Department of Health

Autumn Performance Report 2005

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
December 2005

Cm 6704

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Contents

Introduction

The Government set new priorities for public spending with significant extra resources in key services such as education and health. The Government also made a commitment to link this extra investment to modernisation and reform, to raise standards and improve the quality of services. The aims and objectives of the Department of Health are enshrined in the Public Service Agreement (PSA) which was published in the HM Treasury White Paper, *Public Services for the Future: Modernisation, Reform, Accountability*, in December 1998.

The 2000, 2002 and 2004 Spending Reviews (SRs) build on the success of the original Comprehensive Spending Review (CSR) by setting further challenging targets. The SR2002 set spending plans and measurable targets, the PSAs for 2003/04 to 2005/06. The SR2004 sets spending plans and PSAs for 2005/06 to 2007/08.

These PSAs are set out in the White Papers:

2000 Spending Review: Public Service Agreements, July 2000;

2002 Spending Review: Public Service Agreements, July 2002; and

2004 Spending Review: Public Service Agreements, July 2004.

We are now working towards achieving the targets set out in SR2004. Health services are now able to plan over a three-year period supported by three-year budgets. This allows organisations to look in-depth at their services, plan change with confidence and implement improvements year-on-year.

In July 2004, the Department of Health published the planning framework, *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08*. This sets out the national targets for the NHS and social care that apply from April 2005, and these are closely based on the PSA targets attached to SR2004. It also set out the architecture of the new planning and performance system. Its main features are:

- a shift to a system in which standards of quality and care will be the key national driver for improvements;
- a reduced set of national targets to accelerate progress in a focused set of priority areas;
- more headroom for local communities to address local priorities;

- financial and performance assessment incentives aligned to support improvements in the system; and
- local organisations taking a greater lead in service modernisation.

The Department of Health's aims and objectives that were agreed in SR2004 are set out below. There is then an analysis of progress against these targets. This is followed by an analysis of progress against the Department's efficiency targets. Analysis of live PSA targets resulting from SR2002, SR2000 and CSR1998 is set out in Annex A.

The Department of Health's Aims and Objectives SR2004

Aim

Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

Objectives and Performance Targets

Objective I: Health of the Population

1. Improve the health of the Population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

   - Substantially reduce mortality rates by 2010;
   - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
   - from cancer by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
   - from suicide and undetermined injury by at least 20%.

2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

3. Tackle the underlying determinants of health and health inequalities by:

   Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.

   Halting the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole **(Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport)**

   Reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. **(Joint target with the Department for Education and Skills)**.

Objective II: Long Term Conditions

4. To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

Objective III: Access to Services

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.

6. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

Objective IV: Patient/User Experience

7. Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:

    - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
    - increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

Departmental Public Service Agreement Targets Analysis SR2004

Further to the 1998, 2000 and 2002 Spending Reviews, the 2004 Review continued the process of delivering improvements in services, through the innovation of Public Service Agreement targets. The targets from that Review are laid out in the table below with updates on progress.

Objective I: Health of the Population

PSA Targets	Measure	Progress
Target 1 Improve the health of the Population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women. Substantially reduce mortality rates by 2010.		
– from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole;	**Death rate from heart disease, stroke and related illnesses** amongst people aged under 75.	**Heart disease, strokes and related illnesses – overall mortality – on course** The 1995-97 baseline figure for overall mortality for heart disease in people aged under 75 in England was 141.0 deaths per 100,000 population. However, in 2002-04 (3 year average latest available data) the rate had fallen to 96.7 deaths per 100,000 – a fall of 31.4%. 3 year average rates have fallen for each period since the baseline. If the trend of the last 10 years were to continue, the target would be met before the target period. **Inequality dimension – on course** 3 year average rates have fallen in the Spearhead Group and England as a whole for each period since the baseline. During this period the inequality gap has reduced from a baseline absolute gap of 36.7 deaths per 100,000 population in 1995-97 to 27.6 deaths per 100,000 population in 2002-04. (The target for 2010 is to reduce the absolute gap to 22.0 deaths per 100,000 population or less.) The gap has, therefore, reduced by 24.7% since the baseline, compared to the required target reduction of at least 40% by 2009-11.

