Treasury Minutes on the First, Second and Fourth Reports from the Committee of Public Accounts 2004-2005

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TREASURY MINUTES DATED 6 APRIL 2005 ON THE FIRST, SECOND AND FOURTH REPORTS FROM THE COMMITTEE OF PUBLIC ACCOUNTS, SESSION 2004-2005

First Report

Home Office

Prison Service

The management of sickness absence in the Prison Service

PAC conclusion (i): The Prison Service continues to experience unacceptably high levels of sickness absence of 14.7 days on average per person in 2002-03 with over 20 per cent of staff taking 11 days or more per annum. The Prison Service should set annual sickness absence milestones to increase momentum towards reducing average sickness absence in prisons to the target of nine days per person.

1. The Prison Service (the Agency) accepts this recommendation. The original target of nine days set in 1999 was calculated on the basis of reducing absence rates by 30 per cent from the 1998-99 baseline, in line with targets set across government departments by the Cabinet Office. At the time, absence rates in the Agency were reported at 12.6 days. However, as the Comptroller and Auditor General's report has acknowledged, reported sickness absence rates in the Agency at the time were deflated due to significant levels of under recording, possibly by as much as 25 per cent. Actual rates in 1998-99 may have been as high as 15.9 days. The Agency has implemented a broad and robust strategy to reduce sickness absence. As part of this strategy, milestone targets were first introduced in April 2003 and set at reducing the average sickness absence rate to no more than 13.5 days for the financial year 2003-04.

2. As reported in the Comptroller and Auditor General's report, the Agency exceeded that milestone, with average sickness absence for the financial year at 13.31 days per member of staff. A new milestone of 12.5 days was set in April 2004 in respect of the financial year 2004-05. Average sickness absence rates in the Agency had fallen to 12.7 days in the 2004 calendar year. A new milestone target has recently been agreed of 11.5 days for 2005-06 and further milestones will be set in future years to reduce absence rates further.

3. The Agency remains committed to reducing sickness absence rates as far as possible, although when comparing sickness rates against other employers it is necessary to take account of the physically demanding nature of the work of prison officers and the attendant risk of assault, which adds of the order of one day per year to the average sickness absence rates. This is acknowledged in the Comptroller and Auditor General's report, which notes that at least seven per cent of sickness absence in the Agency can currently be attributed to assaults and accidents at work. Nevertheless, the Agency is committed to securing a 30 per cent reduction in sickness absence by 2007-08, based on a revised and more accurate 1998-99 baseline of 15 days and is therefore working to ensure average sickness absence rates are reduced to no more than 10.5 days by March 2008. Further milestones will then be agreed towards the long-term target of nine days by 2010.

PAC conclusion (ii): The Prison Service should consider whether more rigorous checks could be carried out at the recruitment stage to identify candidates' potential health and fitness risks. The stressful and physically challenging nature of the work may contribute to sickness levels, and the Service needs to be confident that recruits have the necessary aptitudes.

4. The Agency accepts this recommendation and has already taken significant steps to improve the assessment of the health and fitness of potential recruits. In addition to general health screening of all recruits by occupational health specialists prior to an offer of employment being made, all prison officers who joined the Agency after April 2001 have been required to pass a mandatory job related fitness test as part of the selection process, and to repeat the test on an annual basis. Failure to pass the test may result in the officer's dismissal. Results of an internal study show that officers who are required to pass the annual fitness test take an average of 12 per cent less sickness absence than a comparative cohort of officers who joined prior to April 2001. Work is also underway to identify safe and practical ways to prepare staff for exposure to potentially difficult and traumatic events such as incidents of prisoner suicide and self-harm. Other measures planned to improve the health of new entrants include a programme of immunisation to protect prison officers and other staff from the risks of communicable diseases.

PAC conclusion (iii): The Prison Service should consider the costs and benefits of not paying staff for the first three days of any period of sickness absence in line with the approach used by private sector prisons to manage sickness absence.

5. The Agency has considered this recommendation, but does not propose to change terms and conditions of service in the manner suggested. The Agency's reasons are as follows. Absence rates in the Agency are characterised by high levels of long and medium term sickness rather than short-term sickness. There has been a 12 per cent fall in short-term absence rates since 2002-03. This can be attributed to robust application of new attendance rules introduced in 2002. Absences up to seven days' duration accounted for only 2.2 days of the overall average absence rate of 13.3 days during 2003-04. Absence of between one and three days will form only a small proportion of this, and those likely to be influenced by a stoppage in pay would be even smaller. The Agency does not consider that the relatively modest gains in reduced absence rates which may result from such changes would outweigh the operational risks of doing so. For example, a report, published in January 2005 by the Prison Reform Trust, highlighted poorer recruitment and retention rates in private sector prisons. However, the Agency does intend to review terms and conditions of employment in respect of absence management with Trades Unions, focusing, for example, on full and half pay entitlement during longer periods of absence for new employees in the first instance.

PAC conclusion (iv): Some prisons are difficult to work in and it is essential to have managers able to motivate and encourage staff to attend…. The Prison Service should set differential sickness absence targets taking account of the relative difficulties of each type of prison establishment, which should inform staff planning so that absence problems are not further compounded by unrealistic staffing assumptions.

6. The Agency accepts this recommendation. The Agency's strategy for reducing sickness absence is broad and includes tackling poor performance, maintaining appropriate staffing levels, improving the processes for the management of sickness absence, increasing support to staff by welfare and occupational health interventions and addressing any issues relating to poor moral and management through implementation of its new People Strategy. The operational staffing requirement of each prison is assessed on the basis of the operational needs of the prison and takes full account of the different roles of prisons and their different prisoner profiles. Similarly, annual targets for reducing sickness absence are already set for each prison, which take account of a range of factors, including the role of each prison and its prisoner profile, in addition to past performance on absence management.

