas has also narrowed.

30. Similarly, **infant mortality fell to 4.4 per thousand live births in 2008-10,** the lowest ever recorded. Furthermore, the rate of infant mortality fell by 20% in the 'routine and manual' group' compared to by 8% in the 'managerial and professional' group between 2002-4 and 2008-10, **showing a positive impact in addressing the social gradient associated with infant mortality**.

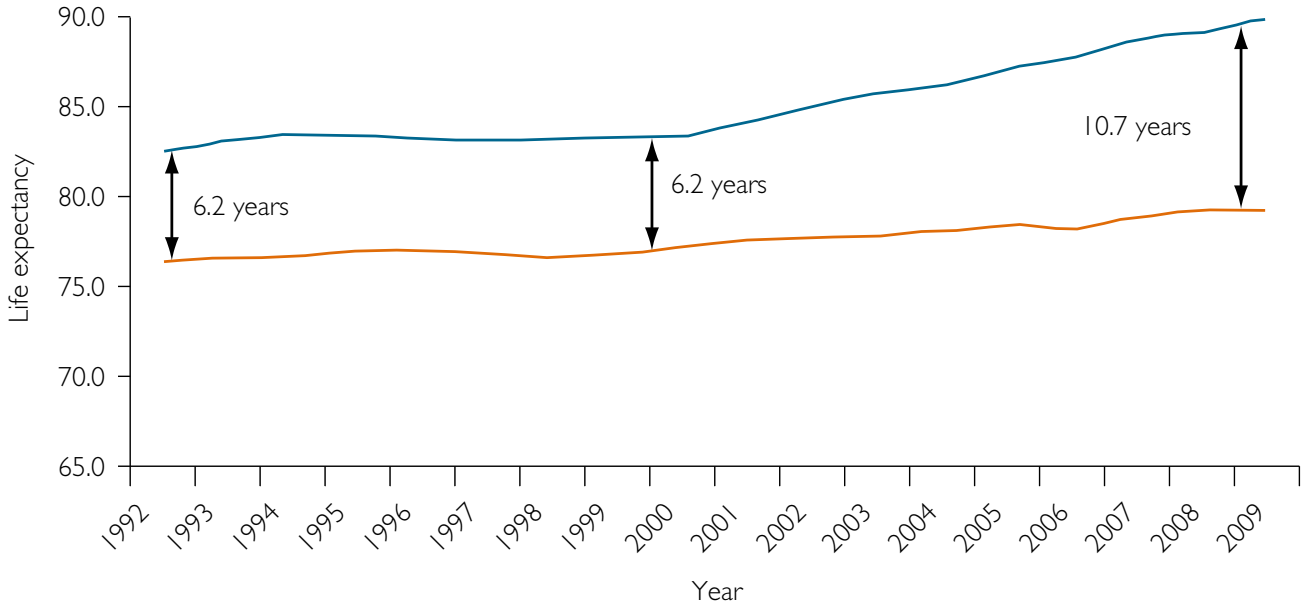
31. The data above illustrate the complexity of health inequalities – where inequalities in life expectancy continue to widen even when they are falling in some of the major killers. But the data also show that it is possible to achieve reductions in inequalities, to make real progress on outcomes. In cancer, cardiovascular disease and infant mortality quite a lot is now known about what can be done to improve outcomes in disadvantaged groups and areas. As a country, broader and deeper understanding is required about effective interventions to narrow inequalities across a much wider range of diseases and conditions, including mental health conditions. For example, people with mental health problems such as schizophrenia and bipolar disorder die on average 16-25 years earlier than the general population, and depression doubles the risk of coronary heart disease in adults. By embedding the need to address inequalities in the NHS and Public Health Outcomes Frameworks, establishing legal

Diagram 7: National variation in life expectancy

Variation in male life expectancy, between highest and lowest local authority



Variation in female life expectancy, between highest and lowest local authority



Source: Office for National Statistics, *'Life expectancy at birth and at age 65'*
http://www.ons.gov.uk/ons/rel/subnational-health4/life-expec-at-birth-age-65/2004-06-to-2008-10/ref-results-for-england-and-wales.xls

Diagram 8: Three year average death rates from Cancer 1999-01 to 2008-10 for persons under 75, comparing England and the areas which had the worst health and deprivation*

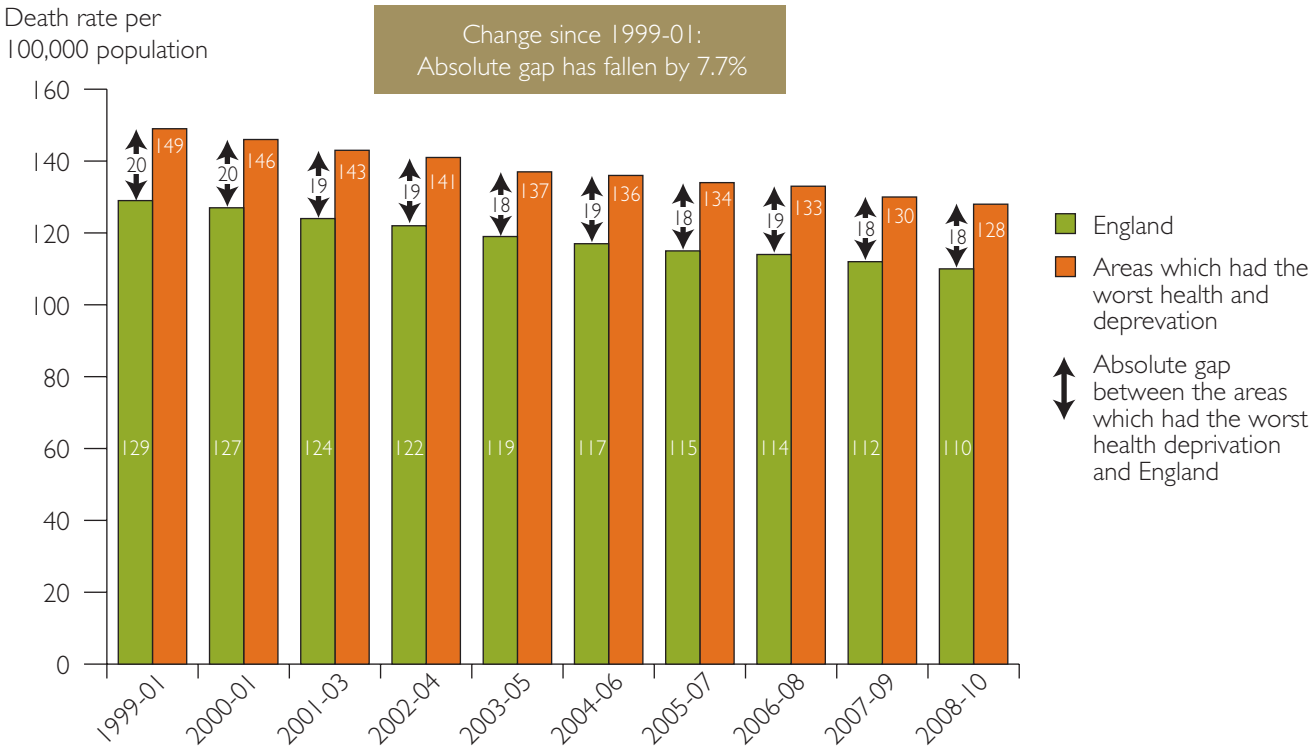
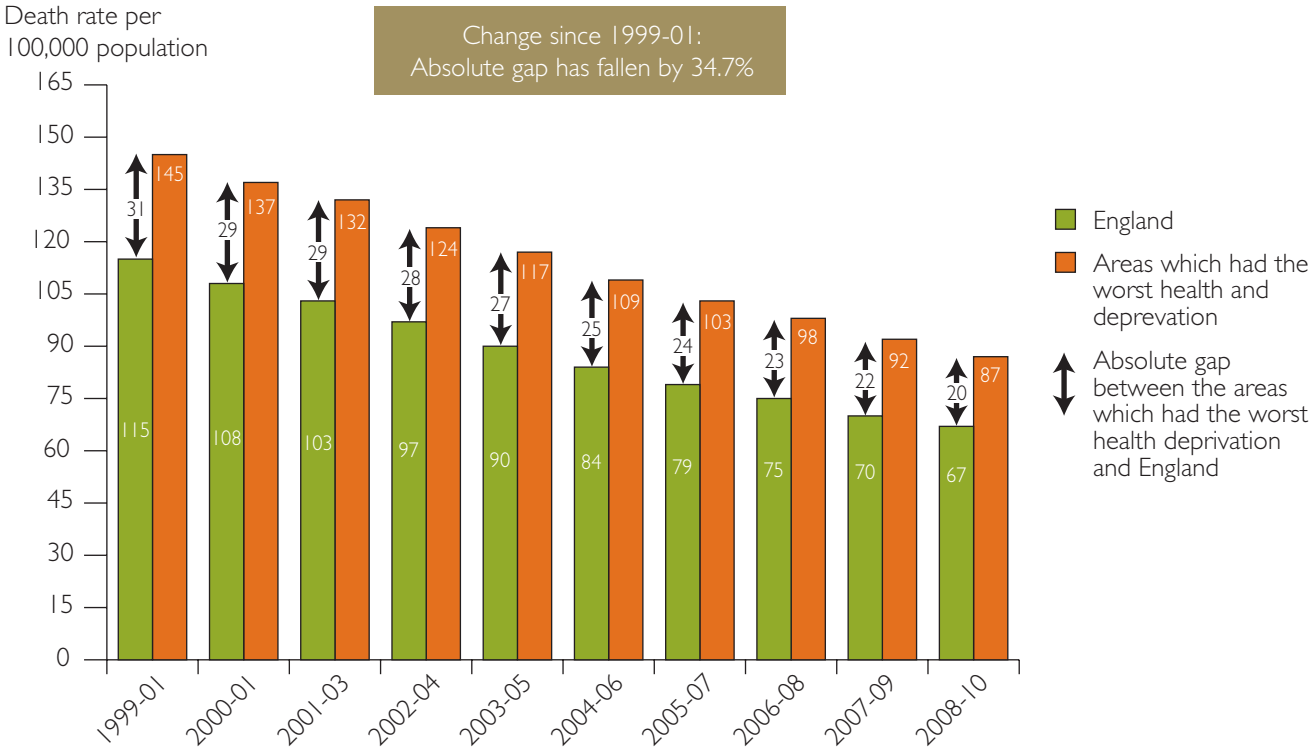