PSA Targets	Measure	Progress
– from cancer by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole;	**Death rate from cancer** amongst people aged under 75.	**Cancer – overall mortality – on course** The 1995-97 baseline figure for overall mortality for heart disease in people aged under 75 in England was 141.2 deaths per 100,000 population. However, in 2002-04 (3 year average, latest available data) the rate had fallen to 121.6 deaths per 100,000 – a fall of 13.9%. 3 year average rates have fallen for each period since the baseline. The milestone for 2004-06 has been passed and if the trend of the last 10 years were to continue the target would be met. **Inequality dimension – provisionally met** 3 year average rates have fallen in the Spearhead Group and England as a whole for each period since the baseline. Following a small increase in the inequality gap in the first monitoring period, the gap has reduced slightly from a baseline absolute gap of 20.7 deaths per 100,000 population in 1995-97 to 18.8 deaths per 100,000 population in 2002-04. (The target for 2010 is to reduce the absolute gap to 19.5 deaths per 100,000 population or less.) The gap has therefore reduced by 9.4% since the baseline, compared to the required target reduction of at least 6% by 2009-11. However, due to the sensitivity of this target to change, continuing vigilance is required to consolidate this achievement.
– from suicide and undetermined injury by at least 20%.	**Death rate from intentional self-harm and undetermined injury** amongst people of all ages. Baseline is average of 1995, 1996 and 1997. (All using ONS mortality statistics age standardised to allow for changes in the age structure of the population.)	**Suicide and injury of undetermined intent – encouraging reduction but more rapid decline required in future years** The 3 year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen and in 2002-04 is now 6.6% below the baseline. Although progress is now towards the target, the rate of decline has slowed and if the trend of the last 5 or 10 years were to continue, the target would not be met. A downward trend has been maintained, however, and we are continuing to take action at local, regional and national level to help reduce the number of suicides in our communities. For example, we are taking action to reduce suicides among groups at particular high risk, such as young men and people who self-harm.
Target 2 Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.	**Mortality in infancy by social class:** the gap in infant mortality between "routine and manual" groups and the population as a whole. Baseline is average of 1997,1998 and 1999.	**Infant Mortality – challenging target, further work required on delivery chain** Data for 2002-04 (3 year average) show no change in the gap between the "routine and manual" groups and the population as a whole, compared with last year. Over the period since the target baseline, the gap has widened, and the infant mortality rate among the "routine and manual" group is now 19% higher than in the total population. This compares with 13% higher in the baseline period of 1997-99, although there have been year-on-year fluctuations in intervening years.

PSA Targets	Measure	Progress
	Life expectancy by local authority: the gap between the fifth of areas with the "worst health and deprivation indicators" (the Spearhead Group) and the population as a whole. Baseline year is average of 1995,1996 and 1997.	**Life expectancy at birth – challenging target, further work required on delivery chain** Data for 2002-04 (3 year average) indicate that since the target baseline, the relative gap in life expectancy between England and the Spearhead Group has increased for both males and females, with a larger increase for females. For males, the relative gap increased by 1%, for females by 8%. However, the targets included in the Department's PSA will strengthen the levers for progress, especially the new inequalities elements of the cancer and heart disease mortality targets. The Department's Health Inequalities Unit is currently working with PMDU and HMT on a review of the life expectancy element of the Health Inequalities PSA. This will include a detailed mapping of the delivery chain with the aim of improving our ability to achieve this element of the target. The review will result in a more defined and forward looking delivery plan for health inequalities, and will influence our own review of the delivery of the infant mortality element of the target. A new Health Inequalities PSA Board is being established to drive delivery, using the review's recommendations as a platform for action.
Target 3 Tackle the underlying determinants of health and health inequalities by:		
– Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.	**Smoking**: reduction in numbers of adult (26%) and routine/manual (31%) groups of smokers (2002/03 baselines). Prevalence from General Household survey.	**Adult Smoking Rates – on course** The percentage of adults smoking has fallen by 2% since 2001. Whilst 27% of the whole population smoked in 2001, this figure had fallen to 25% in 2003, Of these, the routine and manual figures were 33% and 32% respectively. These figures are taken from ONS General Household Survey 2003.
– Halting the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole **(Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport)**.	**Obesity**: Prevalence of obesity as defined by National BMI percentile classification for children aged between 2 and 10 years (inclusive) measured through the Health Survey for England. Baseline year is weighted average for 3 year period 2002-04	**Obesity – awaiting baseline figures** Progress against the target will be measured through the Health Survey for England. The baseline will be established for the 3 year period 2002-04 once data from the 2004 Health Survey for England is available in winter of 2005/06.

PSA Targets	Measure	Progress
– Reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. **(Joint target with the Department for Education and Skills)**.	**Teenage Conceptions**: The under-18 conception rate is the number of conceptions to under 18 year olds per thousand females aged 15-17. Baseline year is 1998. ONS Conception Statistics.	**Teenage Conceptions – encouraging reduction but more rapid decline required in future years** The under-18 conception target is now a shared PSA target between the Department of Health and DfES in light of the move of the Teenage Pregnancy Unit to DfES in June 2003. Data for 2003 show a 9.8% reduction in the under-18 conception rate for England since 1998. Between 1998 and 2003, rates have declined overall in 8 out of 9 regions (London has remained static), and in around 75% of Local Authorities. Every top tier Local Authority is implementing a 10 year local teenage pregnancy strategy. These strategies and annual forward action plans set out to deliver under-18 conception rate reduction targets of between 40% and 60% by 2010. To ensure targets are achieved, work is underway to intensify delivery of the strategy to vulnerable groups and high rate neighbourhoods. The 4th full year of implementation of local strategies ended in March 2005 and all 30 action points set out in the Teenage Pregnancy Strategy are being implemented. In December 2004, the 3rd Annual Report of the Independent Advisory Group was published and makes recommendations to ensure the continued success of the Strategy.