PAC conclusion (v): All managers in the Prison Service should be trained in how to manage sickness absence and to encourage attendance. The Prison Service should set a target for quick completion of such training, and establish a rolling programme for new recruits and for refreshing existing staff knowledge.

7. The Agency accepts this recommendation. A People Management Toolkit was launched by the Agency's Training and Development Group in July 2004 which is focused on first line managers, and includes a dedicated module on attendance management. This training package is currently being rolled-out across the Service. All new first line managers are given access to the course on promotion and the course is also available to existing managers who are assessed by their managers as requiring development in this area. In addition, the Agency now provides nationally accredited management qualifications for governors and other managerial grades. Line managers also have access to professional HR support and advice on handling sickness absence. Almost all prisons now have a dedicated Head of Personnel, and all Areas an Area Personnel Adviser, who either hold a graduate level qualification from the Chartered Institute of Personnel and Development (CIPD), or are studying for this qualification. Most area either have or will shortly appoint a Leadership and Development Adviser, further strengthening professional support to line management in this field.

PAC conclusion (vi): The Prison Service should identify the public and private prisons with relatively low sickness absence, establish the reasons for their success and disseminate the lessons learned. The Prison Service should monitor actions taken by other Prison Governors to implement the lessons learned.

8. The Agency accepts this recommendation. Monitoring and audit systems are now in place to review performance on a regular and systematic basis. Governors regularly review the application of best practice locally to enhance performance, supported by a system of standards auditing that reviews compliance with the Agency's absence management rules and procedures on a regular basis. Guidance is provided to governors on best practice on a regular basis.

PAC conclusion (vii): The Prison Service has been slow to implement initiatives recommended by this Committee in 1999 with many not becoming effective until 2002. With the cost of sickness absence currently estimated at £80m million, the Service needs to act urgently to take a tighter grip of the problem.

9. The Agency does not accept this criticism. It considers that the actions it has and continues to take, and which were acknowledged in the Controller and Auditor General's report, demonstrate the commitment of the Agency's Management Board to tackling high levels of absence as a corporate priority. The significant reductions in absence rates achieved in the last few years demonstrate the success of this strategy, with absence rates in 2004 14 per cent lower than in 2002-3.

10. Measures were immediately put in place in response to the recommendations by the Committee in 1999. A comprehensive overhaul of sickness data and collection systems was instigated to address the problems of under recording. New attendance procedures were introduced in 1999, modelled on good practice highlighted within the report by the Comptroller and Auditor General. A dedicated Attendance Team was established at the Agency's headquarters in 2000 to lead and co-ordinate measures to implement the Committee's recommendations and to introduce new measures to improve the management of absence. Leading specialist consultants, Marsh Risk Consulting, were recruited to study the causes of absence in detail in key prisons and make recommendations.

11. A programme to tackle long-term sickness cases was developed in conjunction with BMI Occupational Health Services and led by a dedicated Task Force. This resulted in a sustained increase in the number of staff leaving on medical capability grounds. New rules, including the Bradford Formula, were introduced in 2001 and were widely seen as effective. These policies were reviewed again in a study conducted by Professor James of Middlesex University Business School and were considered robust and in accordance with best practice at that time. Regrettably, these new procedures had to be withdrawn following a successful legal challenge by the Prison Officers' Association (POA), which led to absence rates increasing temporarily until new procedural rules were agreed and re-launched in November 2002.

12. The Agency has also improved the provision of occupational health support to staff. The Agency has a proactive Staff Care and Welfare Service providing support for an average of 7,000 members of staff per year. The Agency's Occupational Health provider currently offers support to nearly 8,000 members of staff per year. 24 prison establishments now employ occupational health nurses on site and call-off contracts are in place for the provision of local clinics, stress counselling, specialist medical advice, work place assessments and the referral of staff with musculo-skeletal injuries for physiotherapy, chiropractic advice or osteopathy. A major programme is currently underway to provide immunisation against communicable diseases such as Hepatitis B and Tuberculosis for all operational staff and other staff on a risk assessment basis.

PAC conclusion (viii): The Prison Service should use sickness absence data to benchmark performance internally and externally, and to take clear action where particular prisons under perform.

13. The Agency accepts this recommendation. A comprehensive new system of attendance monitoring based on information technology enhancements was introduced in January 2004 following further development of the Agency's corporate PERSONNEL database. Systems now in place enable the tracking of all staff breaching attendance triggers for both long and short-term sickness. Relevant management information is now available at national, regional and local levels to report on problem areas. A "traffic light system" now monitors performance at each prison allowing the quick identification of poor attendance rates at individual prisons. Information and analysis of all aspects of sickness absence is published in a quarterly report, circulated to all senior managers and governors. An earlier study in March 2003 identified that a small number of prisons were disproportionately affecting overall sickness absence rates. As a result of this study, 50 prisons were targeted for special assistance and guidance by the central Taskforce during 2003-04. As a result, 19 prisons from this group had reduced sickness rates by at least 20 per cent by April 2004. The annual Civil Service report on sickness absence prepared by the Cabinet Office is already circulated to all prisons.

PAC conclusion (ix): Staff morale in the Prison Service was adversely affected by problems with the implementation of the new Home Office payroll software, which impacted on employees' receipt of their correct pay. The Home Office should review the lessons learned for future projects including the human impact of IT system weaknesses.