Diagram 9: Three year average death rates from Circulatory Diseases 1999-01 to 2008-10 for persons under 75, comparing England and the areas which had the worst health and deprivation*



* Source: Mortality Monitoring Bulletin: Life expectancy, all-age-all-cause mortality, and mortality from selected causes, overall and inequalities: Update to include data for 2010, published by DH 27 October 2011. Report based on DH analysis of ONS data.

duties for key organisations and setting expectations, the Department has put in place a framework to stimulate much greater focus and attention on the practical steps that can be taken to reduce health inequalities.

32. The Department, and organisations at all levels of the health, public health and care systems, are committed to reducing health inequalities and promoting equality by tackling the differences in access to, and outcomes of, NHS treatment; addressing the wider, social causes of ill health and early death; and improving individual healthy lifestyles. To do this, the Department has:

- **established legal duties on health inequalities** for the Secretary of State (including public health) and NHS commissioners, which build on the existing duties of all public bodies in relation to promoting equality;
- **supported the establishment of the University College London Institute of Health Equity** to help promote the findings of the Marmot review across the health and care system;
- **established the Inclusion Health Programme** to address the needs of those most vulnerable to poor health;
- ensured that the Public Health Outcomes Framework and the NHS Outcomes Framework have **a strong focus on reducing health inequalities**; and
- as part of the recent health reforms, the Department will also take on a new focus on building relationships across Government to address the root causes of health inequalities and the social determinants of health.

33. The Department has also introduced the **NHS Atlas of Variation**. This series was first published in November 2010 and expanded in December 2011, and supports local decision-making by highlighting variation. Through adjusting for different levels of need, and other external factors which can influence outcomes, the Atlas helps ensure that comparisons between areas are more meaningful, reflecting variation based on factors which NHS is able to influence, such as the spread of best practice or differences in care pathways. The Atlas highlights the importance of open and transparent data and supports the search for unexplained variations, helping clinicians work collaboratively to understand what is going on in their area. This can be a catalyst for driving quality improvement and reducing inequalities. The content of the Atlas is broad, supporting elements of all of the domains of the outcomes frameworks.

Health and Wellbeing for the Whole Population

KEY MESSAGE: The Public Health White Paper focuses on population health gain via wider determinants and the impact on behaviour across the life course. Changing adults' behaviour could reduce premature death, illness and costs to society, avoiding a substantial proportion of cancers, vascular dementias and over 30% of circulatory disease; saving the NHS much of the estimated £3.5 billion cost of alcohol misuse; and saving £13.9 billion a year, the societal costs related to drug-fuelled crime.

34. Public health has a vital role to play in preventing ill health, in keeping people healthy and in reducing health inequalities. The Health and Social Care Act 2012 transferred responsibility for commissioning the majority of public health services to local authorities, though the NHS retains responsibility for commissioning some specific public health services.

35. Stronger links between the NHS and public health are required. The NHS can support public health, for example through the implementation of 'making every contact count', following the recommendation of the NHS Future Forum. Improving public health also has significant potential to support the NHS, both directly and indirectly. It can help to keep people out of hospital, through improving health and preventing ill health, particularly in relation to smoking, alcohol and obesity. Improved physical health can also play an important part in improving mental health and wellbeing, which can in turn prevent the onset of mental health problems. It can also keep people in better health for longer, helping people to live the lives they want. In future years, the annual report will cover performance against all of these domains. This year, the focus is on key achievements and challenges.

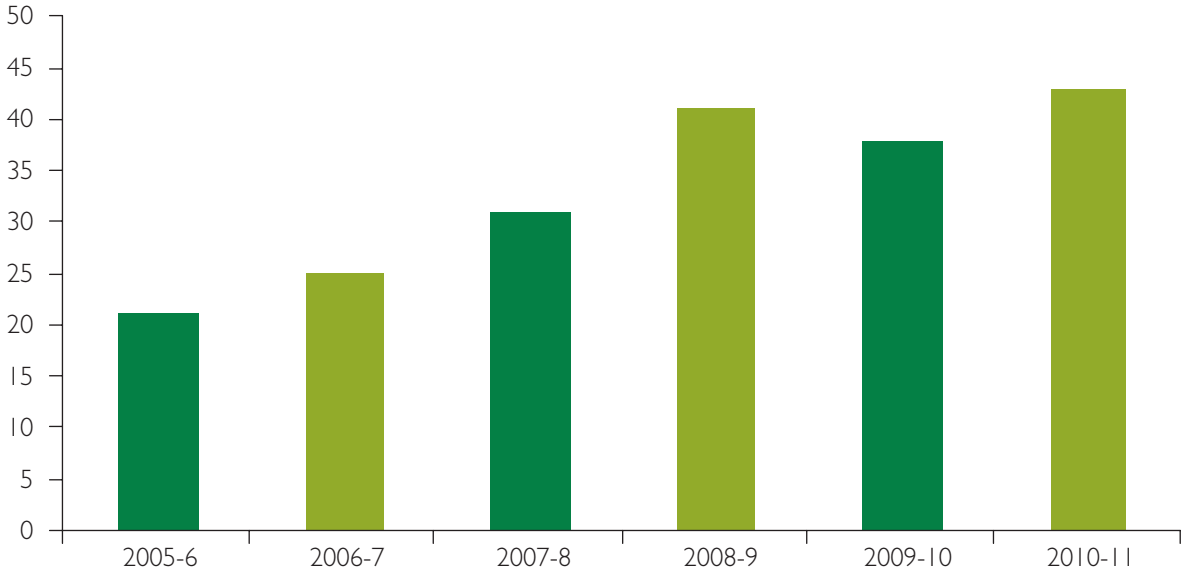
36. Future years of the annual report will see a greater focus on the Public Health Outcomes Framework, and the overarching objectives of achieving increased healthy life expectancy and reducing the differences in life expectancy and healthy life expectancy between communities. The nature of public health is such that improvements in these outcomes will take years - sometimes even decades - to see a marked change. The Public Health Outcomes Framework will therefore focus both on these longer-term objectives, as well as providing supporting indicators that will give a clear idea about whether progress is being made year-by-year.