Objective II: Long Term Conditions

PSA Targets	Measure	Progress
Target 4 To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions	**Reduction in number of emergency bed days** as measured through Hospital Episode Statistics. Reduction in numbers of very high intensive users of care.	**Reduction in Number of Emergency Bed Days – on course** Between 2003/04 and 2004/05, the number of emergency bed days decreased by 1.80%, from 32,450,854 to 31,868,191.

Objective III: Access to Services

PSA Target	Measure	Progress
Target 5 To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.	**Progress towards the 18-week target** will be measured by waiting times for individual stages of treatment (ie number of patients on NHS waiting lists) until the launch of the full GP referral to hospital treatment measure.	**Progress towards the 18 week target** The 18 week delivery programme has developed an initial assessment that has identified 4 key operational challenges that need to be addressed by the NHS in delivering the 18 week target by end December 2008. These challenges are: – long waits and clearance times; – managing the patients through their entire patient journey; – meeting any potential outpatient and diagnostic activity shortfalls; – ensuring the 18 weeks and system reform agendas are aligned. We are now producing the delivery plan that will outline the Department's work and priorities for the NHS over the coming 3 years. This will be completed by the end of December and, following ministerial approval, will be published in early 2006. Good progress has been made with this work overall.
Target 6 Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.	Annual returns from the **National Drug Treatment Monitoring Service (NDTMS)**, which provides details on the number of drug misusers entering in, successfully completing and sustaining treatment.	**Participation in Drug Treatment – we are ahead of schedule to meet this target** – The results from the National Drug Monitoring System (NDTMS), reveal that 160,450 people received specialist, structured drug treatment in England during 2004/05, an increase of 27% on 2003/04 (125,545) and 89% on the 1998/99 baseline of 85,000. – In addition, over 30,000 more people had either successfully completed or continued treatment at the end of March 2005 compared to March 2004.

Objective IV: Patient/User Experience

PSA Target	Measure	Progress
Target 7 Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.	**The national survey programme** (under the administration of the Healthcare Commission) will gather feedback from patients on different aspect of their experience of care in NHS trusts.	**Surveys – on course** Trusts are continuing to gather the views of patients through the national patient survey programme, an extensive patient research programme that covers the NHS in a wide range of care settings. It is designed not only to provide patient feedback at a national level, but also to provide local feedback to be used by individual Trusts for quality improvement. Since the first survey was conducted in 2001/02, around one million patients have taken part in 13 surveys across 7 different NHS settings. 4 surveys were conducted in 2004/05. Results for the emergency care and outpatient surveys were published in February 2005, while results for the Primary Care Trust (PCT) and Mental Health service surveys were published in September 2005. The results for each NHS organisation participating in these surveys – and nationally aggregated data – are available on the Healthcare Commission website (http://www.healthcarecommission.org.uk/NationalFindings/Surveys/PatientSurveys/fs/en?CONTENT_ID=4000117&chk=XPJRIh). The Department designed the methodology used to measure improvements in the patient experience in collaboration with the Healthcare Commission. Since the PSA technical note was first published, the Healthcare Commission has proposed a change to the methodology. DH is working with the Healthcare Commission to review the proposed change and other aspects of the methodology, and the new scores will be published after this work has been completed. In the latest patient surveys (2004/05), patients are asked: *"Overall, how would you rate the care you received?"*

	Emergency care	Outpatients	Mental health Services
Excellent	34%	37%	25%
Very Good	36%	41%	29%
Good	18%	16%	23%
Fair	8%	5%	14%
Poor	3%	1%	5%
Very Poor	2%	1%	4%

The 2004/05 PCT survey included a new question asking patients: *"Was the main reason you went to your GP surgery or health centre dealt with to your satisfaction?"* Around 7 in 10 (73%) answered *"yes completely"*, 24% answered *"yes to some extent"*, while 4% answered *"no"*.

These figures are not directly comparable with those from previous surveys.