14. The Home Office accepts this recommendation. The Home Office has recently welcomed a separate report by the Comptroller and Auditor General on what occurred on the introduction of the Payfact system to the Home Office Pay and Pensions Service (HOPPS) in July 2001, and the recommendations included on improving future programme and project delivery. The Home Office sees this as a valuable contribution to the current programme of improvement to business processes and programme, project and risk management within HOPPS. The Home Office will shortly respond to the Comptroller and Auditor General's report to demonstrate how it is rectifying the identified past shortcomings. The guidance and support now provided by the Home Office centre of excellence in programme and project management takes full account of the need to see such projects as business change projects, and incorporates best practice from the Office of Government Commerce (OGC). The importance of benefits realisation, risk management, transition planning to operational use, and stakeholder management is emphasized in the guidance. All procurement based projects are subject to the OGC Gateway™ Review process, and high risk projects are assessed against the OGC Common Causes of Failure.

Second Report

Department of Health

Tackling Cancer in England: saving more lives

PAC conclusion (i): The Department should publicise some simple guidelines to help people recognise and act on appropriate symptoms for major cancers….

1. The Department of Health (DH) accepts this recommendation in principle. It is not yet clear if guidelines will be the most appropriate means to raise awareness of cancer among the general public although they are an option.

2. The NHS Cancer Plan, published in 2000, gave a commitment to develop a cancer public awareness campaign. Any such campaign must be based on sound evidence. DH therefore commissioned several pieces of research to identify why patients may delay seeking help from their GP when symptoms become apparent and also why GPs may delay referring patients to a specialist. This has included a review of international literature on factors that influence patient delay plus some cancer specific studies for example looking at the factors associated with a delay in the presentation of lung, ovarian and bowel cancers.

3. The results of these studies were presented to DH in July 2004 and some have subsequently been published in peer review journals. These provide the platform for our developing work on raising public awareness. DH is now working with cancer charities, researchers and health service professionals to develop a pilot programme to promote awareness of cancer symptoms, and encourage earlier presentation by patients to have their symptoms checked out. Work on the pilots will begin later in 2005.

4. To ensure that some positive action was taken between the publication of the NHS cancer plan in 2000 and the availability of the research on which our more detailed programme is being based, DH has also provided funding to a number of voluntary organisations to support their work on raising public awareness of specific cancers.

PAC conclusion (ii): ….Cancer Networks should identify areas where cancer is diagnosed at a more advanced stage, with reference to measures of deprivation, so as to determine and tackle the underlying reasons for late presentation.

5. DH accepts this recommendation in principle. We agree that cancer networks should be aware of areas in their locality where patients are more likely to be diagnosed with cancer at an advanced stage. However, reasons for an advanced diagnosis are complex. Deprivation may be one factor but others are likely to include: patient delay in coming forward with symptoms; difficulty for GPs in identifying patients with likely cancer and delays in receiving diagnostic tests within the hospital system. These are all areas that are being tackled.

6. For networks to take action it is important that the type and quality of information available to them is improved. For example, the regional cancer registries have implemented a Cancer Information Service (CIS) which is accessible to authorised health professionals and organisations. It gives direct access to information on cancer incidence, mortality and survival. Information on disease stage is collected for a number of cancers. Work is underway to improve the quality and completeness of this information and to extend it to other cancers. Cancer registry information can be examined according to strategic health authority (SHA), network, primary care trust (PCT) and local authority boundaries. It can also be analysed according to different socio-economic factors including deprivation.

7. In addition, the Healthcare Commission is taking forward work on national clinical audits for a number of cancers. These audits will drive up quality of cancer services for patients by enabling clinicians working in different centres to compare their results and to identify where improvements can be made. They may also provide an insight into which groups, such as those from deprived areas, are more likely to present with more advanced disease so that action can be taken locally to address that if appropriate.

8. DH has also set a national inequalities target for cancer which is based on narrowing the gap in mortality between the population as a whole and the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) by at least 6 per cent by 2010. The primary interventions that will help to deliver this target include promoting earlier presentation by patients with symptoms, improving the rate of urgent referrals for suspected cancer by GPs and improving access to diagnostics in Spearhead Group areas.

PAC conclusion (iii): Action is needed to help GPs improve their ability to identify symptomatic patients… including better guidance; closer monitoring of GP referrals; and the development of GPs specialising in cancer as champions to spread good practice among the profession.

9. DH accepts this recommendation. It is vital that GPs refer patients with suspected cancer appropriately. DH issued GP cancer referral guidelines in 2000 to help GPs determine those patients who need to be referred urgently to a specialist within two weeks, those who can be referred for a routine appointment and those who can be safely watched at primary care level. These guidelines have recently been reviewed by the National Institute for Clinical Excellence (NICE) and a revised version is due to be published shortly.

10. DH recognises that written guidelines have limitations. DH has therefore commissioned several pieces of research (as referred to in response to recommendation (i)) on cancer symptom profiles and referral strategies for primary care to inform further work in this area. This research has included a summary of international research on practitioner factors in delay in diagnosis and a project aimed at discovering which symptoms, physical signs or blood tests, either alone or in combination, predict the future occurrence of cancer. The results of these studies were presented to DH in July 2004 and some have subsequently been published in peer review journals. They are informing DH's work on ensuring appropriate GP referrals.