Health improvement – challenges

Substance Misuse

37. The Government outlined its approach to tackling drugs and alcohol dependence in its Drugs Strategy: *'Reducing demand, restricting supply, building recovery: supporting people to live a drug free life'*[35]. The *Annual Review of the Strategy (2012)*[36] identified that the treatment system is improving. Diagram 10 below[37] shows the success of drug treatments over the last few years. The Department has worked on a number of initiatives across Government to contribute to this success – for example the development of eight drug and alcohol payment by results (PbR) pilots – which aim to shift the provision of drug

Diagram 10: Percentage of people completing drug treatment free of dependency



and alcohol treatment from engaging people in treatment to a recovery focus through financial incentivisation.

Smoking prevalence

38. Smoking rates are starting to decline, after having remained static for a few years. Table 11 opposite[38] gives estimates of smoking prevalence rates per region between July 2010 and June 2011. Local stop smoking services continue to be popular, and **provisional figures show 804,307 people set a quit date through NHS Stop Smoking Services between January and December 2011, 7% higher than the comparable figure for 2010**. Smokers who use NHS Stop Smoking Services are four times more likely to quit successfully than smokers who choose to quit alone.

39. **Legislation to end the sale of tobacco from vending machines came into force in England in October 2011**. As vending machines were self-service, they offered young people easy and poorly supervised access to tobacco, so banning them will reduce the number of young people starting smoking and extend a supportive environment for adult smokers who are trying to quit.

Table 11: Smoking prevalence by locality

Region	Sample size	Current smoker
North East	18,802	22.1%
North West	38,427	22.6%
Yorkshire and The Humber	25,774	22.9%
East Midlands	17,193	20.8%
West Midlands	25,341	20.5%
East of England	22,132	19.8%
London	29,437	19.7%
South East Coast	14,030	19.1%
South Central	20,876	18.4%
South West	24,791	19.5%
England	236,803	20.5%

40. The Department has also continued its programme of marketing communications to encourage people to stop using tobacco, for example through outreach work through the NHS Smokefree website and helplines, and the NHS "Quit Kit" that was made available through pharmacy partners over the New Year.

Alcohol

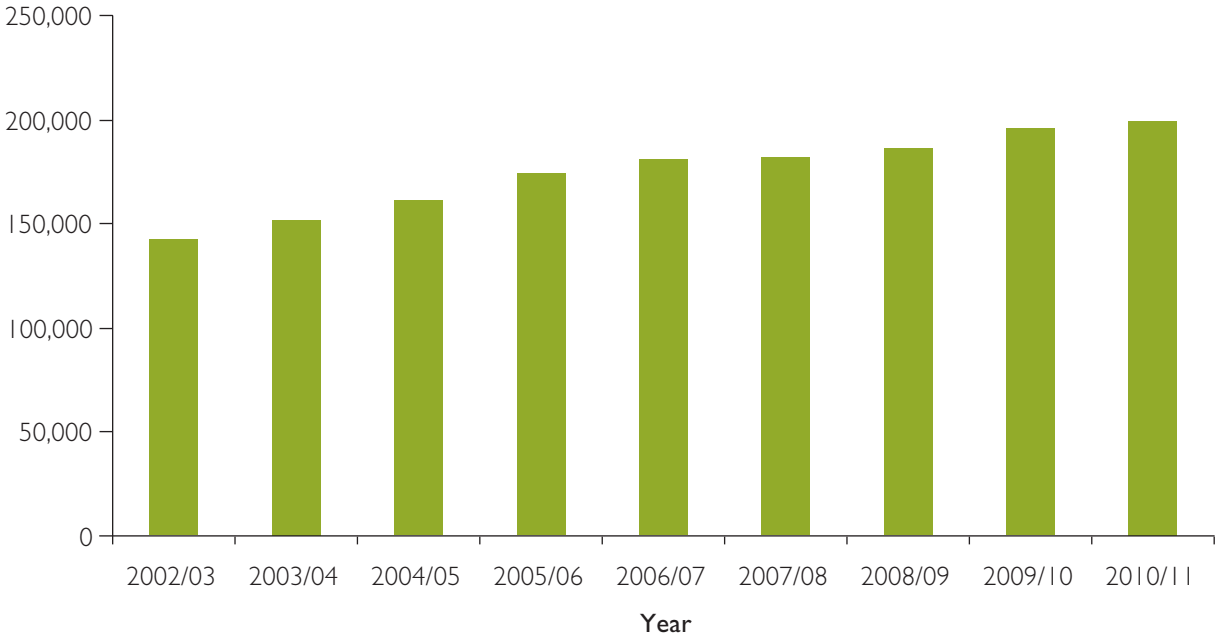
41. In March 2012, the Government's Alcohol Strategy[39] was published. The measures included within the Strategy show the determination to tackle the causes of alcohol misuse, including through ending the availability of cheap alcohol and ensuring that local areas have the powers they need to prevent harm to their communities. A billion units of alcohol will be shed by the alcohol industry by 2015 through a collective Responsibility Deal pledge through improving the choice available of lower strength products. Diagram 12[40] below shows that the number of admissions in England with an alcohol-related primary diagnosis has increased by 40% since 2002/03. **New estimates show that alcohol misuse costs the NHS around £3.5 billion every year,[41] which is the equivalent of £120 per taxpayer.**

42. Levels of excessive alcohol consumption have grown steadily over the past 50 years. It is estimated that in an average community of 100,000 people, each year:
    - **2,000** people will be admitted to hospital with an alcohol-related condition;
    - **1,000** people will be a victim of alcohol-related violent crime;
    - **over 13,000** people will binge-drink;
    - **over 3,000** will be showing some signs of alcohol dependence; and
    - **over 500** will be moderately or severely dependent on alcohol.

Obesity

43. In October 2011, the Department published '*Healthy Lives, Healthy People: A call to action on obesity in England*'.[42] This announced the Government's new national ambitions for a downward trend in excess weight in both children and adults by 2020 and sets out how, by working together, a wide range of partners will be able to make these ambitions a reality. It included a *calorie reduction challenge* to the nation to reduce its energy intake by 5 billion calories (kcal) a day. In 2010, the Health Survey for England[43] reported that 26.4 million (62.8% of the adult population) people in England were of excess weight with 11 million (26.1%) being obese. Obesity is a major driver of demand for health services – **the latest estimate of the cost to the NHS of overweight or obesity-related conditions is £5.1 billion each year.**[44]

Diagram 12: Number of admissions with an alcohol-related primary diagnosis



44. Obesity is a leading cause of serious diseases such as heart disease, cancer and type 2 diabetes. For example, there are currently 1.9 million people registered with type 2 diabetes, which is thought to be an underestimate, and it is estimated that there will be 3.4 million people suffering from type 2 diabetes by 2020. This increase is at least partly caused by projected increases in obesity. Type 2 diabetes is largely preventable, in particular through lifestyle changes such as a healthier diet and more exercise.

Family Planning

45. Statistics on conceptions, including teenage conceptions, are compiled and published by the Office of National Statistics (ONS).[45] The statistics for the first quarter of the 2011 calendar year show that in England in quarter 1 of 2011/12:
    - the under-18 conception rate **decreased by 13.5%** compared to quarter 1 of 2010/11;
    - the under-16 conception rate was 6.4 per thousand women, compared to 7.5 in quarter 1 of 2010/11, **a reduction of 14.7%**; and
    - the percentage of under-18 conceptions ending in abortion was 50.4%, compared to 50.8% in quarter 1 of 2010/11.