PSA Target	Measure	Progress
Target 8 Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:		
– increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and	**Those being helped to live at home** are those that receive community based services but are not in residential or nursing care. Only those that are care managed by Social Services, ie are assessed by Social Services and have a care plan, will be included in the target.	**Older People Supported Intensively to live at Home – on course** We will assess performance on this first element of PSA 8 from 2005/06 and so data for the first assessed year will not be available until the Autumn of 2006. To recognise the crucial voluntary and community sector (VCS) contribution to non-intensive home care, we are also piloting a related collection to assess the VCS contribution to this target.
– Increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	**Those people receiving more than 10 contact hours of home care and 6 or more visits per week** divided by the population of people supported by councils in residential care and nursing homes.	**Older People Supported Intensively to live at Home – on course** The number of older people supported intensively to live at home in 2004/05 shows a strong upward trend, increasing to 32% of the total supported by councils in residential care and in their own homes. Our interim target for this part of the PSA (to reach 30% of the total by 2005/06) was met 2 years early. This good overall progress masks significant variations between councils and so we are working with the *Care Service Improvement Partnership (CSIP)* to scope specific interventions that will support improved performance in the lowest quartile of ranked councils.

Gershon Efficiency Targets

Efficiency Programme

The Gershon Report *"Releasing Resources to the Front Line"*, published in March 2004, committed the Department of Health to achieving the following targets as part of the 2004 Spending Review:

- Annual Efficiency Gains of £6.5bn by March 2008, at least half of which should be cashable;
- a reduction in whole time equivalent civil servants of 720 by March 2008;
- the relocation of 1,180 whole time equivalent posts out of London and the South East by March 2010.

Efficiency Gains

Programme Structure

The programme comprises 6 main workstreams on which progress is reported:

i) **Productive Time**: Modernising the provision of front line services to be more efficient and also improving the quality of patient treatment and service, by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce;

ii) **Procurement**: Making better use of NHS buying power at a national level to get better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies and other consumables and pharmaceuticals;

iii) **Corporate Services**: Ensuring NHS organisations can share and rationalise back office services, such as finance, ICT and human resources;

iv) **Social Care**: Improving commissioning of social care and other cash releasing and non-cash releasing gains from the design of social care processes by Local Authorities;

v) **Public Funding & Regulation**: Reducing operating costs of the Department of Health, Arms Length Bodies, Strategic Health Authorities and Primary Care Trusts through reducing processes and functions and restructuring, merging or abolishing existing organisations;

vi) **Central Budgets**: Reducing or eliminating centrally managed budgets where they do not provide value for money, and releasing to frontline NHS organisations.

Measurement Processes

Aggregate efficiency gains are assimilated through a large number of projects and business changes. Detailed measurement and assurance processes have been developed for each resulting efficiency gains. These have been verified and agreed with HM Treasury, and Office of Government Commerce.

In reporting efficiency gains we are required to demonstrate that these have not been achieved at the expense of reductions in service quality. We have agreed balancing quality measures appropriate to individual workstreams and projects.

Details of agreed measurement processes and quality assurance are provided in an Efficiency Technical Note (ETN) available on the Department of Health website www.dh.gov.uk. The Health Efficiency Programme continues to evolve to underpin gains up to and beyond 2008. The ETN will be updated to include further approved measures as required.

Reported Gains to Date

The following gains have been recorded for 2004/05 and up to Quarter 2 2005/06:

Workstream	**2004/05 (£m)**	**2005/06 Q2 (£m)**
Productive Time	671	707
Procurement	333	814
Corporate Services	14	30
Social Care	0	112
Public Funding & Regulation	13	46
Central Budgets	0	0
Total Health	**1,031**	**1,709**

Calculation of mid year (Q2) gains excludes some benefits where performance data is only available on an annual basis or where there are significant unavoidable time lags.

Of the total reported gains £1,544m are cashable, resulting in either additional cash within the total DH budget being released from non-frontline to frontline services, or cash freed within existing frontline services that can be reallocated for additional patient treatments or extension of services.

Progress Highlights

1. *Productive Time*

   – Better management of patient admissions has reduced the average hospital length of stay between March 2004 and March 2005 cutting treatment costs by over £300m and freeing up more than 1 million bed days to treat more patients more quickly.

- Improving medical techniques, technology and associated process redesign means that an increasing number of treatments are being done as day cases. Almost 70% of all planned procedures are now done this way, reducing treatment costs by about £20m and enabling more patients to go home earlier.
- Improved proactive care of patients, particularly those with chronic conditions resulted in 2% fewer Emergency Bed Days during 2004/05 releasing over £200m for additional patient treatments.
- Reduced levels of staff sickness and reduced use of agency staff in 2004/05 has meant that about £65m has been saved for investment in better patient care.
- The Integrated Service Improvement Programme (ISIP) has developed and launched a single framework to enable NHS organisations to plan and deliver service improvement and efficiency. ISIP provides the NHS with a structured approach to integrating and managing multiple change projects and uses a single set of measures, benchmarks and metrics to support change. It is a key enabler for continued frontline efficiency gains.
- Significant opportunities to minimise variances in care and encourage a shift towards best practice has been launched covering 5 major Health Resource Groups (HRGs). This is the first in a series of easy to use *"Focus On…"* publications that will help the NHS provide better patient care more efficiently.