11. For example, the Cancer Services Collaborative "Improvement Partnership" (CSC-IP), part of the Modernisation Agency, has been working with stakeholders to develop a programme of pilots for decision support systems for GPs. One proposal (currently awaiting ethics approval) will test the feasibility of using patient questionnaires and local tests to ascertain the likely risk of a patient needing an urgent referral for suspected bowel cancer. A further proposal using an electronic system to assist GPs in implementing the referral guidelines is well developed and criteria for selecting pilot sites are being considered.

12. GP referral patterns are already monitored by PCTs and cancer networks and there are various locally developed feedback processes in existence across the country aimed at ensuring that more appropriate referrals are made.

13. DH and Macmillan Cancer Relief entered a three year partnership between 2002-2004 to provide around £3 million (from a central budget) over three years to support a lead clinician in cancer within every PCT. Although central funding from DH has now come to an end, Macmillan is continuing to provide a support programme for the GPs and other healthcare professionals in primary care who have been designated Primary Care Cancer Leads (PCCLs). Part of the PCCL's role is to spread good practice, including promoting the adoption of the Good Practice Guide on cancer in primary care, published jointly by Macmillan, the NHS Modernisation Agency and the Cancer Action Team in June 2004.

PAC conclusion (iv): ….The Department needs to develop a mechanism to record the time taken to assess and diagnose all patients who are routinely referred and then diagnosed with cancer. Delays in the patient pathway should be identified and reduced by redesign of services drawing on good practice such as that identified in the C&AG's Report.

14. DH accepts this recommendation. Work already taking place to help GPs identify patients most likely to have cancer (see response to recommendation iii) should help reduce the number of patients referred routinely who are subsequently diagnosed with cancer. There will, inevitably, be a small number of patients where cancer is not suspected and who will have been referred routinely prior to diagnosis. The new target, announced in the June 2004 NHS Improvement Plan, to ensure that for all patients the whole patient journey from referral to start of treatment will be a maximum of 18 weeks will mean that waits for routine referrals for any patient are kept to a minimum. More specifically, the NHS Cancer Plan has a target that by the end of 2005 all patients diagnosed with cancer will be treated within one month of the date of decision to treat them. This includes patients who were not initially referred urgently by their GP for suspicion of cancer so they will benefit from quick treatment once diagnosed.

15. The CSC-IP is working with trusts to identify bottlenecks in the system and support the redesign of services where this will lead to streamlining the patient pathway. This process includes a mechanism for assessing whether patients were originally referred urgently or routinely, where this is appropriate to the stage of the patient pathway under review.

16. The CSC-IP and cancer networks are also involved in providing feedback on referral practice to primary care. Many GPs actively seek out such information on the patients on their cancer register (introduced under the new General Medical Services contract last year), to enable them to manage the patient pathway more effectively. The CSC-IP plays a key role in sharing good practice across and between cancer networks, including the impact of service improvement on waiting times for patients with a cancer diagnosis.

PAC conclusion (v): Better information is needed on how far cancer has advanced at the point of diagnosis… The Department should press ahead with its work to develop a database of waiting times for cancer diagnosis and treatment in order to set priorities for improvement and deal with blockages.

17. DH accepts this recommendation. As noted in response to recommendation (ii), work taking place by the regional cancer registries and as part of the national cancer clinical audits overseen by the Healthcare Commission should provide more information about the stage of disease at diagnosis.

18. On waiting times for diagnosis and treatment, the Cancer Waiting Times database has been used to collect data on diagnosis and treatment of all cancers since September 2003. Reports available locally to the NHS from the system are used by the CSC-IP to set priorities for service improvement work locally. More recently, the National Cancer Waits Project has identified 28 "demonstrator sites" (one trust in each SHA) who will receive tailored support from the CSC-IP to ensure improved progress in delivering the 2005 cancer waiting times targets, and to develop and share best practice.

PAC conclusion (vi): Patients and the public should have the information to help them press for improvements in cancer services in their locality. Information about the level of cancer service provision, whether surgery is being carried out by specialists, and the performance of service providers should be disseminated locally.

19. DH accepts this recommendation. The Manual of Cancer Services (2004) provides a series of measures to enable cancer networks to assess the quality of cancer services they provide – both self assessment and peer review are used. A number of these measures are relevant to this recommendation including the following:

- each cancer network should produce a directory of cancer services for its local population;
- the network user group should agree a strategy for the network covering, among other things, information for patients;
- the network board should send annually updated information to its constituent bodies to inform them of the service improvements and/or developments it has achieved or planned and how it is addressing inequalities of care and improvements in cancer outcomes – it is expected that such information would be made publicly available although it will be for cancer networks to determine the best means to do this locally;
- a variety of measures about reconfiguring services to ensure that patients requiring complex procedures only have these undertaken by teams with suitable expertise and experience.

20. A three year rolling programme of cancer peer review started in November 2004 – each cancer network will be peer reviewed once over a three year period against the measures within the Manual. Following peer review visits a network report is produced by the review team. The report is distributed widely within the cancer network and it will be for cancer networks, SHAs and PCTs to decide how best to make this information available locally. For example, it is possible that the reports will be referenced in the annual prospectus published each year by PCTs. Making these reports publicly available is part of the process of making information available to the public to support informed choices.

21. The nhs.uk website is the principal vehicle to provide information to support patients' choice of hospital – it includes information from the star ratings on Trusts' performance against the cancer two week wait target. It also includes waiting times information by Consultant so patients can compare waiting times for different specialists. The Healthcare Commission, which is now responsible for assessing performance of NHS Trusts, has agreed to receive copies of each peer review visit report. Discussions are on-going about whether the results from these reports might feed into the assessment methodology that will, in future, replace the star rating process.