46. The Department has set its commitment to support breastfeeding through the Health Child Programme. The breastfeeding initiation rate was 74.0% in 2011/12, which is similar to 2010/11 (73.7%) The prevalence of breastfeeding at 6-8 weeks in quarter 4 of 2011/12 was 46.9% of all infants due a 6-8 weeks check, slightly higher than the figure of 45.3% recorded in quarter 4 of 2010/11.

47. The performance standard for the percentage of women having an assessment of their health and social care need, risks and choices by 12 weeks and six days of pregnancy is 90%. **The latest data indicates performance is being maintained above the standard**.

48. The Government is committed to doubling the number of places on the Family Nurse Partnership programme*, to at least 13,000 places by 2015. Progress on this commitment is on track, and as of April 2012 there were over 9,000 places available in 80 local areas, up from around 6,000 places in April 2011.

49. The Department has also launched the NHS Information Service for Parents[46] for parents-to-be and new parents, providing regular free emails and SMS messages offering timely NHS advice, and signposting them to other quality assured information.

Health improvement – what the Department has done

The Responsibility Deal

50. As an important part of the Department's wider approach to help people lead healthier lives, the Responsibility Deal[47] has engaged industry and other partners in promoting healthy living. The momentum of the Responsibility Deal continues to build, with over 390 partners signed up. Through working in partnership with business, the Department has delivered far more action, more quickly than it could have done through regulation. People are now seeing the results in their everyday lives:

* The FNP is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two.

- by the end of 2012, over 70% of high street fast food and takeaway chains will have calories on menus;
- 70% of retailers and around half of major high street restaurants have made significant reductions in salt, including in staples like bread, cakes, cereals and sauces;
- artificial trans fats have largely been removed from foods;
- 24 leading companies have made wide-ranging commitments to cap and cut calories, including Coca-Cola, Kraft, Mars, Nestle, Subway along with the biggest retailers; and
- by the end of 2013, 80% of drinks on shelves will have units clearly labelled and 34 major companies behind brands like Echo Falls, First Cape and Heineken have committed to taking a billion units off the market through providing a greater choice of lower strength products and smaller measures, as well as removing products from sale.

Change4Life

51. Change4Life[48] is a society-wide movement that aims to prevent people from becoming overweight by encouraging them to improve their diet and to exercise more. It is the marketing component of the Government's response to the rise in obesity.

52. Change4Life continues to enjoy very high levels of trust and engagement amongst its target audience – **awareness is over 85%**, and more than **570,000 families have joined the movement**.

53. Ambitious plans for the Department's summer physical activity campaign – **Games4Life**[49] – are also developing well. On 9 May, phase one of the campaign was launched at the School Games Finals in the Olympic Park, and more than 6,000 primary schools were sent Games4Life packs on the importance of being active every day.

Key Change4Life achievements

A million mothers say they have changed their behaviour as a result of the campaign. In January 2012, the Department's **Supermeals** campaign promoted quick, healthy meals on a budget. Results were very positive, with:

- record-breaking numbers of hits to the website and use of the online recipe finder;
- more than 630 pieces of coverage, making it the Department's most successful launch yet;
- over 4 million recipe planners distributed – 41% of people who got one took some action as a result; and
- in a small experimental study, use of the recipe planners led to a doubling of fruit and vegetable consumption and significant reductions in consumption of calories, saturated fat and salt.

February's **alcohol** campaign – the first under Change4Life – also landed very well:

- TV and digital advertising prompted more than 92,000 uses of the online drinks checker. Of the people who used it, more than seven in 10 said it would encourage them to drink less alcohol.
- overall, the campaign communicated effectively the long-term health harms associated with drinking over the guidelines and is steadily driving self-identification amongst its audience.

Awards and recognition

54. Department of Health staff have been recognised for their contribution at the Account Planning Group (APG) Creative Strategy Award 2011 where the Department won Gold for the Smokefree Generation campaign. At the Civil Service Awards 2011,

the Department won the Collaboration Award for the Public Health Responsibility Deal, and the Analysis and Use of Evidence Award for work revolutionising prison drug treatment in this country.

Mental health

55. The Public Health Outcomes Framework includes a range of indicators focused on mental health and wellbeing, as well as an indicator on the mortality of people with serious mental illness. Public Health England will publish national and local level performance data against each of these indicators, providing the evidence for local and national transparency and accountability of public health and other public services with a role in improving outcomes for people with mental ill health. At the same time, Public Health England will have a clear role in providing expertise and information on the best evidenced interventions for improving the public health and wellbeing of people and communities, as well as building this evidence base further.

Health protection

Immunisation

56. Measles, Mumps and Rubella (MMR) uptake in England has returned to levels not seen since 1998 when vaccination rates dipped following the publication of the discredited Wakefield research. MMR uptake (one dose by age 2) exceeds 90% in all SHA areas except London, where it is 85.6%. Vaccine uptake rates are lowest in London, but the rate of improvement is greatest in this area.

57. In March 2012, the latest coverage statistics for the Human Papillomavirus (HPV) vaccination programme were published[50]. HPV is one of the most common sexually transmitted infections. HPV types 16 and 18, (the types against which the vaccine primarily protects), cause over 70% of cervical cancer. The figures show that the high level of vaccine coverage achieved in 2008/09 and 2009/10 for the routine cohort (girls aged 12/13) was exceeded in 2010/11 with 84.2% of 12/13 year old girls completing the three-dose course. More than 700,000 doses of vaccine were given through the routine and mop-up programmes during 2010/11. These figures show that this vaccination continues to be a great success, and the UK has one of the highest HPV vaccination rates in the world.

Screening

58. The NHS Operating Framework 2011/12 states that commissioners should continue to ensure that cervical screening results continue to be received within 14 days. As recommended by the Advisory Committee on Cervical Screening (ACCS), the operational standard for achieving this has been set at 98%. As at the end of March 2012**, 98.1% of women were receiving their results within 14 days.**

59. As from 23 August 2010, all PCTs in England were offering bowel cancer screening to people in the 60 to 69 years age range who are registered with a GP. As at the end of March 2012, over **13 million kits** had been sent out and over nearly **8 million** returned. **Over 12,000 cancers had been detected**, and over 62,000 patients had undergone polyp removal. The NHS Bowel Cancer Screening Programme is currently being extended to men and women aged 70 to 74. When the extension is fully rolled out, **around 1 million more men and women will be screened each year.**

60. The age extension of the breast screening programme has now started and full roll-out to women aged 47-49 and 71-73 is expected to be completed after 2016. A randomised control trial evaluating the net effects of extending the age range for breast screening is now underway. At the end of March 2012, 52 out of 80 local programmes had implemented the extension randomisation and a further nine were unsuitable for randomisation and were inviting only the 47-49 year-olds. 19 programmes are still to

expand, citing lack of digital mammography, staffing shortfalls and funding as issues.

61. A phased roll out of the national abdominal aortic aneurysm screening programme, which screens men aged 65, began in spring 2009. Data from the NHS Abdominal Aortic Aneurysm Screening Programme show that, as of March 2012, **160,000 men** had been screened by the programme **with 2,500 abdominal aortic aneurysms detected for the first time.** Uptake of screening has been over 80% during the first three years of the programme.

Winter planning

62. Due to the efforts of all NHS organisations in recent years on winter preparedness, the NHS coped particularly well last winter. Levels of flu were considerably lower than the year before. Vaccination rates went up for most of the targeted groups.* The Department is making every effort to ensure the health service is as prepared as it can be for 2012/13.

* For people aged 65 and over, the vaccination uptake rate in 2011/12 was 74%, compared with 73% in 2010/11. For 'at risk' people under 65, this was 52% compared to 50% in the previous year. 45% of frontline healthcare workers were vaccinated, compared to 35% in 2010/11. However, vaccination rates for pregnant women fell, from 37% in 2010/11 to 25% in 2011/12 for healthy women, and from 57% to 51% for those considered 'at risk'.