2. *Procurement*

- Price reductions for branded (PPRS) and generic drugs effective in 2004 and early 2005 have realised £697m, rising to an annual £975m by March 2006,
- Recently renegotiated national procurement contracts for NHS supplies and services are already providing annualised savings of £90m.
- The first 3 regional procurement hubs have been established successfully and cover over 15% of NHS organisations.

3. *Shared Services*

- The Shared Services Joint Venture Company established in April 2005 now has service contracts with over 60 NHS organisations for the processing of financial transactions. A service for payroll processing has recently been established.

4. *Public Funding & Regulation (PFR)*

- Local NHS proposals for restructuring and reducing the number of SHAs and PCTs are now being reviewed and assessed. The programme is on track for completion by March 2007 realising operating cost reductions of at least £250m per year.
- The first phase of NHS Arms Length Bodies reduction and restructuring has reduced the number of bodies from 38 to 33. Overall ALB operating costs have reduced by £60m for the current year.

5. *Social Care*

   – Local Authorities achieved over £100m of efficiency gains in Adult Social Care in 2004/05 and predict further significant gains in the current year. A nationally co-ordinated but locally led programme of major business improvement opportunities is being launched to support continued efficiency gains through to 2008.

Expected Progress and Deliverables by March 2006

The Department of Health expects to achieve a further £750m of annual efficiency gains towards our 2008 target. Achievement will be under-pinned by key deliverables in each workstream:

1. *Productive Time*

   Continued process improvement by local organisations under-pinned by the ISIP framework resulting in further reductions in length of stay and emergency bed days.

   Inclusion of financial gains accruing from improvements in service quality and patient outcomes.

   Development of comprehensive performance benchmarking providing organisations with information to identify scope for service improvement and efficiencies.

   Development and launch of a further set of improvement guides for key Health Resource Groups.

2. *Procurement*

   Completion of 2nd Wave of national contracts procurement and increased local uptake of existing contracts supported by benchmarking information.

   Establishment of 2nd Wave of regional procurement hubs.

3. *Corporate Services*

   Completion of opportunity analysis for extending Shared Service provision to HR processes, and continued sign up of NHS organisations to the service.

4. *Social Care*

   Launch of 3 major business improvement opportunities – Homecare Monitoring, Contact Centres and Direct Payments – enabling Local Authorities to build on gains achieved to date.

5. *Public Funding & Regulation*

   Further reduction in ALBs from 33 to 26 in March 2006.

Confirmation of new SHA & PCT structure and completion of key appointments.

6. *Central Budgets*

Review of central budgets and reallocation of released funding to take effect from March 2006.

Reduced Civil Service Headcount

The Department committed to a gross reduction of 1,440 full time equivalent civil servant posts in the central departments through its Change Programme launched in early 2004. Of these half (720) were transfers to other NHS Bodies and half (720) were net reductions as defined in the Gershon target.

The Change Programme is now complete except for a small number of outstanding transfers. At September 2005, the net reduction in full time equivalent headcount is 695. (This is subject to formal verification with HM Treasury).

Lyons Relocations

The Department is committed to the relocation of 1,180 posts out of London & South East by March 2010.

By September 2005, 343 relocations had been completed comprising: Healthcare Commission (129 posts to Manchester, Bristol, Leeds and Nottingham), General Social Care Council (103 posts to Rugby), NHS Connecting for Health (75 posts to Leeds).

Relocation processes are underway for posts in the NHS Institute, Health & Social Care Information Centre and NHS Professionals. These will all be complete by March 2006, increasing completed Lyons relocations to around 600.

Annex A
Departmental Public Service Agreement Targets (SR2002) Analysis

Further to the 1998 and the 2000 Spending Reviews, the 2002 Review continued the process of delivering improvements in services, through the innovation of Public Service Agreement targets. The targets from that Review are laid out in the table below with updates on progress.