PAC conclusion (vii): A deadline should be set for ending the current wide variations in prescribing of anti-cancer drugs such as Herceptin. The recommendations by the National Cancer Director regarding resources, clinical practices and enhancements in NICE guidance should be implemented speedily, with a clear timetable for monitoring their impact and reviews of progress.

22. DH does not accept the recommendation to set a deadline for ending the variation in prescribing of cancer drugs. There will always be some measure of variation because of different treatment options, patient preferences etc. However, DH does accept the need to implement the National Cancer Director's recommendations against a clear timetable and to review progress. Work is already progressing on the two cancer specific recommendations as follows:

- a draft capacity planning model for use by chemotherapy delivery suites, pharmacy aseptic units and industry when preparing submissions to NICE was issued for consultation in March by the CSC-IP. This will be a vital tool for all staff involved in the delivery and preparation of chemotherapy and for commissioners and providers of chemotherapy services in planning and developing high quality services;

- action plans have been received from all cancer networks where uptake of any NICE approved cancer drug in their locality was below the national average. The plans are encouraging, confirming that the profile of implementing NICE appraisals has increased and that where problems have been identified they have been, or are in the process of being, addressed locally. A repeat analysis, again based on data provided by IMS Health, will be issued in the autumn to confirm if variations are reducing as a result of this action. This data has limitations but is the best available on chemotherapy prescribing at the present time.

23. In the longer term more robust data is needed and the introduction of electronic prescribing will address this. DH has already started work with the National Programme for Information Technology (NPfIT) and key stakeholders to identify the requirements for chemotherapy within such a system.

PAC conclusion (viii): Some areas benefit more than others from the current distribution of pathologists, diagnostic radiographers and scanner provision… the Department should work towards greater equity of provision over an explicit timescale.

24. DH accepts this recommendation. DH is working towards greater equity of access across the country both in terms of equipment and staff. This is largely being achieved through the NHS allocation process which offers fairer funding and local freedom to match services to need. However, some specific actions have also been lead centrally.

25. Allocations of additional equipment used in the diagnosis of cancer have been made by identifying those areas with a lower number of scanners per million to ensure access to diagnostic machines in any area of the country is on an equitable basis. The intention, agreed with SHAs, was to work towards a similar number of machines per head of population across the country. With the additional scanners from both the New Opportunities Fund and the NHS Cancer Plan central programme the average magnetic resonance imaging (MRI) scanners per million population has increased from 4.5 to 5.7 and computed tomography (CT) from 6.5 to 7.6 (excluding machines in private hospitals). A further 53 machines are due to be delivered this year and the full impact of the expansion should be felt around mid 2005 when all the machines are due to be scanning at full capacity providing a further 175,000 extra MRI scans and 240,000 CT scans each year.

26. In addition a mobile MRI service has been put in place to ensure that patients in areas of greatest need are reached. There are 12 mobile units that can be moved from location to location to maximise available capacity and improve access for patients. This new service provides a 15 per cent increase in the capacity available to the NHS – approximately 131,000 extra scans will be available. A second wave of national independent sector procurements for diagnostics was announced on 19 February. This is aimed at further expanding capacity, stimulating innovation and increasing patient choice and accessibility. In 2007-08, the NHS and independent sector will in total provide 8.9 million "scans" (MRI, CT, and non-obstetric ultrasound). This is an increase of 2.4 million scans from the current position in 2004-05. Of these, 1.4 million will be undertaken in the NHS and 1 million provided by the independent sector. Overall this is an average of 9,735 additional scans per constituency.

27. Progress against the Cancer Plan target of 1,000 additional cancer consultants by 2006 has progressed well with an additional 975 cancer consultants since 1999. Specifically, the number of clinical radiologists has increased by 352 (23 per cent), histopathologists by 239 (28 per cent) and diagnostic radiographers by 848 (8 per cent) over the same period. Work is also underway to increase the number of training places in key areas. For example, the number of diagnostic radiographer training places at universities has doubled and SHA Workforce Development Directorates (WDD) plan to increase training places for diagnostic radiography by a further 164 (17 per cent) between 2003-04 and 2005-06 and therapeutic radiography by 83 (29 per cent) over the same period. In addition, there has been investment in training for histopathology senior house officers (SHOs) resulting in six new schools being introduced with a further six planned for 2005-06. DH is also developing radiological academies which will allow up to 50 per cent more students to be educated at any one time.

28. This overall increase in the number of cancer specialists and radiographers working in the NHS, and the plans for further increases, will enable Networks to recruit additional staff and improve equity of access to services. However, it is for cancer networks to work in partnership with strategic health authorities, workforce development directorates and postgraduate deaneries to assess, plan and review their workforce needs including the education and training of all staff linked to local and national priorities for cancer.

29. To further increase capacity new ways of working are also being identified through service modernisation to assist the development of new roles and changing skill mix. This work challenges the conventional roles of clinicians and provides more flexibility in how services are provided, for example, extending clinical roles of certain staff to include roles previously only undertaken by doctors. Not only can this free up time of some clinicians it can also provide an alternative means of providing services where particular staff shortages may be evident without reducing quality of that service. For example, a four-tier skill mix model in radiography has been successfully introduced in some areas. This includes the introduction of an assistant practitioner role and an advanced practitioner role to take on extended clinical roles including those previously undertaken by doctors. Each SHA has been given £52,000 to invest in modernisation of the radiography workforce.

PAC conclusion (ix): ….Besides continuing efforts to recruit more staff, there is a clear need for identification and dissemination of good practice and re-design of radiotherapy services. The National Cancer Director should lead and co-ordinate this activity, following from his recent "stocktake" sessions with relevant stakeholders.