A Focus on: Making People's Care more Integrated

KEY MESSAGE: Care is "integrated" when it is joined up around the needs of people, their families and their carers. Whilst integration of care processes, services and structures may help in efforts to achieve this, the evidence shows that adopting an approach to care that is centred on the individual is the key to success.

63. All parts of the system need to contribute if care is to be more integrated. The 2012 Act provides the basis for better collaboration and interaction between partners in the reformed system. CCGs, the NHS Commissioning Board and Monitor all have duties to promote integrated care. Health and wellbeing boards will encourage commissioners of both social care and healthcare to work in more integrated ways. There will also be a renewed focus on social care reform and the links between social care and the health system, as will be emphasised in the forthcoming Care and Support White Paper and Bill.

64. **In March 2012, the Department published a report on a two-year independent study of local areas who had piloted new approaches to integrated care in their areas**[51]. The evaluation looked at 16 sites across England and found that there is no single approach that suits all situations. This provides a key lesson from the study: local initiative will be critical in shaping the pace and direction of improvements in integrated care.

65. The Department is currently running another pilot study in a closely related-area – personal health budgets – which offer a more personalised way of funding the care of people with a high level of need. As with integrated care, personal health budgets put the person at the heart of decision-making about their care. The final evaluation of this study will be published in October this year and should help inform system-wide improvements in integrated care.

66. As highlighted in the report from the second NHS Future Forum in January this year, the Government recognises that more still needs to be done to improve integrated care. The Department is therefore very keen to work collaboratively with a range of partners and stakeholders, to share a better understanding of integrated care and what is needed to do to make this a reality. As part of this journey, one of the key tasks for the Department this year and next will be to improve the ways integrated care is measured, to help ensure that it improves continuously.

Promoting Growth, Innovation and Research

KEY MESSAGE: Health research plays a key role in improving the health of the people of this country by enabling decisions about health and social care policy and practice to be based on the most reliable and relevant evidence. Research stimulates the economic growth of the country by supporting a vibrant, world-class NHS platform for research investment by the life-science industry.

67. The Government is committed to the promotion and conduct of research as a core function of the health service. The Department's commitment to research is reflected in the two main documents that drive performance and behaviour in the NHS – the 2011/12 NHS Operating Framework and the 2011/12 NHS Outcomes Framework.

National Institute for Health Research

68. The **National Institute for Health Research** (NIHR) is funded by the Department to improve the health and wealth of the nation through research. Through the NIHR, the Government is increasing the volume of applied health research for the benefit of patients and the public, driving faster translation of scientific discoveries into tangible benefits for patients and the economy, and developing and supporting the people who conduct and contribute to applied health research. During the last year, the NIHR has taken the following major actions to speed up the translation of advances in basic research into benefits for patients and the economy:

- **In August 2011, the Government announced a record £800 million investment**[52], over five years from April 2012, for 11 NIHR Biomedical Research Centres and 20 Biomedical Research Units supporting research across a wide range of disease areas including dementia.
- **In March 2012, the Government announced two new NIHR Patient Safety Translational Research Centres**, which will carry out research to advance and refine new ways of improving safety in hospitals and in the community, which will translate into real benefits for patients.
- **In March 2012, the Government announced that over £100m will be invested in 19 NIHR Clinical Research Facilities** around the country to develop new treatments to benefit thousands of patients.
- **The Government is also working in partnership with Cancer Research UK to fund Experimental Cancer Medicine Centres by jointly investing £35m funding over the next five years.**

Key research developments funded by the NIHR infrastructure

The NIHR's Biomedical Research Centre at South London and Maudsley NHS Foundation Trust was commended at the Health Service Journal awards for developing a brain scan that can **detect the early signs of Alzheimer's disease**.

A new trial at the NIHR Biomedical Research Centre based at Moorfields and the UCL Institute of Ophthalmology is investigating the safety of **using retinal cells** derived from stem cells to treat people with advanced **Stargardt disease**, a form of macular degeneration that causes disabling loss of sight in young people. The trial may offer hope to young people suffering from Stargardt disease, which is currently an untreatable inherited eye condition.

Research undertaken by researchers at the NIHR Collaboration for Leadership in Applied Health Research and Care in Nottingham found that outcomes for service users with **depression** associated with physical health conditions are improved by close cooperation between their GP and mental health services, including a psychiatrist. This was found to be the case for both the short (6 months) and longer (5 years) terms.

Research Programmes

69. In March 2012, the NIHR completed the call for proposals for applied health research on dementia.[53] **This will see over £17m research funding for research on projects that aim to improve the quality of life for those living with dementia and the people who look after them**.

70. During the course of the last year, following research supported through the NIHR Health Technology Assessment Programme, the Department announced plans to encourage the introduction of an innovative life-saving emergency treatment into the NHS, for use following serious accidents and violent incidents such as stabbings. **This decision is expected to save many lives that would otherwise be lost by preventing post-trauma catastrophic blood loss.**

71. **In the Plan for Growth,[54] the Government made a commitment to build a consensus on using e-health record data to create a unique position for the UK in health research.** The Department published the Government's plan for a secure data service on 31 October 2011 called the Clinical Practice Data Research Datalink (CPRD), which came into operation on 29th March 2012. The Health and Social Care Information Centre will launch a complementary secure data linkage service in September 2012 which will deliver data extracts using linked data from primary and secondary care and other sources on a routine basis, made available at an unidentifiable, aggregate level. Those undertaking formal research will go to CPRD for data linkage and the Information Centre will deliver the linkage on behalf of CPRD. The Information Centre will provide linkage services directly to customers where the purpose is not formal research.

Increasing access to research evidence

72. The Government supports the principle that ideas and knowledge derived from publicly funded research must be made available and accessible. The Department has made significant progress in putting the principle into practice. The flagship NIHR Health Technology Assessment programme has already established an open access journal for its research outputs: *Health Technology Assessment*. The journal is ranked in the top 10% of medical and health-related journals. In 2011, the web-site received nearly half a million visits. All issues are available for download free of charge from the NIHR Health Technology Assessment website.

NIHR Professorships

73. In February, the Department announced the results of the first round of nominations for the NIHR Research Professorships. These awards support up and coming research leaders in the early part of their research career who have shown the ability to promote effective translation of research from 'bench to bedside' or from 'campus to clinic'. These individuals are expected to become the senior leaders of translational research in the future.

Innovation, Health and Wealth

74. Innovation, Health and Wealth, the NHS Chief Executive's report on the adoption and diffusion of innovation in the NHS, sets out a delivery agenda for translating research into practice – spreading innovation at pace and scale throughout the NHS. It includes a number of actions that will deliver improvements in the quality and value of care delivered in the NHS, making sure patients get the highest quality care, even during times of financial constraints. In particular:

    - it requires a change in culture so that staff have the right knowledge and skills;
    - it means working collaboratively with all those who have an interest in healthcare, whether from industry, academia or the scientific community;
    - it means aligning strategic priorities, with compelling evidence, with leadership and with staff engagement; and
    - it means empowering patients to make informed choices, driving change through their actions.

75. Innovation, Health and Wealth sets out what the NHS and its partners must do to achieve this and make the spread of innovation central to all the Department does. The actions are designed to achieve a systematic change in the way the NHS operates. It sets an ambition for the NHS: a commitment to innovation; support for research; and the rapid adoption of the best, most transformative, most innovative ideas, products and services.

Education, Training and Workforce

KEY MESSAGE: Services have focused on front-line care and have reduced administrative staffing levels. For example, there has been a significant amount of work done towards meeting the Government's commitment to increase the number of health visitors by 4,200 by April 2015.

76. In January 2011, the Department published '*Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*'[55]. This document sets out a strategy for improving workforce planning, education commissioning and quality assurance of education and training. The ambition is to build a flexible workforce that can respond rapidly to future challenges, that aspires to excellence in training to improve trainee experience, and is supported by a fairer and more responsive funding system.