Objective I: Improve Service Standards

PSA Targets	Measure	Progress
Target 1: Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to 3 months by 2008.	**Number of patients on NHS waiting lists.**	**Outpatient Waiting Times – on course** Number of English residents waiting more than 4 months (17 weeks) – Quarterly figures • September 2002 – 111,502 • September 2003 – 34,170 • September 2004 – 148 • September 2005 – 229[1] Number waiting more than 3 months (13 weeks) – Quarterly figures • September 2002 – 257,613 • September 2003 – 160,745 • September 2004 – 77,537[3] • September 2005 – 39,205 **Inpatient Waiting Times – on course** Number of English residents waiting more than 9 months – Monthly figures • October 2001 – 116,681 • October 2002 – 87,503 • October 2003 – 38,954 • October 2004 – 367[3] • October 2005 – 92[2] Number waiting more than 6 months – Monthly figures • October 2001 – 258,945 • October 2002 – 242,516 • October 2003 – 163,230 • October 2004 – 69,948[3] • October 2005 – 24,812

1 Of the 229 patients who have been waiting over 17 weeks, 121 were waiting for an appointment at English Trusts and 108 were waiting for an appointment at Welsh hospitals.
2 Of the 92 patients who had been waiting over 17 weeks, 86 were waiting for an appointment at English Trusts and 6 were waiting for an appointment at Welsh hospitals.
3 Figures revised since publication of Autumn Performance Report 2004

PSA Targets	Measure	Progress
Target 2: Reduce to 4 hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004; and reduce the proportion waiting over 1 hour. Note: After discussions with clinicians' representatives in December 2003, the Department agreed that there were certain exceptions where only an A&E department offered the facilities and expertise most suited to a patient's condition and that such a patient might reasonably need to stay longer than 4 hours. These cases are considered clinical exceptions to the target and the Department agreed that it would consider providers to be meeting the target from January 2005 if they ensured that at least 98% of patients stayed less than 4 hours – 2% has been allowed for clinical exceptions.	**Waiting time for patients in A&E departments, Walk-in Centres and Minor Injury Units.**	**A&E Waits – on course** During July to September 2005, 99% of all attenders were admitted, transferred or discharged within 4 hours of arrival.
Target 3: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.	**PCT performance is measured through the Local Delivery Plan Return (LDPR)** and has previously been reflected in the PCT performance ratings. The Primary Care Access Survey is one of the LDPRs and requires PCTs to contact all of their practices on a specific day to monitor the national access target.	**Primary Care Access – on course** The results of the November 2005 survey showed that nationally: • 99.2% of patients were able to be offered a GP appointment within two working days • 99.3% of patients were able to be offered a primary care professional appointment within 1 working day. The Department is now developing an improvement plan which will include broadening the scope of the 24/48hr Access Target to include advance booking, improvements to the current reporting system and ensuring there are responsive telephone systems in place. Strengthened checks will include tighter monitoring by Primary Care Trusts (PCTs) through varying monthly survey dates, a sample check of PCT data and introducing local patient surveys.

PSA Targets	Measure	Progress
Target 4: Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.	**DH monthly central data collection** measures percentage of patients given the opportunity to choose most convenient date from a range of dates.	**Booking – early stages of delivery** Figures for September 2005 show that there has been a percentage point increase of 0.3% in the number of day cases booked over the past year. • September 2003 – 76% • September 2004 – 98% • September 2005 – 98.3% The number of inpatients' appointments booked (day cases & ordinary admissions) has increased by a percentage point change of 3.8% over the past year. • September 2003 – 64% • September 2004 – 92% • September 2005 – 95.8% Outpatient booking has increased over the past year; by a percentage point change of 7.1%. • September 2003 – 40% • September 2004 – 80% • September 2005 – 87.1% We are confident that the service will be able to deliver the PSA target. **Electronic booking** The "Choose and Book" initiative, which enables patients to book initial hospital appointments from the GP surgery at a time and place of their choice, was launched in Summer 2004. The emerging rate of implementation will see the continued roll out of Choose and Book through 2006. **Choice – on course** By the end of the year all eligible patients will be offered the choice of at least 4 providers at the point of GP referral to consultant-led first outpatient appointments. Some patients are already benefiting from choice of hospital. Patients waiting longer than 6 months for elective surgery are now offered the choice of having faster treatment at an alternative provider. Since April 2004 72,806 patients have accepted such a choice of offer. Since January 2005, cataract patients have been offered the choice of 2 or more providers at the point of referral. From April 2005, patients needing cardiac surgery have been given the choice of 2 or more providers at the point of referral by the cardiologist.

PSA Targets	Measure	Progress
Target 5: Enhance accountability to patients and the public and secure sustained national improvements in patient experience as measured by independently validated surveys.	**Results of surveys administered by the Commission for Healthcare Audit and Inspection** (now known as the Healthcare Commission).	**Enhanced accountability** We have taken the opportunity of the *'Your Health, Your Care, Your Say'* consultation to take a strategic look at patient and public involvement to ensure that future patient, user and carer involvement, as well as public engagement is as fit for purpose as possible. This review has been wide-ranging, considering existing arrangements as well as what will best fit the patient-led NHS we are working towards. We want to build on the best of what forums deliver, as well as the excellent work of overview and scrutiny committees and the involvement activity currently developing throughout the NHS and social care settings. As a result of the review, we have deferred the abolition of the Commission for Patient and Public Involvement in Health (CPPIH) from August 2006 to summer 2007. Our plans to reduce the number of forums to 1 per Primary Care Trust and to transfer the appointment of forum chairs and other CPPIH functions to the NHS Appointments Commission have been put on hold, pending the outcome of the review. The results of the review will feed into the White Paper due to be published at the turn of the year. **Surveys – on course** **See SR2004 PSA Target 7**