30. DH accepts this recommendation. The CSC-IP supports clinical teams to ensure that all patients in a cancer network benefit from redesigned and improved services. The care pathway for radiotherapy is complex as it includes multiple steps such as simulation, planning and multiple attendances for treatment. A fundamental part of the work of the CSC-IP is to get local teams to map the capacity and demand of the service against which service improvements are measured. There are 51 radiotherapy departments in England and they have all taken part in, at least, an initial capacity and demand study.

31. In addition, a National Radiotherapy Advisory Group has been established, to build on the "stocktake". It is considering all aspects of planning and delivery of radiotherapy services including, streamlining service delivery, service quality, equipment requirements, training and workforce needs and future developments. The group will advise Ministers on the development and delivery of high quality radiotherapy services. The National Cancer Director is co-chairing this group and as such is leading and co-ordinating the work as the Committee recommend.

PAC conclusion (x): Primary Care Trusts in their role as commissioners of cancer services should promote the concentration of cancer surgery in the hospitals which carry out higher volumes of such operations, in line with best practice. The National Cancer Director should report progress made in this respect.

32. DH accepts this recommendation. Where there is evidence to support the concentration of complex cancer surgery in hospitals carrying out high volumes of these procedures this is included within the Improving Outcomes series of guidance for different cancer types started by DH and taken over by NICE. Cancer Networks have been asked to produce action plans for each piece of guidance setting out how it will be implemented (including reconfiguration of services where advised in the guidance) with milestones that will be locally performance managed by SHAs and reported into DH as part of the Local Delivery Plan monitoring. These plans are produced in consultation with Specialised Commissioning Groups where services need to be planned across a large population.

33. In addition to routine performance managing, implementation of each piece of guidance, including issues around volume and outcomes where they are covered, will be assessed as part of the peer review process. As noted in the response to recommendation (vi) following peer review visits a report is produced by the review team. This will form part of the process of making information available to the public and support the public in making informed choices. In addition, once the peer review programme is complete the Cancer Action Team, which reports to the National Cancer Director, will produce a summary report of the national position.

PAC conclusion (xi): The Department should commission research into the long term effectiveness of its Stop Smoking services….

34. DH accepts this recommendation. DH has recently commissioned a pilot study to explore the viability of collecting 52 week quit rates. Findings from the study will be published in a forthcoming supplement of the journal Addiction.

35. Preliminary findings show the NHS Stop Smoking Services are achieving long term quit levels comparable to outcomes found in clinical trials of behavioural support and cessation aids. The NHS Stop Smoking Services can increase a smokers success rate by up to fourfold. Even so, smokers find it hard to quit and nicotine addiction is a major barrier to quitting, however these success rates achieved by specialist behavioural support combined with nicotine replacement therapy or Zyban are very encouraging.

36. Further funding to look at long-term quit rates will be considered along with other research & development requirements arising from the current tobacco policy agenda.

Fourth Report

Home Office

Department for Constitutional Affairs

Improving the speed and quality of asylum decisions

PAC conclusion (i): Departments should compare the additional administrative costs of resourcing to meet surges in demand, with the additional programme and other costs which will arise if backlogs are allowed to accumulate. The National Audit Office estimated that up to £500 million might have been saved if the Home Office had been able to put in place sufficient staff and infrastructure to meet the significant rise in asylum applications in 1999 and 2000. Instead, backlogs of applications accumulated, increasing support and accommodation costs paid to the applicants and their families while decisions were awaited, and making the removal of unsuccessful claimants more difficult.

PAC conclusion (ii): Departments also need to consider the end to end impact on delivery chains of tackling major shifts in demand for services. The Home Office's decision to move caseworkers from deciding applications to work on removing failed asylum seekers helped to increase the number of removals, but impacted adversely on the clearance of the application backlog. While some £50 million was saved by increasing removals, the National Audit Office estimated that the impact on the backlog of applications may have cost some £200 million of the overall £500 million potential savings forgone.

1. The Home Office (HO) accepts that sound financial decisions need to be made, balancing the costs and benefits of programmes and their resourcing. The Immigration and Nationality Directorate (IND) has established a delivery planning process for allocating the IND budget which seeks to achieve this balance.

2. The assumption that the HO could have put in place sufficient staff and infrastructure to meet the rise in asylum applications is critical to the calculation of the National Audit Office (NAO) savings estimates. These are theoretical figures, and HO do not consider that they could have been achieved in practice. Decisions on investment in infrastructure, and an assessment of the benefits it will bring, must take into account practical constraints on delivery, for instance the time to recruit and train high quality staff; the time to build up capacity at all points in the system, including infrastructure; and the competing pressures on resources within the Department. HO decided to put resources into removals casework because, unless decisions to refuse asylum are followed up by action to remove, the result is to encourage further unfounded applications, which would add to the cost of asylum support. Indeed, this decision by IND was an example of the practice of considering the end to end impact on delivery change that is commended by the Committee: by contrast, to have concentrated all the available resources on decision taking, as the NAO savings estimate assumes, would simply have displaced the cases to later stages in the process, and would have involved foregoing the beneficial impact of improved removals performance on subsequent levels of intake.