Workforce Data

77. The number of full time equivalent staff employed in the Hospital and Community Health Services between April 2011 and March 2012 is shown in table 13 below[56]. The data does not include primary care, staff working in social enterprises, bank or agency staff. The table shows that total numbers of staff have declined slightly by 0.6%, or 6,200 Full Time Equivalents (FTEs). Of this change, professionally qualified clinical staff numbers

Table 13: Full Time Equivalent staff numbers employed in Hospital and Community Health Services between April 2011 and March 2012

	Apr-11 ('000s)	May-11 ('000s)	Jun-11 ('000s)	Jul-11 ('000s)	Aug-11 ('000s)	Sep-11 ('000s)	Oct-11 ('000s)	Nov-11 ('000s)	Dec-11 ('000s)	Jan-12 ('000s)	Feb-12 ('000s)	Mar-12 ('000s)	% change
Professionally qualified clinical staff	**558**	**558**	**557**	**556**	**556**	**557**	**560**	**561**	**560**	**561**	**561**	**560**	**0.4%**
Of which:													
All HCHS doctors (incl locums)	100	99	99	100	101	101	102	102	102	102	102	101	2.0%
Qualified nursing, midwifery & health visiting staff	309	309	308	307	306	306	308	309	308	308	308	308	–0.3%
Total Qualified scientific, therapeutic & technical staff	132	132	131	131	131	132	132	133	132	133	133	133	0.8%
Qualified ambulance staff	17.8	17.8	17.8	17.8	17.8	17.9	18.0	18.0	18.0	18.0	18.0	18.0	0.9%
Non-clinical staff	**487**	**485**	**484**	**482**	**481**	**480**	**480**	**480**	**478**	**479**	**479**	**478**	**–1.7%**
Of which:													
Support to clinical staff	293	293	292	291	291	291	290	290	289	290	290	289	–1.3%
NHS Infrastructure support (excluding managers)	156	155	155	154	154	153	153	153	153	153	153	153	–2.1%
Managers & senior managers	37.3	37.2	37.0	36.8	36.6	36.6	36.5	36.5	36.4	36.3	36.2	36.1	–3.3%
Total	**1,044**	**1,043**	**1,041**	**1,038**	**1,037**	**1,038**	**1,040**	**1,041**	**1,038**	**1,040**	**1,040**	**1,038**	**–0.6%**

Source: Taken from the NHS Health and Social Care Information Centre.

increased by 0.4%, or 2,300 FTEs, while non-clinical staff numbers fell by 1.7% or 8,500 FTEs. The proportionate fall was particularly large for managers and senior managers, where total numbers fell by 3.3%.

Education and training commissions: non medical

78. Diagram 14 below shows the number of training places commissioned in the main professional groups between 1996/97 and 2012-13.

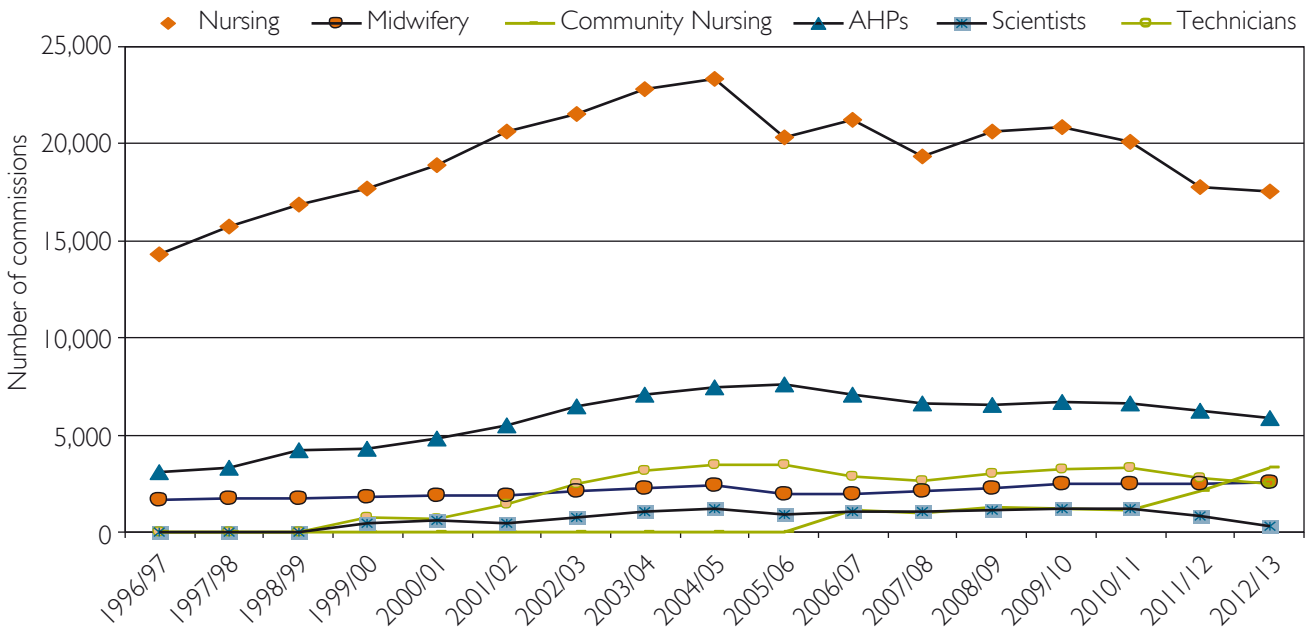
Nursing

79. Responding to recommendations on the quality of nursing care from the NHS Future Forum, the Prime Minister set up the Nursing and Care Quality Forum. The Department and the Nursing and Midwifery Professional Advisory Board will examine and make recommendations on best practice in recruiting, training and inducting nurses, to produce a nursing workforce with the right set of values and behaviours for the NHS. This work will be taken up by Health Education England, which will ensure that training commissioning levers and national contracts will be used to standardise the quality of recruitment processes.

Increasing the numbers of health visitors

80. The Government committed to increase numbers of health visitors by an extra 4,200 (over 50%) by April 2015. This extra capacity will increase the ability for local teams to improve public health outcomes and to provide personalised care. Thanks to the concerted support of the profession itself, the NHS, Higher educational institutions and wider partners, the system is on track to meet the commitment, with over 6,000 new health visitors being trained before 2015. **In 2011/12, three times as many health visitors began training compared to in 2010/11**. Diagram 15 shows the increase in health visiting training commissions since 2010, as well as planned growth to 2015.

Diagram 14: Non-medical commissions 1996-97 to 2012-13



Notes:
2012-13 figures are planned
Groupings of professions changed in 2012-13
Figures are based on financial years

Source: SHA monitoring returns since 1999/2000

Apprenticeships

81. Meanwhile, the service continues to make progress on implementing innovative aspects of education and training. One particular example is the way in which plans for Apprenticeships are being developed. NHS Employers leads this key national activity with employers in the NHS and represents the NHS on the national Apprenticeship Ambassador Network (AAN).

Case Study: Implementation of Apprenticeships in the North West of England

In 2011/12, NHS trusts in the North West employed over 27% (2,500) of the Apprentices. This region is leading a sustainable whole community workforce plan with all their NHS employers. From a baseline in 2009/10 of 240, the North West alone has supported over 5,500 Apprenticeships – 46% of which were in 2011/12.