Objective II: Improve Health and Social Care Outcomes for Everyone

PSA Targets	Measure	Progress
Target 6: Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75.	**Death rate** from heart disease, strokes and related illnesses amongst people aged under 75. Death rate from cancer amongst people aged under 75. Both using ONS mortality statistics age standardised to allow for changes in the age structure of the population.	**on course** **See SR2004 PSA Target 1**

PSA Targets	Measure	Progress
Target 7: Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and CAMHS services, and reduce the mortality rates from suicide and undetermined injury by at least 20% by 2010.	**Annual mapping of CAMHS to monitor success.** For crisis services there are 2 main forms of measurement: i). Number of patients who are subject to at least 1 consultant episode (acute home-based) per annum is measured. ii). Number of Crisis Resolution teams established.	**Access to CAMHS – continuing progress** The main findings of the 2004 CAMHS Mapping exercise were: • reported spend on CAMHS increased by 26.8% from 2003/04 to 2004/05 • the number of CAMHS with on-call arrangements changed from 54 out of 130 (57%) in 2003 to 78 out of 139 (56%) in 2004. • the number of CAMHS providing specialist services for children with Learning Disabilities increased from 48 out of 130 (37%) in 2003 to 62 out of 139 (45%) in 2004 • 677 out of 989 (68.5%) CAMHS Teams had an upper age limit of 17 or over • the CAMHS Workforce increased by 14.6% compared with 2003. **Access to Crisis Services – key delivery point** The key enabler for improving access to crisis services is the implementation of sufficient numbers of Crisis Resolution Teams and their achieving the full caseload. Number of Crisis Resolution Teams now in place: • September 2002 – 62 • March 2003 – 102 • September 2003 – 137 • March 2004 – 179 • September 2004 – 212 • March 2005 – 343 Number of people receiving crisis resolution services: • 2002/03 (Q4 2002/03) – 28,500 • 2003/04 (Q4 2003/04) – 45,800 • 2004/05 (Q4 2004/05) – 68,800 • 2005/06 (Q2 2005/06) – 48,800[2] [2]Due to definitional issues some data has been estimated
	Death rate from suicide and undetermined injury. Baseline of 9.2 deaths per 100,000 population for the 3 years 1995 to 1997. Note: the baseline has been revised on the basis of better population information from the national census.	**Suicide and Undetermined Injury – encouraging reduction but more rapid decline required in future years** **See SR2004 PSA Target 1**
Target 8: Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.	**Those people receiving more than 10 contact hours of home care and 6 or more visits per week** divided by the population of people supported by councils in residential care and nursing homes.	**Older People Supported Intensively to Live at Home – met** **See SR2004 PSA Target 8**

PSA Targets	Measure	Progress
Target 9: Reducing the under-18 conception rate by 50% by 2010.	**The under-18 conception rate** is the number of conceptions to under 18 year olds per 1,000 females aged 15-17. Baseline year is 1998.	**Under-18 Conception Rate – encouraging reduction but more rapid decline required in future years** **See SR2004 PSA Target 3**
Target 10: Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 and increase year-on-year the proportion of users successfully sustaining or completing training programmes.	**Annual returns from the National Drug Treatment Monitoring Service (NDTMS)**, which provides details on the number of drug misusers entering, in, successfully completing and sustaining treatment.	**Participation in Drug Treatment Programmes – on course** **See SR2004 PSA Target 6** Annual data for 2004/05 shows that there has been a 89% increase in the participation of problem drug users in drug treatment programmes since the baseline year of 1998.
Target 11: By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.	**Mortality in infancy by social class:** the gap in infant mortality between "routine and manual" groups and the population as a whole. Life expectancy by Local Authority: the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. Baseline year is average of 1997, 1998 and 1999.	**Challenging target, further work required on delivery chain** **See SR2004 PSA Target 2**

Objective III: Improve Value for Money

PSA Target	Measure	Progress
Target 12 Value for money in the NHS and personal social services will improve by at least 2% per annum, with annual improvements of 1% in both cost efficiency and service effectiveness.	**Value for money based on unit costs of procedures and services**, adjusted for quality, underlying inflation and mix of cases. Service effectiveness element of target based on quality indicators published by the Department.	**Value for Money – too early to assess** To measure progress against value for money targets, the Department of Health has developed an interim value for money measure which measures value for money in terms of improvements in cost efficiency. In 2003/04 this measure suggests that value for money through cost efficiency increased by 2.1%. The Department, in conjunction with the Office for National Statistics (ONS) and the Atkinson Review team, has developed a new measure for adult social services output. We will continue to work with ONS to develop a cost efficiency measure based on the work already completed. The new output measure takes account of changes in quantity but not quality of care. The Personal Social Services Research Unit (PSSRU) at the University of Kent and London School of Economics has been commissioned to develop a further measure of output taking account of changing quality of care and client dependency. This research will report later in the year.