3. In practice, HO took initial decisions on an unprecedented number of asylum applications in the period 2000-2002. Indeed, the backlog in 1997 stood at some 50,000, rose to 100,000 but now stands at under 10,000 cases: the lowest for a decade. Since 2002, by investing in the IND infrastructure, significant improvements have been made to the asylum system. For instance, the closure of Sangatte, improved detection technology and the introduction of juxtaposed controls have all made a significant contribution to the reduction in intake. It is now easier to see the financial benefits being accrued from these measures. In 2003-04, there was a reduction of approximately £60 million in asylum support costs compared with 2002-03. IND has a target to reduce asylum support costs by £450 million, by 2007-08, compared with £1,070 million in 2002-03. The future allocation of IND resources will take into account the overall cost-effectiveness of proposed investments.

PAC conclusion (iii): The Treasury should be sensitive to the risk of administrative cost limits inhibiting timely action to save programme expenditure, especially where the costs fall on one Department and the potential savings on another. There may be an "invest to save" case to avoid significant backlogs accumulating at points in the delivery chain, increasing programme costs because administrative costs are capped.

4. The Treasury is sensitive to the challenges of responding to unexpected fluctuations in programme demand. In line with a recommendation made by Sir Peter Gershon in his report 'Releasing resource to the front line: Independent Review of Public Sector Efficiency, July 2004', the 2004 Spending Review removed from administration costs controls the frontline service elements of IND's costs. This reclassification provides IND with greater flexibility to match decision-making capacity to the number of applications.

PAC conclusion (iv): The Department should look to expand its fast track procedures, drawing on its experiences at Harmondsworth and Oakington and on those of other countries such as the Netherlands. At Harmondsworth, the initial decision and appeal stages currently take three and four days respectively. In the Netherlands, some 40 per cent of asylum applications are handled through fast track processes taking around seven working days, whereas only nine per cent of cases are fast tracked in the United Kingdom.

5. HO accepts the recommendation that we should look to expand the fast-track procedures. This work was already underway prior to the NAO report. HO announced on the 7 February the use of Yarl's Wood for fast tracking claims from female applicants. We have also announced our intention to have up to 30 per cent of applicants handled through a detained fast track by the end of 2005.

6. Our steady expansion of the detained fast track processes has ensured that we learn lessons as we go along and we have had to defend their fairness and legality in the Courts.

7. However, not all applicants can or should be detained whilst their asylum claims are considered. We have to adopt some of the detained Fast Track case management approaches within the non-detained setting. This joined-up, end-to-end case management approach lies at the heart of the new asylum process set out in the Five Year Strategic Plan. It will ensure that we further accelerate the processing of applications in the non-detained route.

PAC recommendation (v): The Department for Constitutional Affairs should consider whether a more demanding joint target could be set to improve the Appellate Authority's speed in handling appeals, and hence reducing costs for the taxpayer in supporting asylum seekers until their appeal is determined. The Directorate and Appellate Authority had a joint target for 2003–04 to clear 60 per cent of all applications within six months. Almost half of all applications, however, did not proceed to the appeal stage and therefore only a small proportion needed to be cleared quickly through the appeal stage for the target to be met.

8. The Department for Constitutional Affairs (DCA) accepts the importance of improving the speed of handling in appeals and had already acted on this: The Asylum and Immigration (Treatment of Claimants, etc.) Act received Royal Assent on 22 July 2004. Section 26 of the Act introduces the new Asylum and Immigration Tribunal, in place of the current two-tier tribunal structure. It also introduces a new system of higher court oversight and powers enabling new legal aid arrangements.

9. Currently around 75 per cent of refused asylum cases appeal against their initial decision (in addition, around 20 per cent of cases are refused asylum but granted Humanitarian Protection or Discretionary Leave) and 70 per cent of refusals at adjudicator stage lead to an application for permission to appeal to the Tribunal. At the same time the percentage of cases granted asylum at initial application and the percentage granted at adjudicator appeal has dropped significantly. This means the proportion of cases proceeding to each appeal stage is increasing.

10. The package of measures will streamline the process, prevent abuse of the system and ensure cases reach earlier finality. The new system is to be implemented in April 2005 reducing DCA's appeal process times for new cases to an expected maximum of 18 weeks.

11. We will continue to review targets each year and ensure that they reflect the circumstances at that time and are challenging for DCA and the Directorate to deliver.

PAC recommendation (vi): Cases not dealt with through the fast track process have a target of 61 days for a decision even though on average a caseworker spends only some nine hours on the case to reach a decision. Whilst recognising that applicants need time to prepare their case, the Home Office should seek to shorten elapsed times by reducing the time taken to fix an interview and despatch decisions, and by drawing on processes employed in its fast track centres.

12. HO accepts the recommendation that there is room to reduce processing times further, and has already introduced projects to speed up the asylum decision making process in non detained cases. We have, for example, begun operating a process in the North West under which the substantive asylum interview is brought forward much earlier and decisions taken in under one month, with unfounded claimants' cases tightly managed through the rest of the process by one team.

PAC recommendation (vii): Over the last five years, the proportion of appeals allowed has consistently exceeded the Directorate's target of 15 per cent, and has frequently exceeded 20 per cent. The appeals allowed rate has also varied significantly for applicants from different countries. The Directorate should examine why appeals are upheld, particularly amongst nationalities where appeal allowed rates are highest, and disseminate the lessons for improved decision-making to its caseworkers.

13. HO accepts this recommendation. The published statistics show that there has been an improvement in the proportion of appeals allowed during 2004. In the fourth quarter of 2004 16 per cent of asylum appeals were allowed and 81 per cent dismissed compared to 22 per cent allowed and 76 per cent dismissed in the first quarter of 2004. (A small proportion of appeals are abandoned or withdrawn.)