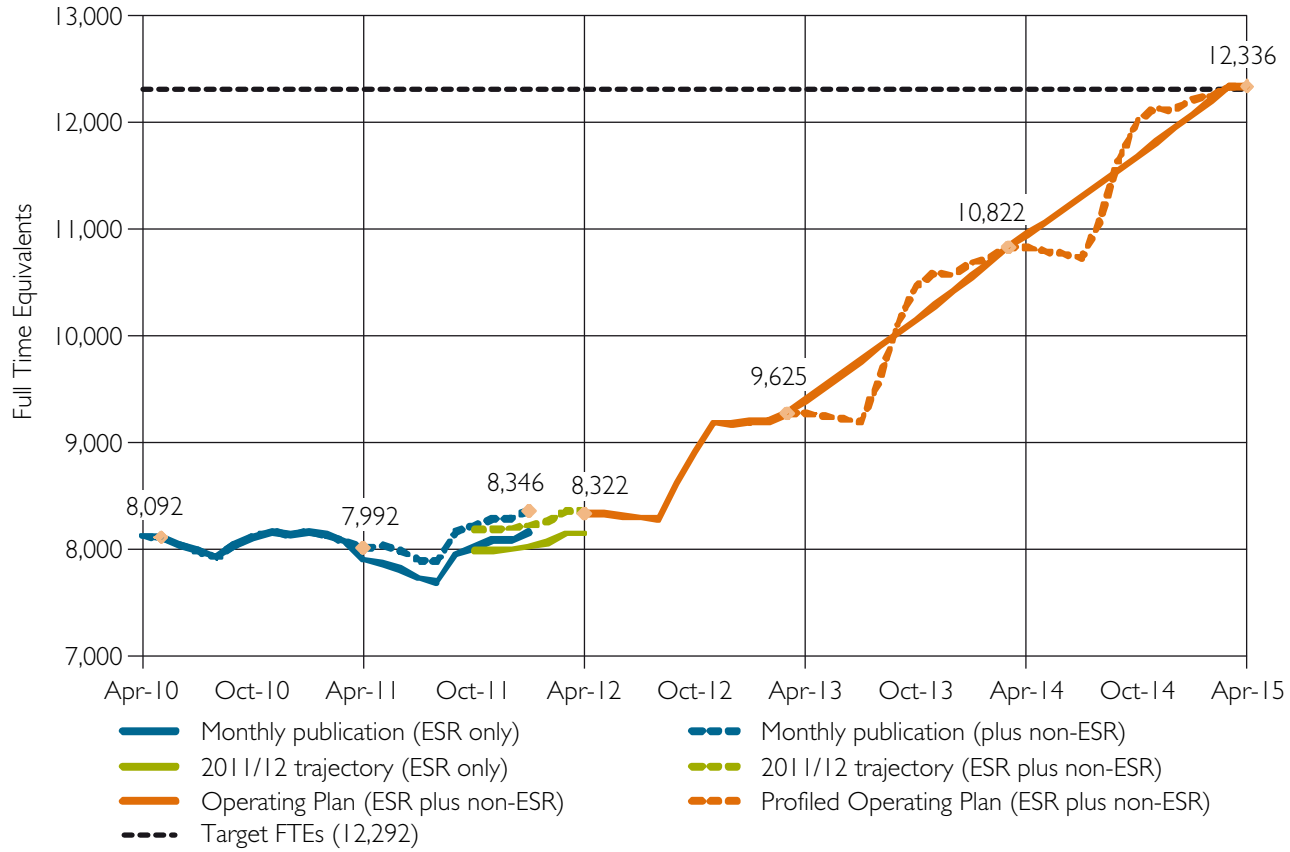
Modernising Scientific Careers

82. The UK wide Modernising Scientific Careers (MSC) programme has made significant progress, covering all aspects of healthcare science education and training, including the establishment of a National School (Deanery) of Healthcare Science and a lead national commissioner. To date there are 13 accredited Higher Education Institutions offering BSc (Hons) degrees supporting the practitioner training programme with 268 new trainees enrolled. In addition, in 2012, there will be over 400 new scientist trainees in the system, including those supported by SHAs and employers in an in-service training model.

Medical training and medical and dental school commissions

83. The number of medical and dental students entering university for each year is shown in Diagram 16 below, and has remained broadly constant since 2004/5. The Better Training

Diagram 15: Health Visitor trajectories, England



Better Care taskforce, chaired by Sir Jonathan Michael, is taking forward national work to implement the recommendations of Sir John Temple[57] and Professor John Collins in junior doctor training and workforce practice. This includes working with the General Medical Council to improve the Foundation Programme curricula.

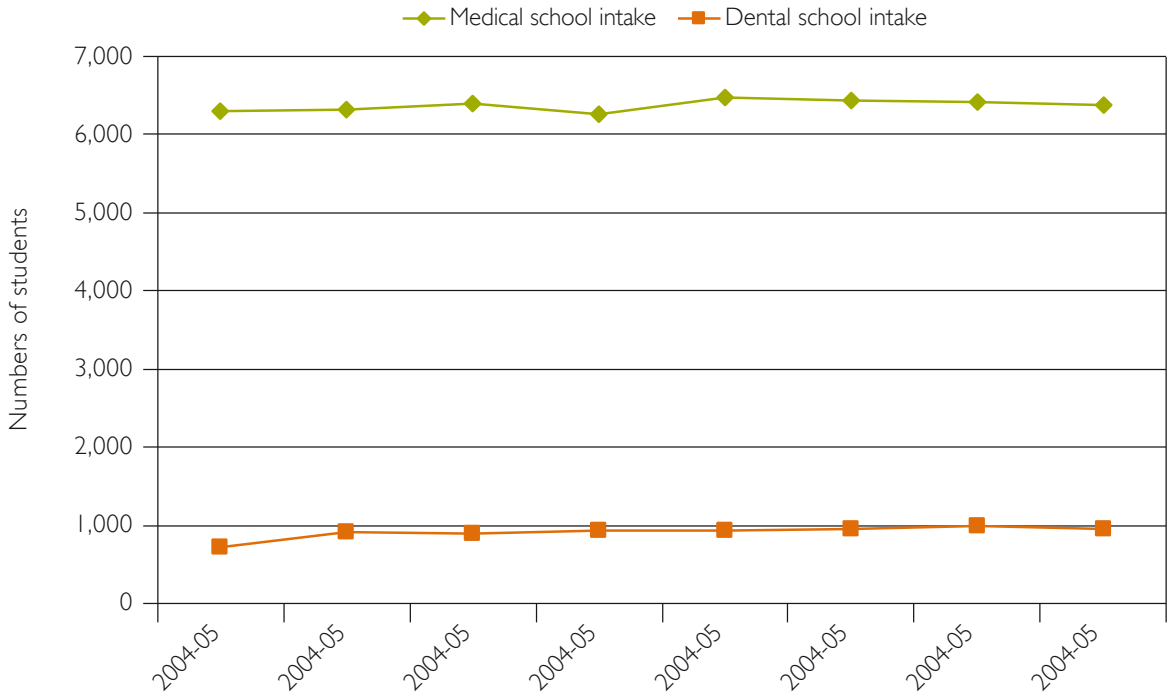
Supporting staff

84. To support the health and wellbeing of NHS staff, there has been a drive to provide improved access to quality occupational health and staff support services. Promoting staff health and wellbeing can help reduce sickness absence, which costs the NHS around £1.7 billion each year and places additional pressure on colleagues.

85. The latest report published by the NHS Information Centre, provided the results for October to December 2011. This showed that sickness absence has fallen from 4.47% to 4.35% compared to the same quarter in 2010. The underlying rate of sickness absence fell from 4.48% in 2009 to an average of 4.08% over the 12 months to December 2011. The value of the staff time this realises is £170 million.

86. The results of the latest NHS Staff Survey show that 87% of staff said they feel satisfied with the quality of care they provide to patients, with 90% of staff feeling their role makes a difference to patients. These figures are the same as in 2010. There continues to be an increase in the proportion of staff receiving appraisals, up from 77% in the 2010 survey to 80% in 2011. However, staff engagement fell marginally across NHS trusts between 2010 and 2011.

Diagram 16: The number of medical and dental students entering university per year



E: Future years: The Role of the Secretary of State's Annual Report

E: Future years: The Role of the Secretary of State's Annual Report

1. This year's Secretary of State's Annual Report introduces the concept of the Annual Report itself and sets the tone for reports in future years. The intention is that future reports should be focused on outcomes rather than process measures and system change. There are already a number of different annual reports produced across the health system, and the Secretary of State's annual report will complement these existing publications.