Departmental Public Service Agreement Targets Analysis – SR2000

The majority of SR2000 targets were subsumed within the SR2002 targets and details were given in previous performance reports.

Of those 3 targets that were not carried forward, target 6 was met and final reporting has taken place, responsibility for target 7 now lies with DfES, and target 10 is reported on here.

Objective II: Improving patient and carer experience of the NHS and Social Services

Objective V: Value for money

PSA Target	Measure	Progress
Target 10	**Reference Cost Index**	**Reference Cost Index – on course**
The cost of care commissioned from Trusts that perform well against indicators of fair access, quality and responsiveness, will become the benchmark for the NHS. Everyone will be expected to reach the level of the best over the next 5 years, with agreed milestones for 2003/04.		The NHS Trust National Reference Cost Indices for 1999/00, 2000/01, 2001/02 and 2002/03 provide evidence on the extent to which variation in performance is reducing. The dispersion of costs between NHS Trusts as measured by the coefficient of variation of the trimmed market forces factor adjusted Reference Cost Index (RCI) for NHS Trusts, has been decreasing. The coefficient of variation (defined as standard deviation divided by mean) has fallen from 24% in 1999/00, to 21% in 2000/01, to 17% in 2001/02; to 15% in 2002/03, and to 12% in 2003/04.

Departmental Public Service Agreement Targets Analysis – SR1998

Targets 1, 2, 5, 13 and 20 have been subsumed into SR2002 targets. Final reporting took place in the Autumn Performance Report 2003 and Departmental Report 2004 with regards to the majority of the other targets; information on those that remain live, targets 3, 4 and 32, is given below

Objective I: To reduce the incidence of avoidable illness, disease and injury in the population

PSA Target	Measure	Progress
Target 3 Reduction in the death rate from accidents by at least 20% by 2010, from a baseline of 15.9 per 100,000 population for the 3 years 1995 to 1997.	**Death rate from accidents and adverse effect.**	**Slippage** Data for 2002-04 (3 year average) show a rate of 15.9 deaths per 100,000 population – a rise of 1.0% from the baseline (1995-97).
Target 4 Reduction in the rate of hospital admission for serious accidental injury by at least 10% by 2010, from a baseline estimate of 315.9 admissions per 100,000 population for the financial year 1995/96.	**Rate of hospital admission for serious accidental injury** requiring a hospital stay of 4 or more days.	**Slippage** These data are single financial year figures, available annually. Single year data for financial year 2003/04 show a rate of 330.1 admissions per 100,000 population – an increase of 4.5% from the baseline estimate (1995/96).

Objective IV: To manage the staff and resources of the Department of Health so as to improve performance.

PSA Target	Measure	Progress
Target 32 As part of the new Framework for Managing Human Resources in the NHS, targets for managing sickness absence have been set consistent with the Cabinet Office recommendations of a reduction of 20% by April 2000. Performance improvement on targets will also be set for NHS Trusts on Managing Violence to Staff in the NHS aimed at reducing the levels of absence due to sickness or injury caused by violence.	**Measurement of the time staff are absent from work** as a proportion of staff time available.	**No change** Sickness figures are no longer collected as part of the NHS Performance Ratings. The Department of Health NHS sickness absence survey 2004 found that sickness absence rate, defined as the amount of time lost through absences as a percentage of staff time available, was 4.6%. Over 99% of NHS organisations took part in the survey. This figure has remained virtually unchanged since 2000. Targets were set for managing violence: To reduce the number of incidences by 20% by the end of 2001/02; and, To reduce the number of incidences by 30% by the end of 2003/04. In November 2003 the NHS, supported by the NHS Security Management Service, introduced a comprehensive framework of measures to tackle violence against NHS staff. In 2004/05 it is estimated that 85,000 frontline NHS staff received training on how to prevent and manage violence. In the same period the number of identified criminal sanctions taken against those that had physically assaulted staff rose from 51 in 2002/03 to 759. In 2002/03 there were 59,992 reported incidents of violence in NHS mental health and learning disability environments. In 2004/05 the number of physical assaults against staff working in mental health and learning disability environments was measured at 43,309. Figures for the number of physical assaults in the acute, primary care and ambulance sectors for the period 2004/05 will be published in early 2006. The Healthcare Commission's staff survey in 2004 saw a 1% reduction in NHS staff experiencing abuse and violence over that reported for 2003.

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