14. A good number of factors influence the outcome of asylum appeals unrelated to the quality of the initial decision – for example, evidence presented by the appellant at appeal, changes in country circumstances or emerging caselaw. There is not a simple and direct correlation between the outcome of an appeal and the quality of the initial decision made.

15. Nevertheless we do have a system of assessment feedback on decision quality from Home Office staff presenting immigration appeals to initial decision caseworkers and we will increase the frequency of that feedback starting in April 2005.

16. We accept that a relatively high allowed appeal rate persists for a limited number of nationalities and we have been conducting some work in an attempt to better understand the reasons behind this. We consider that differences in allowed appeal rates are influenced by a complex interplay of factors. The allowed rate can change for particular nationalities over time. We are continually monitoring trends in allowed rates, to identify countries where this is happening, in order to identify the underlying issues. This is an ongoing process.

17. An action plan was introduced in February 2004 to increase the level of Presenting Officer (PO) representation at hearings. This plan included the recruitment, training and mentoring of new POs. which is continuing. This plan has succeeded in increasing the PO representation rate. Internal management information shows that the rate was 98 per cent in January 2005 compared to 69 per cent in February 2004.

PAC recommendation (viii): In 2003, applications for asylum were received from some 146 different nationalities, placing a significant burden on caseworkers in understanding the country circumstances, especially as these can be localised within a particular country. The Home Office should expand, beyond more senior staff, the number of caseworkers with expertise on particular countries or regions of the world to improve the quality and consistency of its decision-making.

18. HO accepts this recommendation subject to the overriding business need of deciding at least 75 per cent of all new applications within two months of the date of application.

19. We understand the benefits of having caseworkers who have particular knowledge on certain countries. For each country there is a senior caseworker who is an expert. Also, caseworkers can turn to specialist country information officers and make use of the relevant country reports and supporting materials. In addition, the Asylum Casework Directorate is organised so that each case management unit (CMU) generally concentrates on a limited number of countries. In many respects a high degree of specialism is inescapable since in the fourth quarter of 2004, for example, 60 per cent of all asylum applications came from just 10 countries.

20. At the same time, we need to be geared up to deal with the other 40 per cent of applications that came from over 120 countries. The actual mix of countries in the caseload changes from month to month, so, in addition to specialising in one or two main asylum producing countries, caseworkers must also be flexible enough to handle claims from a wide range of countries. Too much country specialism would prevent this. Also, all asylum claims have to be assessed against the same legal and policy framework and caseworkers are trained to be able to apply this knowledge to any asylum claim.

21. We believe we have maintained a reasonable balance between flexibility and specialism that meets the business needs but we recognise the need to keep this under close review.

PAC recommendation (ix): The cost of legal aid for asylum applicants in the United Kingdom is expected to be £146 million in 2004-05, and accounts for example for 30 per cent of the cost of the initial decision stage. The Department for Constitutional Affairs reported that it had not compared the cost of legal aid with that of other countries. It should act to fill this gap in its knowledge.

22. The latest resource forecast for Asylum and Immigration legal aid in 2004-05 is £103 million. DCA believes that early access to good quality legal advice can be important for many individuals seeking asylum and can benefit the decision making process. We take full account of the need to avoid delay when developing and implementing our asylum legal aid arrangements.

23. DCA accepts the recommendation to undertake a comparison of our legal aid costs. To supplement information about total costs, we are working to obtain details of related information, including volumes and local structures, in a sample of other countries. In order to make any comparison meaningful we will need to take account of the local arrangements in other countries including the different legal systems and the arrangements for dealing with asylum applications. These other factors are likely to be important in any comparison exercise, for example In those countries with an inquisitorial system some costs are likely to fall on the judiciary and the courts that here would be met from legal aid. As far as possible in drawing comparisons we will take into account the available information about whole system costs not simply those relating directly to legal aid and its equivalents. We are aiming to complete this comparison work by July 2005

PAC recommendation (x): The Directorate has put in place procedures to detect possible multiple applications, but has not always acted promptly to investigate concerns raised by third parties about potentially fraudulent claims. Amongst a sample of 65 backlog cases examined by the National Audit Office, four contained evidence from third parties that the claims could be fraudulent but no action had been taken. There should be a clear contact point within the Directorate for whistleblowers and for following up information received, and robust procedures for acting upon likely cases of fraud.

24. HO accepts this recommendation. We agree that we need to make proper use of allegations about potentially fraudulent claims, whilst recognising that some of the allegations may be unfounded or malicious. It is fair to say that most allegations received do not refer to whether asylum has been claimed but rather that a particular person is working or studying illegally or has married in other than genuine circumstances. Because this is the case, we have established Managed Migration Intelligence Units so that new allegations in relation to potential student and marriage abuse cases can now be forwarded direct to the Units for them to assess the potential of the intelligence. Allegations where there is a live application outstanding are put onto the file, so that the caseworker can take the information into account when making a decision on the application.

25. As it is IND's policy not to acknowledge allegations (unless specifically requested to) in order to protect the author, it can often appear that IND has not actually acted on the information received.

26. Other allegations are received and sorted by Evidence & Enquiry on behalf of the Immigration Service. We are currently exploring how we might better process these allegations within acceptable timescales.

27. The HO piloted an 'allegations hotline' for some months during 2002 but the quality of the intelligence received was not sufficient to justify the expense and the pilot was discontinued. If a member of the public rings the Immigration and Nationality Enquiry Bureau (INEB) to make an allegation, they are asked to write to IND. There are currently no instructions for asylum caseworkers for how to deal with allegations received during the asylum decision making process but we will issue guidance to caseworkers within the next four months.

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