2. The Department provides an annual audited group account both for itself and for organisations within the Department's resource accounting boundary. This consolidated account reports financial information across the system, and is laid before Parliament. The Department's Year End Annual Report also includes a Governance Statement written by the Permanent Secretary in her capacity as Principal Accounting Officer. The Governance Statement reflects the control structure of the organisation, outlines how successfully the organisation has managed risks and performance and what assurance has been given in this regard. It also reflects significant control issues reported in the individual Governance Statements of underlying organisations within the resource accounting boundary to the extent that those issues are material at the overall group level.

3. The Chief Medical Officer produces an annual, independent report to government, 'on the State of the Public's Health.' The first report was published 154 years ago and this year's report will add to this historical record. Over the years, Chief Medical Officers have produced different styles of report but the purpose has always been the same; surveillance of the public's health and independent advocacy.

4. The Secretary of State's Annual Report will link to the Chief Medical Officer's report, and at its heart will be the demonstration of the Secretary of State's accountability for the health service. In future years, there will be three core components of the report.

   a) **Performance of the health service.** This will include all NHS and public health services commissioned by the NHS Commissioning Board, CCGs, local authorities and the Secretary of State.

   b) **Secretary of State's statutory duties.** The Secretary of State will be required by the Health and Social Care Act 2012 to report on quality improvement and the reduction in health inequalities. The report would also be expected to cover all of Secretary of State's duties.

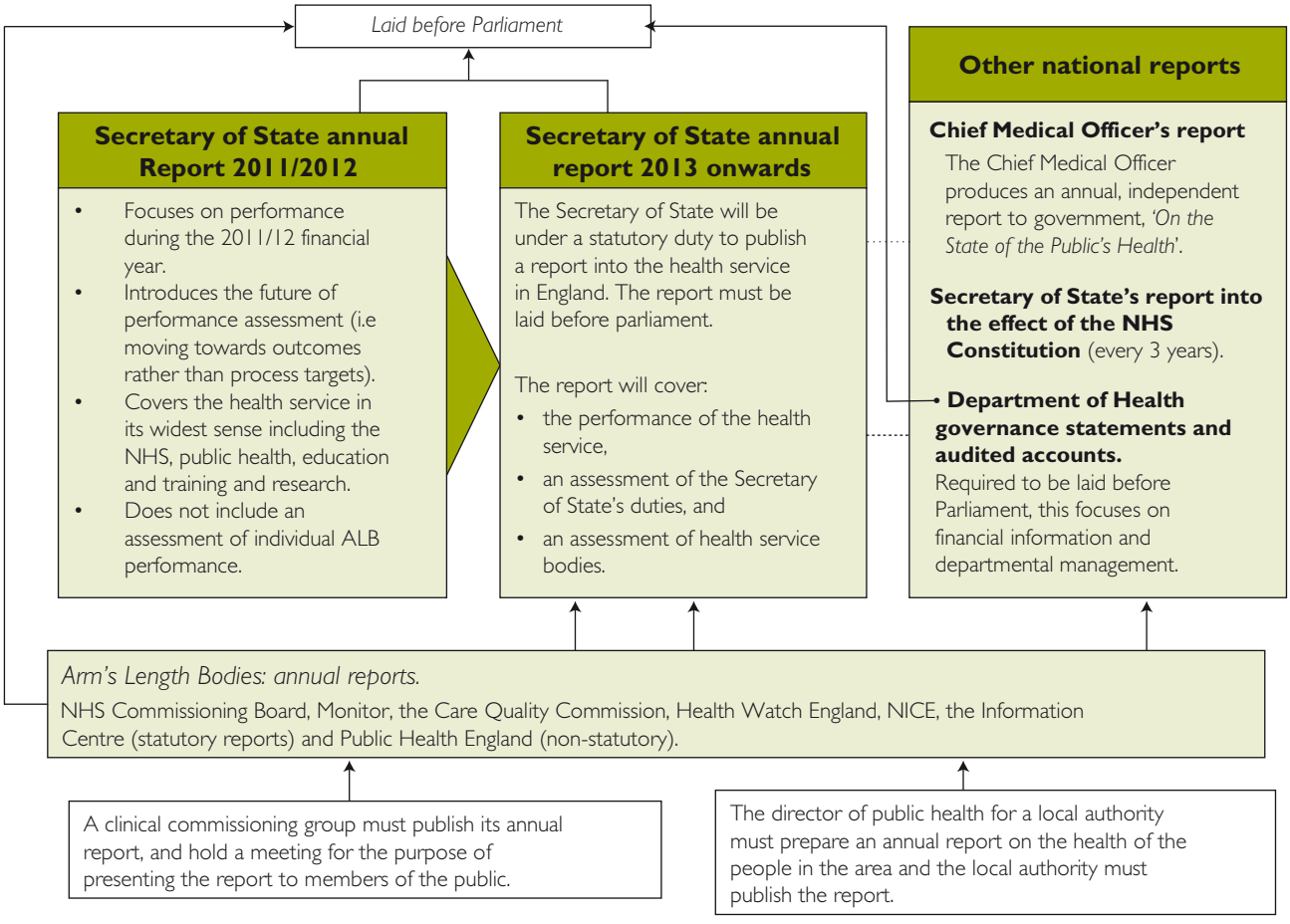
   c) **Assessment of health service bodies.** The Health and Social Care Act 2012 allows the Secretary of State to include as assessment of the exercise of the legal

functions of the NHS Commissioning Board, Monitor, the Care Quality Commission, Health Watch England, NICE, the Information Centre.

5. As many of the duties of new Arm's Length Bodies will be commenced from 1 April 2013, next year's report (covering the performance during the 2012/13 financial year) will be unable to conduct a full assessment of all of these organisations. There will, however, be more to say about how bodies have been preparing to take on their full functions. The first full assessment of how these duties have been exercised will take place in the report on the performance of the health service in 2013/14.

6. Whilst this year's report has been published in July, publication of future reports is expected to take place in October. This will allow individual Arm's Length Bodies time to publish their own annual reports and to publish final accounts for the previous financial year. The diagram below shows the changing role of the Secretary of State's report between 2011/12 and 2012/13 and how it fits with other reports.

Diagram 17: Key annual reports and the changing role of the Secretary of State's report



Glossary

Clinical Commissioning Groups – Clinical Commissioning Groups are groups of GPs and other health professionals that will be responsible for designing local health services in England from April 2013.

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Commissioning for Quality and Innovation (CQUIN) framework – the CQUIN framework enables those commissioning care to pay for better quality care, helping promote a culture of continuous improvement.

Duty – a legally-defined responsibility to perform certain acts or meet certain standards of performance.

Foundation trusts – NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control, enabling them to be more responsive to the needs of local populations.

National Clinical Audit – assesses the quality of patient care across all NHS providers by measuring activities and outcomes, using that information to stimulate clinicians to improve their performance, to help patients choose providers, to guide commissioners, and to support regulation and performance management.

NHS Constitution – the NHS Constitution describes the principles and values of the NHS in England, and the rights and responsibilities of patients, the public and staff.

NHS Operating Framework – the Operating Framework sets out the priorities for the NHS for each financial year.

Patient Reported Outcome Measures (PROMs) – PROMS provide information on how patients feel about their own health, and the impact of the treatment or care they receive.

Personal health budget – an extension of personalised care planning, that gives people more choice and control over the services they receive by giving them more control over the money that is spent on their care.

Primary care trusts (PCTs) – the NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services such as district nursing, for a local area. The 151 PCTs have been clustered into 51 PCT Clusters.

Provider – organisations which provide services direct to patients, including hospitals, mental health services and ambulance services.

Strategic health authorities (SHAs) – the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level. These 10 bodies have been clustered into 4 bodies.

Venous thromboembolism (VTE) – a condition in which a blood clot (thrombus) forms in a vein. An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system.

Endnotes

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